STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365826	A. Building B. Wing	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure Residents #45 and #235's authorization to manage funds were witnessed by a person not affiliated with the facility in any manner. This finding affected two residents (#45 and #235) of five residents reviewed for personal fund accounts. The facility census was 84. Findings include: 1. Review of Resident #45's medical record revealed she was readmitted on [DATE] with diagnoses including acute respiratory failure, diabetes, and difficulty in walking. Review of Resident #45's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she exhibited intact cognition. Review of Resident #45's undated Authorization and Agreement to Handle Resident Funds form indicated the resident signed the form, and the form did not contain a witness signature as required. 2. Review of Resident #235's medical record revealed he was admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, vascular dementia, and metabolic encephalopathy. Review of Resident #45's MDS 3.0 assessment dated [DATE] revealed he exhibited severe cognitive impairment. Review of Resident #235's undated Authorization and Agreement to Handle Resident Funds form revealed the power-of-attorney signed the form, and the form did not contain a witness signature as required. Interview on 02/27/23 at 8:20 A.M. with Human Resources #821 confirmed Residents #45 and #235's Authorization and Agreement to Handle Resident Funds forms were not witnessed as required.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to disperse Resident #136's funds following discharge from the facility in a timely manner. This finding affected one resident (#136) of five residents reviewed for personal fund accounts. The facility census was 84. Findings include: Review of Resident #136's medical record revealed she was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes, and anxiety disorder. Review of Resident #136's undated Authorization and Agreement to Handle Resident Funds form revealed she had a resident fund account. Review of Resident #136's progress note dated 12/30/22 at 12:05 A.M. revealed she was observed without vital signs and hospice was made aware. Review of Resident #136's medical record revealed a check to the State of Ohio Attorney General's Office in the amount of $1,213.63 (one thousand two hundred thirteen dollars and sixty-three cents) was mailed on 02/27/23. Interview on 02/27/23 at 8:20 A.M. with Human Resources #821 confirmed Resident #136's resident funds were not dispersed because she was waiting on any pending charges from the corporate office.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on medical record review, staff interview, and facility policy review the facility failed to ensure advanced directives were present in the electronic medical record (EMR), paper medical record (PMR), and failed to ensure physicians orders were in place for Resident #285. The facility also failed to ensure advance directives were updated per care plan for Resident #337. This affected two residents (#285 and #337) of two reviewed for advance directives. Findings include: 1. Review of the EMR revealed Resident #285 was admitted to the facility on [DATE] with diagnoses including anxiety, human immunodeficiency virus (HIV), type two diabetes, and chronic kidney disease. Review of the EMR and PMR revealed Resident #285 had no documented advance directives in place. Observation of Resident #285's EMR, PMR, and physician orders on [DATE] at 4:26 P.M. with Registered Nurse (RN) #447 revealed no documented advance directives. Interview on [DATE] at 4:26 P.M. with RN #447 revealed Resident #285 did not have advance directives located in the EMR, PMR, or physician orders. RN #447 revealed she would need to alert the Director of Nursing (DON) #2 and start an audit of her own. RN #447 revealed Resident #285 had been in the facility for at least five days. Review of the facility document titled Advance Directives, revised [DATE], revealed the facility had a policy in place that advance directives would be respected in accordance with state law and facility policy. Further review of the policy revealed information about whether or not the resident had executed an advance directive would be displayed prominently in the medical record. Review of the document revealed the facility did not implement the policy. 2. Review of the closed record for Resident #337 with an admitted [DATE] and date of death in facility as [DATE] revealed his diagnoses included diabetes, chronic ischemic heart disease, dementia, and atrial fibrillation. Review of the Do Not Resuscitate (DNR) Order Form, dated [DATE], revealed Nurse Practitioner (NP) #969 changed Resident #337's code status to a DNR- Comfort Care-Arrest (DNR-CCA). Review of the care plan dated [DATE] revealed Resident #337 was a full code per resident's wishes. Interventions included staff would initiate cardiopulmonary resuscitation (CPR) until emergency services arrived, advance directives would be placed in chart, and call emergency services for help. Review of the Physician Orders for [DATE] revealed Resident #337 had an order dated [DATE] that revealed his code status was DNR-CCA. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 1:35 P.M. with Minimum Data Set (MDS)/ RN #824 verified Resident #337's care plan was not revised to reflect Resident #337's accurate code status. Review of the policy labeled, Advance Directives, last revised on [DATE], revealed advance directives would be respectful in accordance with state and facility policy. The policy revealed the plan of care for each resident would be consistent with his or her documented treatment preferences and/ or advance directives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on staff interview, record review, and facility policy review the facility failed to maintain a safe, comfortable and homelike environment for residents when the facility failed to prevent a staff-to-staff altercation witnessed by residents. In addition, the facility failed to ensure Resident #64's enteral feeding equipment was maintained in a clean and sanitary manner. This affected 26 residents (#11, #12, #13, #17, #18, #19, #21, #22, #25, #27, #28, #31, #33, #46, #49, #52, #56, #57, #60, #64, #68, #69, #72, #73, #76 and #79) of 84 residents residing in the facility. Findings include: 1. Interview on 02/07/23 at 3:10 P.M. with the Administrator revealed within the last two weeks, two agency staff were given a Do Not Return (DNR) on the spot. The Administrator revealed the agency staff refused to leave the building, and the Manager on Duty (MOD) had to call the police to remove them from the facility. Interview on 02/07/23 at 3:15 P.M. with the Director of Nursing (DON) revealed she was unable to recall the agency staff that received a DNR but verified there was a staff-to-staff altercation witnessed by the residents. Interview on 02/08/23 at 3:20 P.M. with Resident #52 revealed she was present when staff were arguing on the [NAME] Memory Care Unit on 01/28/23. Resident #52 revealed the local police department arrived to assist with the situation to remove the staff from the building. Resident #52 revealed there were also other staff present during the staff-to-staff altercation and other residents asking if it was safe to be in the facility. Interview on 02/08/23 at 3:27 P.M. with Dietary Manager (DM) #808 revealed she was present during the staff-to-staff altercation on 01/28/23. DM #808 revealed she was called to the memory care unit on 01/28/23 to assist with escorting two agency staff from the building. DM #808 revealed residents (#11, #12, #13, #17, #18, #19, #21, #22, #25, #27, #28, #31, #33, #46, #49, #56, #57, #60, #68, #69, #72, #73, #76, #79) located on the memory care unit (including Resident #52) were present during the staff-to-staff altercation and when the local police department entered the facility to assist with removing the staff. DM #808 revealed Former Scheduler (FS) #867 was involved. DM #808 revealed FS #867 came to the kitchen and requested assistance with removing Agency Staff (AS) #451, #452, and #453 from the facility. DM #808 revealed FS #867 and AS #451, #452, and #453 were loudly exchanging words in front of residents on the memory care unit. DM #808 revealed FS #867 asked if she could help walk AS #451, #452, and #453 out the building. DM #808 revealed, although she was not present, FS #867 stated she had pushed AS out of her office, slammed her door, and asked them to leave. Review of the local police department (LPD) incidental (call) supplement report revealed the LPD responded to the facility for the report of employees arguing. LPD spoke with FS #867, who reported, she asked three AS employees to leave the premises after she alleged, they failed to perform their job adequately. LPD spoke with AS #451, #452, and #453 who stated FS #867 was not authorized to ask employees to leave, but a verbal disagreement did take place. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled Manager on Duty, dated January 2023, revealed FS #867 was the manager on duty on 01/28/23. Review of the facility document titled Resident Rights, revised December 2016, revealed the facility had a policy in place that residents shall be treated with kindness, respect, and dignity. Review of the undated facility document titled Violence in the Workplace revealed the facility had a policy in place of zero tolerance towards violence in the workplace. Interview on 02/07/23 at 3:10 P.M. with the Administrator revealed there was no internal investigation and verified the above findings. 43063 2. Review of the medial record for Resident #64 revealed an admitted [DATE] with diagnoses including hypertension and diabetes mellitus. Review of the physician's order dated 02/14/23 revealed Resident #64 was on enteral tube feeding continuously at 60 milliliters per hour. Observations on 02/21/23 at 8:51 A.M., 02/22/23 at 10:21 A.M., and on 02/23/23 at 8:20 A.M., revealed dried brown crusty debris on the enteral tube feeding pole base and on the floor beside and below the enteral tube feeding pole. These areas were directly below where the liquid enteral tube feeding containers were hanging. Interview on 02/23/23 at 8:20 A.M. with Licensed Practical Nurse (LPN) #449 verified the floor and enteral tube feeding pole's base was covered in dried brown crusty debris. LPN #449 stated it had to come from weeks of the tube feed dripping on the floor and pole base. Review of the facility policy titled, Cleaning and Disinfection of Environmental Surfaces, revised June 2009, revealed housekeeping surfaces such as floors and tabletops would be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. This deficiency represents non-compliance investigated under Complaint Number OH00139613.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review, and facility policy review the facility failed to address grievances and/ or concerns voiced by residents and families. This affected three residents (#8, #34, #52) out of three residents reviewed for grievances and affected seven residents (Resident #23, #42, #44, #48, #52, #71, and #81) that attended resident council meetings. The facility census was 84. Findings include: 1. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes, morbid obesity, and congestive heart failure. Review of the care plan dated 06/02/22 revealed Resident #52 had an alteration in elimination. She was incontinent of bowel and bladder. Interventions included incontinence care as needed and monitor skin for redness and irritation. Review of the resident council meeting minutes dated 11/29/22 and completed by Activities #803 revealed residents had concerns of not receiving proper care and/ or respect. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #52 had intact cognition. She required extensive assist of two staff with bed mobility. She was totally dependent of two staff with toileting and transfers. She was always incontinent of bowel and bladder. Review of an email dated 01/17/23 at 8:28 P.M. from Licensed Practical Nurse (LPN) #820 to Regional Director of Clinical Services #859 revealed LPN #820 had gone to answer Resident #52's call light and she had expressed that she was waiting to be changed. The email noted that State tested Nurse Aide (STNA) #856 had answered her call light on 01/17/23 at 6:30 P.M. and turned her call light off and stated she would return. The email noted LPN #820 revealed she asked STNA #856 to answer her call light. The email noted she followed up with Resident #52 who stated STNA #856 had not provided incontinence care. The email revealed Resident #52 was lying in bowel movement for an hour, and STNA #856 left the facility without changing the resident. Review of the facility investigation dated 1/20/23 and completed by Regional Director of Clinical Services #859 revealed on 01/17/23 she had received a message by email from LPN #820 regarding Resident #52 not being changed timely by STNA #856. The investigation revealed on 01/18/23 Regional Director of Clinical Services #859 spoke with Former LPN/ Unit Manager #971, and he had returned information that she did get changed. The investigation revealed on 01/20/23 Regional Director of Clinical Services #859 interviewed Resident #52 and said she got changed at shift change and she reported no further concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Complaint/ Grievance Report, dated 01/25/23, and completed by Activities #803 revealed during the resident council meeting, residents voiced concerns that aides were treating them terribly and care needs were not being met. The form revealed call lights were not being answered and they were being left soiled. The form revealed the Director of Nursing (DON) responded on the grievance form on 01/30/23 that she interviewed residents and in-serviced staff. The form also revealed nursing rounds would be done daily by supervisors to ensure residents needs were met. Interview on 02/06/23 at 9:48 A.M. and on 02/07/23 at 11:02 A.M. with Resident #52 revealed it took about five to six hours to get changed most of the time. She revealed she would activate her call light, and when staff answered her call light she would ask to get changed, staff would say they would be back but did not return for several hours. She revealed on 02/05/23 she was not changed for over 12 hours even though she had asked several times. She revealed several weeks ago STNA #856 had answered her call light at approximately 6:30 P.M. and said she would be back, but she never returned. She revealed she notified LPN #820 and she stated she would have STNA #856 change her. She revealed STNA #856 never changed her as she left the facility at the end of her shift. She revealed she did not end up getting changed until approximately 8:00 P.M. She revealed that LPN #820 stated she would notify management regarding what happened but that no one had followed up with her regarding the incident including Regional Director of Clinical Services #859, Administrator and/ or DON, and/ or Former LPN/ Unit Manager #971. Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed she had reported an incident she felt was neglect a few weeks ago as STNA #856 had answered Resident #52's call light and Resident #52 asked to be changed. STNA #856 stated she would be back. LPN #820 revealed Resident #52 reported to her that she needed changed, so she had instructed STNA #856 to change Resident #52, but STNA #856 had never changed Resident #52 and left the facility. She revealed she reported the incident to Regional Director of Clinical Services #859 in writing but did not feel anything was done about it. She revealed she witnessed this occur multiple times especially from the agency staff as they would sit behind the nursing station and not assist the residents with incontinence care. Interview on 02/07/23 at 9:34 A.M. with Regional Director of Clinical Services #859 revealed she had never received an email and/ or anything in writing from any staff member regarding Resident #52 not being changed in a timely manner, including a staff member leaving the facility after Resident #52 had requested to be changed and a nurse requesting the staff change her. Interview on 02/07/23 at 12:40 P.M. with Regional Director of Clinical Services #859 revealed she had found an investigation she had completed on 01/17/23 regarding the complaint Resident #52 and LPN #820 had made. She stated she had forgotten about it until she was looking through her stuff. She verified the complaint/ concern was not placed on the grievance log. Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held resident council meetings monthly. She revealed on 11/29/22 several residents, including Resident #52, revealed they had not received proper care including timely incontinence care. She revealed on 01/25/23 residents complained of being left soiled, and this included Resident #52. She revealed the facility had not had consistent management and it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting, but she felt the issues were not addressed as the same concerns continued monthly especially from Resident #4 not being provided timely incontinence care. She revealed she felt the residents were losing her trust to voice their concerns to as it felt the concerns were not addressed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 02/08/23 at 8:32 A.M. revealed Resident #52 had her call light on, and there was a strong odor of urine and bowel movement coming from her room. She had tears in her eyes and stated, it is happening again as her call light had been on since 7:45 A.M. as she needed changed as she was lying in a soiled mess. She stated she had a bowel movement, and her skin was burning. Observation on 02/08/23 at 8:46 A.M. revealed the Administrator answered Resident #52's call light, and she had explained to him she needed changed. He had asked what nursing station she was assigned to (since her room was in the middle of the two nursing stations). He proceeded to the nursing station and left her call light on. Observation on 02/08/23 at 9:14 A.M. revealed Agency STNA #862 answered Resident #52's call light and she again stated she needed changed. Agency STNA #862 informed Resident #52 she would tell her aide and proceeded to notify STNA #833. Observation on 02/08/22 at 9:22 A.M. revealed STNA #833 walked into Resident #52's room and told Resident #52 she had to collect breakfast trays and then would provide her incontinence care. Observation on 02/08/22 at 9:34 A.M. of incontinence care completed by STNA #833 and STNA #857 for Resident #52 revealed she had excoriation with redness on her peri area and excoriation with bleeding and redness to her buttocks. Resident #52's brief was heavily saturated with urine and there was a large brown dried ring on her bottom sheet. She was incontinent of large amount of bowel movement. STNA #833 verified the above findings. Resident #52 stated she had not been changed since 5:30 A.M. STNA #833 revealed there had been only one aide on the unit on night shift and that she was not able to get to Resident #52 prior. 2. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including dementia, mild protein calorie malnutrition, hypertension, and congestive heart failure. Review of the Treatment Administration Record (TAR) for January 2023 revealed Resident #8 was to have a daily weight upon rising in the morning due to fluid retention and congestive heart failure. The TAR revealed the weight was to be obtained only by a mechanical lift. The documentation revealed a daily weight was not obtained on 01/04/23, 01/05/23, 01/07/23, 01/10/23, 01/12/23, 01/13/23, 01/15/23, 01/16/23, 01/17/23, 01/19/23, 01/24/23, 01/25/23, 01/27/23, and 01/30/23. Review of the Dental Progress Note dated 01/09/23 and completed by Dentist #863 revealed he completed a periodic exam for Resident #8. He revealed she had no natural teeth, and her dentures were well fitting. Review of the care plan dated 01/09/23 revealed Resident #8 was at risk for oral and dental health problems related to dentures. Interventions included coordinate arrangements for dental care, monitor and document signs of oral problems, and provide mouth care. Review of the annual MDS 3.0 dated 01/16/23 revealed Resident #8 had impaired cognition. She required total dependence of two staff with bed mobility and transfers. She was unable to ambulate. She required extensive assist of one staff with personal hygiene and limited assist of one staff with eating. She had no natural teeth. Her weight was 200 pounds, and she had weight loss. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nutritional assessment dated [DATE] and completed by Dietitian #866 revealed Resident #8 was on a mechanical soft diet with a supplement at dinner. She had a history of weight fluctuations and was to have a daily weight. Review of the facility form labeled, Complaint/ Grievance Report, dated 01/23/23, and authored by Licensed Social Worker (LSW) #819 revealed a Cardiologist #950 progress note dated 01/19/19 was attached to the concern form that revealed Resident #8 was to be weighed every morning after urinating and before eating breakfast. The consult stated contact the physician if her weight went up more than three pounds in one day or five pounds in one week. The concern form revealed under documentation of the investigation there was no response regarding the concern with weights not being obtained. Review of the February 2023 Physician Orders revealed Resident #8 had an order dated 07/29/21 upon rising to have a daily weight and was on a mechanical soft diet. Review of the TAR for February 2023 revealed Resident #8 was to have a daily weight upon rising in the morning due to fluid retention and congestive heart failure. The TAR revealed the weight was to be obtained only by a mechanical lift. The documentation revealed a daily weight was not obtained on 02/01/23, 02/02/23, 02/03/23, and 02/06/23. Review of the care plan last revised 02/02/23 revealed Resident #8 had the potential for alteration in nutrition and hydration related to medical diagnoses of dementia, expected weight loss due to fluid shift, and varied intake. Interventions included daily weights, assess, report any signs of edema, and assist with meals. Observation and interview on 02/06/23 at 12:48 P.M. revealed Resident #8 was up in her wheelchair with a mechanical lift sling underneath her. Resident #8 was unable to report if staff had weighed her prior to getting up and/ or if she had any concerns regarding getting weighed due to her cognitive ability. Interview on 02/06/23 at 1:09 P.M. with Agency STNAs #853 and #854 revealed they worked for agency and that it was their first day at the facility. They revealed they were assigned to care for Resident #8 and assisted her up in her chair but were never informed in report that she required a daily weight. Interview on 02/06/23 at 2:25 P.M. with Agency LPN #852 revealed she was the nurse on Resident #8's unit. She revealed STNA #853, STNA #854 and herself were from agency and that it was all their first day working at the facility. Agency LPN #852 revealed she never received instruction that Resident #8 required a daily weight. Agency LPN #852 verified after review of Resident #8's physician orders that she required a daily weight upon arising, and they had not completed a weight prior to her getting up. (continued on next page)

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Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/06/23 at 3:50 P.M. with Resident #8's daughter revealed she was to have a daily weight as this was what her previous Cardiologist #950 had requested. She revealed she had provided the facility the consult as well as voiced her concern that Resident #8 was not getting weighed daily as ordered, but the facility continued to not follow the order. She revealed she had brought up the concern to several management staff including the Administrator. She also revealed she had visited several times when her mother was eating and that the facility had not placed her dentures inside her mouth causing difficulty for Resident #8 to eat. Resident #8's daughter revealed she had brought this concern up many times to the administration, but the problems continued to occur. Observation on 02/07/23 at 8:55 A.M. revealed Resident #8 was in her bed with her breakfast tray in front of her. She was trying to bite into an English muffin and was having difficulty biting a piece off as she did not have dentures in her mouth. Observation revealed her dentures were in the bathroom in the denture cup. She then proceeded to set the English muffin back down without taking a bite and closed her eyes not attempting to eat any further. Interview on 02/07/23 after the observation with STNA #818 revealed she had provided Resident #8 her breakfast tray. She verified she had not provided Resident #8 her dentures prior to providing her tray and stated, Yes, she should have had her dentures in for breakfast. Interview on 02/07/23 at 3:12 P.M. with the DON verified daily weights were not being completed for Resident #8. She revealed she was not aware Resident #8 required a daily weight as she had only worked at the facility for three weeks. She revealed she was unsure how it was communicated to staff which residents required a daily weight but would assume staff would get that information in report. Interview on 02/07/23 at 4:12 P.M. with LSW #819 revealed Resident #8's daughter had brought up the concern in the care conference on 01/23/23 regarding Resident #8 not being weighed daily as ordered. He revealed Resident #8's daughter had brought in an old cardiologist consult as well as stated that Resident #8 had a current physician order for a daily weight that was not getting obtained daily. LSW #819 revealed he filled out a concern form regarding the concern Resident #8's daughter brought up which including attaching Cardiologist #950's consult regarding the daily weight. He revealed he communicated the concern to the DON. 3. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including epilepsy (seizures), multiple sclerosis, anxiety, hypertension, and altered mental status. Review of the nursing note dated 12/28/22 at 11:40 A.M. authored by LPN #820 revealed staff had called her down to the nursing station where Resident #34 was observed in her wheelchair bent over leaning to the side. She had a seizure that lasted four minutes. Review of the care plan last revised 12/29/22 revealed Resident #34 had a seizure disorder related to epilepsy. She had a seizure observed on 12/28/22. Interventions included give medications as ordered, ask resident about presence of aura prior to seizure, and provide post seizure treatment including turn to side, and take vital signs after a seizure. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #34 had impaired cognition. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the February 2023 physician orders for Resident #34 revealed she had an order dated 12/28/22 for Brivaracetam (seizure medication) 100 milligram (mg) tablet by mouth every morning and at bedtime due to seizures. Review of the February 2023 Medication Administration Record (MAR) for Resident #34 revealed she had an order for Brivaracetam 100 mg tablet by mouth every morning and at bedtime due to seizures. She was to receive the medication at 8:00 A.M. and 8:00 P.M. Interview on 02/06/23 at 9:06 A.M. with Resident #34's daughter revealed when Resident #34 does not receive her seizure medication in a timely manner she was likely to have a seizure. She revealed the nurses were to administer the medications at exact times every day to prevent her from having seizures as she had discussed this many times with administration. Interview and observation on 02/06/23 at 9:33 A.M. with Resident #34 revealed she was lying in her bed without any seizure activity. She stated she had not received her morning medications today, 02/06/23, but the nurse should be coming soon. Observation and interview on 02/06/23 at 9:36 A.M. revealed Agency LPN #852 was sitting behind the nursing station. Agency LPN #852 was asked by this surveyor if she was going to be administering medications and she stated she was unable at this time as the facility had not provided her with a log in to get into the resident's electronic medical records. She revealed she had notified management of the facility on 02/06/23 at approximately 8:30 A.M. but was unsure who she had notified. She revealed she was waiting for them to return and provide her the log in. Observation and interview on 02/06/23 at 10:15 A.M. of medication administration with Agency LPN #852 revealed Resident #34 had an order to receive Brivaracetam 100 mg tablet by mouth every morning due to seizures. Agency LPN #852 revealed she was not administering Resident #34 her Brivaracetam as it was scheduled for 8:00 A.M. and the facility had not provided her a log in for the electronic medical record until after 9:30 A.M. She revealed she could not start passing her medications then until after 9:30 A.M. and since the medication was ordered for 8:00 A.M. she was past the time that allowed her to administer as she only could administer one hour prior and one hour after the ordered time. She revealed the medication was for seizures but when asked if Resident #34 had active seizures she revealed she was unsure as she did not get that in report. She revealed she was unsure what the policy at the facility was when medications were late as she stated she was from agency so just went by what she felt was right and did not give medications if they were past the scheduled time. She did not state she would notify the physician of omitting the seizure medication. She revealed she had arrived at the facility at 7:00 A.M. as scheduled and usually a facility had the log in available at the front desk for agency staff, but this was the first day she was at this facility and was unsure of their process. She revealed she had looked for a member of management but was told that they usually do not arrive until between 8:00 A.M. to 8:30 A.M. She revealed she finally was able to speak with a management employee on 02/06/23 at approximately 8:30 A.M. as everyone she had asked prior was also from agency but was unsure who it was and explained she did not have a log in and was unable to start her medication administration pass. She revealed she did not receive her log in until after 9:30 A.M. despite Resident #34's medication being due at 8:00 A.M. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/06/23 at 10:45 A.M. with the DON revealed she had not known Agency LPN #852 did not received a log in in a timely manner. She revealed if a seizure medication was late, the nurse should have notified the physician right away and received orders to administer the medication and not just omit a seizure medication. She verified missing a seizure medication wound increase the risk of Resident #34's risk of seizures. She revealed she would have the nurse contact the physician to get an order to administer her seizure medication. Interview on 02/06/23 at 11:06 A.M. with LPN/ Unit Manager #809 revealed she arrived at the facility on 02/06/23 at 8:30 A.M. and was notified by Agency LPN #852 that she had not received a log in to start her medication pass. She revealed she had to take care of a resident regarding a change in condition so was unable to get the log in but had delegated Scheduler #826 to provide Agency LPN #852 a log in. She revealed she was not aware Agency LPN #852 was not provided her log in until after 9:30 A.M. and was not able to start her medication pass until after that time. She revealed she had notified Resident #34's Nurse Practitioner (NP) #969 and received an order to give Resident #34 her Brivaracetam late. Observation and interview on 02/06/23 at 11:10 A.M. of Agency LPN #852 revealed she administered Resident #34 her Brivaracetam 100 mg tablet. She verified she administered the medications three hours and ten minutes past the scheduled time. Review of the nursing note dated 02/06/23 at 1:03 P.M. and completed by LPN/ Unit Manager #809 revealed she was informed by Agency LPN #852 that she was unable to give Resident #34 her seizure medication because it was outside the scheduled time. LPN/ Unit Manager #809 notified NP #969 and received permission to give medication late. Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed Resident #34's daughter had brought it up several times to ensure Resident #34 received her seizure medications timely as she had seizures. She revealed that was why the seizure medication was scheduled at specific times, 8:00 A.M. and 8:00 P.M., on the MAR. She revealed she was recently present when Resident #34 had a seizure. 4. Review of the concern log dated November 2022 to January 2023 revealed multiple concerns including, but not limited to, staffing, patient care, treatment, and staff turnover. Review of concern form dated 12/29/22 revealed concerns from resident council regarding staff and management continuously leaving and the continuity of care. Review of concern form dated 01/25/23 revealed during the resident council meeting residents voiced concerns that aides were treating them terribly and care was not being met. The form revealed call lights were not being answered and they were being left soiled. Review of the resident council meeting minutes dated 11/29/22 to 01/25/23 revealed multiple topics of concern related to staff not giving proper care, respect, too many agency staff, and staff turnover. Review of the resident council meeting minutes dated 11/29/22 revealed residents voiced concerns that aides were not giving proper care or respect. Review of the resident council meeting minutes dated 12/28/22 revealed residents had voiced concern that management was always leaving. Review of the resident council meeting minutes dated 01/25/23 revealed evening night nurses and aides very disrespectful and not doing their jobs. The minutes' revealed residents were frustrated and discouraged. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/06/23 at 9:10 A.M. with the Ombudsman revealed she held a resident/ family council once a month to discuss concerns at the facility, but it was difficult to ensure follow through of the concerns as the facility had majority agency staff that were not consistent as well as multiple changes in management including the Administrator and DON. She revealed often the same concerns continued to be present. Interview on 02/07/23 at 3:12 P.M. with the Administrator and DON revealed any resident, staff and/ or management was able to complete a grievance form. The Administrator revealed the form came to him and he assigned which department head would investigate the concern. He stated after the concern was addressed, the form came back to him for review, and he submitted it to LSW #819 to add to the grievance log and maintain the individual completed grievances. He revealed he had only been at the facility for approximately one month and the DON was at the facility for approximately three weeks. The DON revealed she was not aware there was a previous grievance submitted for Resident #8 to have daily weights as she revealed that was most likely before she started. The Administrator and DON also revealed they were not aware of previous concerns voiced by Resident #8's daughter regarding Resident #8 not having her dentures in when eating. They revealed they were not aware of specific concerns regarding incontinence care not being done in a timely manner. The DON revealed she had unfortunately witnessed herself staff not answering call lights timely, answering call lights but not providing the care requested, and staff (mainly agency staff) on their cellphones instead of providing care. She revealed right now all she could do was attempt to educate on the spot and routinely monitor. Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held resident council meetings monthly. She revealed the facility had not had consistent management and that it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting, but she felt the issues were not addressed as the same concerns continued monthly. She revealed she felt the residents were losing her trust to voice their concerns to as it felt the concerns then were not addressed. Resident council meeting with seven residents (#23, #42, #44, #48, #52, #71, and #81) including Resident #42 (president of resident council) was held on 02/22/23 at 3:48 P.M. with Surveyor #300 and they revealed they felt they brought up concerns to the facility, but that the concerns were not addressed, followed up on and/ or resolved. They revealed they brought up the same concerns over and over in each meeting. They revealed there was a constant change over in management staff, and their concerns were not addressed. Review of the facility policy labeled, Grievances/ Complaints, Filing, dated August 2020, revealed residents and their representatives have a right to file grievances either orally and/ or in writing to the facility staff or to the agency. The policy revealed the grievance would be reviewed and investigated within five working days. The policy revealed the person filing the grievance and/ or complaint would be informed of the findings of the investigation and the action that would be taken to correct the identified findings. This deficiency represents non-compliance investigated under Complaint Numbers OH00139084.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 39973 Based on observation, record review, facility policy and procedure review, and interview the facility failed to ensure residents were provided adequate and timely personal care to prevent incidents of neglect. This resulted in Immediate Jeopardy and actual harm on 02/06/23 when Resident #55, who required extensive assist of two staff for activities of daily living care and was assessed to be always incontinent of bowel and bladder, went from 02/06/23 at 2:00 A.M. to 1:25 P.M. before being provided incontinence care after repeated requests. Resident #55 was observed to be saturated in urine and dried bowel movement on her bilateral thighs area resulting in the development of a Stage II pressure ulcer (partial thickness wound at the epidermis and dermis level) to her left buttock that was bleeding with excoriation and redness surrounding. The Immediate Jeopardy and actual harm continued 02/08/23 when Resident #52, who required total dependence from two staff for incontinence care and was assessed to be always incontinent of bowel and bladder, went from 02/08/23 at 5:30 A.M. to 9:34 A.M. without incontinence care after repeated requests. Resident #52 was found saturated in urine and bowel movement with a dried brown ring on her bottom sheet resulting in excoriation with redness on her peri area and excoriation with bleeding and redness to her bilateral buttocks. The Immediate Jeopardy continued 02/17/23 when 15 residents, Resident #13, #17, #19, #21, #31, #33, #46, #49, #56, #60, #68, #72, #73, #76 and #235, who resided on the [NAME] unit did not receive medication administration, pain assessments or oxygen saturation monitoring due to a lack of staff onsite to provide care. A situation of neglect (that did not rise to an Immediate Jeopardy level) occurred on 02/06/23 when the facility failed to ensure Agency Licensed Practical Nurse (LPN) #852 had access to the Electronic Medical Administration Record (EMAR) to administer medications resulting in a significant medication error for Resident #34 as the resident did not receive her seizure medication timely. A situation of neglect (that did not rise to an Immediate Jeopardy level) occurred on 02/25/23 when STNA staff failed to provide incontinence care timely at the resident's request. Resident #59 was assisted out of bed by staff at approximately 8:00 A.M. The resident then reported to STNA #857 and STNA #475 he needed changed and was told by STNA #475 that she had already cleaned him up before he had gotten up in his wheelchair and told him to roll back that way despite being incontinent of bowel movement. STNA #475 verified she told Resident #59 this as she stated the workload was heavy and she had another resident who needed care. STNA #857 verified she witnessed STNA #475 and Resident #59's interaction and revealed she then assisted Resident #59 with incontinence care and changed him at approximately 9:00 A. M. She confirmed he was incontinent of bowel and urine. Resident #59 revealed he was furious STNA #475 was not going to change him despite being incontinent of bowel and stated the STNA had done this on prior occasions as well. The resident indicated he later left the facility without notifying staff because he was not staying at a facility that treated him in that manner. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This affected three residents (#52, #55 and #59) reviewed for incontinence care, one resident (#34) observed during medication administration, 15 residents (13, #17, #19, #21, #31, #33, #46, #49, #56, #60, #68, #72, #73, #76 and #235) residing on the [NAME] unit and had the potential to affect all 84 residents residing in the facility. On 02/16/23 at 4:57 P.M. the Administrator and Regional Director of Clinical Services #859 were notified Immediate Jeopardy began on 02/06/23 when a lack of staff resulted in situations of neglect of resident care. The Immediate Jeopardy continued on 02/08/23 as a result of continued incidents of neglect of resident care. The Immediate Jeopardy continued on 02/17/23 when there were not enough licensed staff on duty to ensure medications and assessments were completed for residents on the [NAME] unit resulting in resident neglect. The Immediate Jeopardy was removed on 02/22/23 when the facility implemented the following corrective actions: On 02/16/23 at 6:55 P.M. an audit was completed by Unit Manager/ Licensed Practical Nurse (LPN) #974 to ensure that all staff required to use the electronic medical records for medication administration had access. This was verified as completed 02/16/23. On 02/16/23 at 7:59 P.M. the Administrator submitted a Self-Reported Incident (SRI) related to an allegation of neglect involving Resident #52. On 02/16/23 at 11:42 P.M. Resident #55 was assessed by Regional Clinical Nurse #859 for negative outcomes related to the lack of timely incontinence care. Resident #55 refused to have skin assessed despite education and multiple attempts. Resident has treatment order in place to left buttocks which was ordered on 02/07/23 by Wound NP #968. Resident was updated of current treatment regimen to left buttock and verbalized understanding. This was verified as completed 02/16/23. On 02/16/23 at 11:26 P.M. Resident #52 was assessed by Unit Manager/ LPN #974 for negative outcomes related to the lack of timely incontinence care. Resident #52 has a treatment in place to peri area which was ordered on 02/15/23 by Wound Nurse Practitioner (NP) #968. Resident was updated of new treatment regimen and verbalized understanding. On 02/16/23 at 7:00 P.M. a skin assessment was completed on all residents by Unit Manager/ LPN #975 and Unit Manager/ LPN #974, and Regional Clinical Nurse #859 to ensure that timely and appropriate incontinence care was provided, and residents are free from neglect of care needs by staff. On 02/16/23 at 8:00 P.M. facility current staffing levels were reviewed by the Administrator to ensure adequate staffing for the facility. On 02/17/23 at 8:30 A.M. facility staffing levels were reviewed by Administrator to ensure sufficient staffing to meet resident needs. On 02/17/23 at 9:00 A.M. an audit was completed by Unit Manager/ LPN #974 to ensure that all staff required to use the electronic medical records for medication administration had access. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/17/23 at 10:30 A.M. all residents who can be interviewed were questioned on if they have experienced abuse, neglect, exploitation, or misappropriation while in the facility, and if they are receiving timely personal care. Interviews were completed by Administrator, Admissions #806, Environmental Director #842, Human Resources #821, Medical Records/Housekeeping #835, Licensed Social Worker (LSW) #819, Activities #803, and Dietary Manager #808. On 02/17/23 at 11:42 A.M. the Administrator submitted an SRI related to an allegation of neglect for Resident #55. On 02/17/23 at 1:40 P.M. Resident #34 was assessed by Unit Manager/ LPN #974 for negative outcomes related to not receiving a seizure medication in the appropriate time frame. On 02/17/23 at 1:30 P.M. A medication error report was completed by Unit Manager/ LPN #975 including physician notification and family notification for Resident #34. On 02/17/23 at 1:48 P.M. an audit was completed by Regional Nurse #976 on all residents receiving seizure medication to ensure all medications were administered timely. On 02/17/23 at 2:00 P.M. the Administrator, Director of Nursing, Scheduler #826, Unit Manager/ LPN #974, and Unit Manager/ LPN #975 were educated by Regional Director of Operations #977 on adequate staffing levels to provide timely and appropriate care. On 02/17/23 at 2:00 P.M. a staffing meeting was held by the Administrator to review daily schedule and ensure adequate staffing for the facility. On 02/17/23 at 2:15 P.M. an Ad Hoc Quality Assurance and Performance Improvement (QAPI) was completed including Medical Director #978 via phone. On 02/18/23 at 9:20 A.M. current staffing and schedule were reviewed by Scheduler #826, LSW #819, and Regional Nurse #976 to ensure facility was meeting adequate staffing. On 02/18/23 at 1:00 P.M. Scheduler #826 and [NAME] President (VP) of Clinical Services #977 reviewed schedules for 02/18/23-02/20/23. On 02/18/23 at 1:12 P.M. Scheduler #826 sent weekend schedule to Administrator, Regional Nurse #976, VP of Clinical Services #979, Regional Director of Operations #977, VP of Operations #980, and Human Resources #821 to ensure corporate team had access to facility schedules. On 02/18/23 at 2:15 P.M. Regional Nurse #976 posted on-call list and phone numbers at each nurses' station to ensure all staff have contact numbers for any clinical or staffing concerns. The on-call contact list included: Regional Nurse #976, VP of Clinical Services #979, Regional Director Operations #977, and VP of Operations #980. Beginning on 02/18/23 a plan for audits to be conducted by DON/designee daily to ensure all residents receive timely and appropriate incontinence care and medications were given per physician order and electronic medical record access for all required employees for four weeks then weekly for four weeks then ongoing as needed. Audits verified as completed on 02/18/23, 02/19/23, 02/20/23, and 02/21/23. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Beginning on 02/18/23 a plan for resident and/or responsible party interviews to be conducted by the Administrator/designee daily to ensure that all residents remain free from neglect and are receiving adequate and timely personal care. The interviews will be completed with five residents daily for four weeks and then five residents weekly for four weeks then ongoing as needed. Audits verified as completed on 02/18,23, 02/19/23, 02/20/23, and 02/21/23. Beginning on 02/18/23 a plan for audits to be conducted by the Administrator/designee to ensure sufficient staffing to maintain appropriate care for all residents, 5 times weekly for 8 weeks and ongoing as needed. Audits verified as completed on 02/18/23, 02/19/23, 02/20/23, and 02/21/23. Staff education as part of the facility abatement plan was initiated on 02/16/23 and continued through 02/22/23: On 02/16/23 at 9:00 P.M. the interdisciplinary management team (Administrator, Admissions #806, Environmental Director #842, Human Resources #821, Medical Records/Housekeeping #835, Licensed Social Worker (LSW) #819, Activities #803, Dietary Manager #808 with Regional Clinical Nurse #859 began education for staff including clinical topics on timely and appropriate incontinence care, the facility Quality of Life and Dignity policy, answering call lights timely and prevention of pressure ulcer development. Interview with staff on 02/21/23 from 5:05 A.M. to 5:48 A.M. revealed Agency LPN #989, #983, LPN #848, Agency STNA #988, #984, #985, and STNA #990 were not educated prior to working at the facility. On 02/21/23 at 7:45 A.M. Regional Nurse #976 and Administrator notified of staff not educated prior to start of shift. Interviews with staff on 02/22/23 from 9:59 A.M. to 10:12 A.M. revealed LPN #820 and Agency STNA #944 did not receive education prior to working at the facility. On 02/22/23 at 10:25 A.M. [NAME] President of Clinical Services #979 was notified of staff not being educated prior to shift. On 2/22/23 at 1:00 P.M. the facility implemented a plan to ensure a department head would be assigned to each shift change to ensure education was provided to each employee entering the facility prior to working their assignment. Interview on 02/22/23 from 2:02 P.M. to 2:10 P.M. LPN #820 and Agency STNA #944 received education. All findings will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations. Although the Immediate Jeopardy was removed on 02/22/23, 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 action and monitoring to ensure on-going compliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Findings include: 1. Record review for Resident #55 revealed an admitted [DATE] with diagnoses including congestive heart failure, diabetes, chronic kidney disease, morbid obesity, and hypertension. Review of the care plan dated 09/01/20 revealed Resident #55 had an alteration in elimination related to bowel and bladder incontinence. Interventions included check and change every two hours and as needed, monitor for skin redness and irritation, and provide incontinence care as needed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had intact cognition and required extensive assist of one staff with bed mobility and was totally dependent of two staff with transfers. She required extensive assist of two staff with toileting. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no pressure ulcers during the seven-day assessment reference period. Review of the care plan dated 01/24/23 revealed Resident #55 had actual impaired skin integrity from moisture associated skin damage (MASD) to her right thigh. Interventions included provide wound care per physician order and skin assessment per policy. Review of the Braden scale pressure ulcer risk assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #971 revealed Resident #55 was at high risk for pressure ulcers due to her sensory perception was very limited, constantly moist, bedfast, and problem with friction and shear. Review of the February 2023 physician's orders, revealed Resident #55 had an order to cleanse her left and right inner thighs, apply collagen to the wound base, and cover with a foam dressing every day shift due to excoriation dated 01/08/23. A new order was obtained on 02/07/23 to cleanse her left buttock with normal saline, apply alginate and a foam dressing due to skin compromise (new open area). Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired impaired skin to her left inner thigh from the friction of her brief. There were no measurements, and the treatment was to continue. Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired MASD to her right thigh area due to friction and body fluids. The treatment was to continue as ordered. Interview on 02/06/23 at 10:15 A.M. with Resident #55 revealed she activated her call light and staff answered her call light on 02/06/23 at 8:00 A.M. She revealed she told staff that she needed changed, and they turned off her light and walked out of the room. She revealed she was still waiting the staff to come back. She was unable to name the staff as she stated the staff were all from agency, and stated she had different staff almost every day. Interview on 02/06/23 at 10:35 A.M. with Agency State tested Nursing Assistant (STNA) #854 revealed she was the aide assigned to Resident #55, and she had been on the unit alone for three hours. She revealed she had 27 residents and had not provided the residents (including Resident #55) incontinence care as she had just finished with breakfast trays. (continued on next page)

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	365826	A. Building B. Wing	03/01/2023

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Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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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 - Many	Interview and observation on 02/06/23 at 11:17 A.M. with Resident #55 revealed staff had not come back to provide incontinence care. She again stated she had asked at 8:00 A.M. She revealed the last time she was changed was on 02/06/23 at 2:00 A.M. She revealed staff always said they would be back after they answered her call light, but they never returned. Observation on 02/06/23 at 11:59 A.M. revealed Resident #55 yelled out as Agency STNA #854 walked by her room. Resident #55 stated to Agency STNA #854 that she was still waiting to be changed and stated she had been waiting since 8:00 A.M. Agency STNA #854 stated to Resident #55 that she was waiting for Agency LPN #852 to do her dressing change and she was going to change her at the same time. Agency STNA #854 also told to Resident #55 that she also had to finish changing two other residents down the hall and then she would get to her. Observation on 02/06/23 at 12:38 P.M. revealed Agency STNA #854 asked Agency LPN #852 to let her know when she was ready to change Resident #55's dressings as she was going to change her at the same time. Agency LPN #852 stated she was ready anytime. Agency STNA #854 then stated, well right now, I am going to chart and stuff. Agency STNA #853 who also was assigned Resident #55's unit came up to the nursing station at the same time and proceeded to remain at the nursing station from 12:38 A.M. to 12:45 P. M. on her personal phone and Agency STNA #854 continued to document. Observation revealed on 02/06/23 at 12:45 P.M. Agency STNA #854 stated to Agency LPN #852 oh well, trays are here now. Observation on 02/06/23 at 1:25 P.M. revealed Agency LPN #852 asked Agency STNA #853 to assist her in doing Resident #55's incontinence care and wound care. While in the room, Resident #55 requested only Agency LPN #852 complete her incontinence care and wound care. Agency LPN #852 then proceeded to provide incontinence care. Observation revealed Resident #55's brief was heavily saturated in urine as Agency LPN #852 stated if she had to estimate, Resident #55 had urinated at least five times. Observation also revealed Resident #55 was incontinent of a moderate amount of bowel movement and parts of the bowel movement were dried to her bilateral inner thighs. Agency LPN #852 was asked to describe her skin integrity and she revealed her peri area and buttocks were excoriated with redness and bleeding. She revealed Resident #55 was tender to touch as Resident #55 stated ouch, ouch when provided incontinence care. Resident #55 then proceeded to say it was very sore and tender as she had not been changed since 2:00 AM. (almost 12 hours). Agency LPN #852 completed her wound dressing changes as ordered. She then noted a new open area to Resident #55's left buttock. Agency LPN #852 described the new open area as a Stage II pressure ulcer that measured 1.0 centimeter (cm) in length by 1.0 cm in width, and she revealed she was unable to determine the depth as there was a large amount of bleeding. She revealed the area was surrounded by redness. Resident #55 then became upset and started to cry as Agency LPN #852 was informing her of the new area. Resident #55 again stated that she had not been changed since 2:00 A. M. and that she had asked at 8:00 A.M. and then also again after that, and nobody changed her. She revealed now she had another pressure ulcer and that she would never get healed. Interview on 02/06/23 at 2:15 P.M. with Resident #55's daughter revealed she had informed management staff multiple times regarding her mother not getting changed at least every two hours and that even after she brought up the concern, things had not improved. She revealed she was upset because her mother had a new pressure ulcer because the facility did not provide the care she needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of nursing note dated 02/06/23 at 2:07 P.M. and completed by Agency LPN #852 revealed during wound care Resident #55 was found to have another small open area to her left buttock with moderate amount of blood. The area was about 1.0 cm in size. The wound was cleaned with normal saline, and a dressing was applied. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing revealed incontinence care was to be completed every two hours and/ or as needed if it was needed prior. Review of a facility self-reported incident, dated 02/17/23 revealed the facility reported an incident of neglect involving Resident #55 to the State agency. The SRI revealed the resident was not provided timely incontinence care. Review of the SRI revealed the facility substantiated the incident of neglect. Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infection and skin irritation, and observe the residents skin condition. The policy did not include language to provide perineal care timely. 2. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes, morbid obesity, and congestive heart failure. Review of the care plan dated 06/02/22 revealed Resident #52 had an alteration in elimination. She was incontinent of bowel and bladder. Interventions included incontinence care as needed and monitor skin for redness and irritation. Review of the care plan dated 06/02/22 revealed Resident #52 was at risk for impaired skin integrity due to morbid obesity. Interventions included barrier cream after each incontinent episode, skin assessment as ordered, and turn and reposition as ordered. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #52 had intact cognition. She required extensive assist of two staff with bed mobility. She was totally dependent of two staff with toileting and transfers. She was always incontinent of bowel and bladder. Review of an email dated 01/17/23 at 8:28 P.M. from LPN #820 to Regional Director of Clinical Services #859 revealed LPN #820 answered Resident #52's call light, and she had expressed that she was waiting to be changed. The email noted STNA #856 had answered her call light on 01/17/23 at 6:30 P.M. and turned her call light off and stated she would return. The email noted LPN #820 stated she had asked STNA #856 to answer Resident #52's call light. The email noted she followed up with Resident #52 who stated STNA #856 had not provided incontinence care. The email revealed Resident #52 was lying in bowel movement for an hour, and STNA #856 left the facility without changing the resident. Record review revealed a facility investigation, dated 1/20/23 completed by Regional Director of Clinical Services #859. The investigation revealed on 01/17/23 she had received a message by email from LPN #820 regarding Resident #52 not being changed timely by STNA #856. The investigation revealed on 01/18/23 Regional Director of Clinical Services #859 spoke with Former LPN/ Unit Manager #971, and he had provided information the resident did get changed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Weekly Skin assessment dated [DATE] and completed by LPN #971 revealed Resident #52's skin was intact, and no issues were noted. Review of the Braden scale pressure ulcer risk assessment dated [DATE] authored by LPN #971 revealed Resident #52 was at high risk for skin breakdown. Interview on 02/06/23 at 9:48 A.M. and on 02/07/23 at 11:02 A.M. with Resident #52 revealed it five to six hours to get changed most the time. She revealed she would activate her call light and when staff answered her call light, she would ask to get changed and staff would say they would be back, but they did not return for several hours. She revealed on 02/05/23 she was not changed for over 12 hours even though she had asked several times. She revealed several weeks ago an STNA #856 had answered her call light at approximately 6:30 P.M. and said she would be back but never returned. She revealed she notified LPN #820 and she stated she would have STNA #856 change her. She revealed STNA #856 never changed her as she left at the end of her shift. She revealed she did not end up getting changed until approximately 8:00 P.M. She revealed LPN #820 stated she would notify management of the concern, but they had never followed up with her regarding the incident. Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed she reported an incident she felt was neglect a few weeks ago as STNA #856 had answered Resident #52's call light and Resident #52 had asked to be changed, and STNA #856 stated she would be back. She revealed Resident #52 had also reported to her that she needed changed so she had instructed STNA #856 to change Resident #52, but she never changed her and left the facility. She revealed she reported the incident to Regional Director of Clinical Services #859 in writing. She revealed she had witnessed this occur multiple times especially from the agency staff as they would sit behind the nursing station and not assist the residents with incontinence care. Interview on 02/07/23 at 9:34 A.M. with Regional Director of Clinical Services #859 revealed she had never received an email and/ or anything in writing from any staff member regarding Resident #52 not being changed in a timely manner by staff including a staff member leaving the facility after Resident #52 had requested to be changed and a nurse requesting the staff to change her. During a follow up interview on 02/07/23 at 12:40 P.M. Regional Director of Clinical Services #859 revealed she had just remembered there had been an investigation that was completed regarding the allegation Resident #52 and LPN #820 had made on 01/17/23. She stated she had forgotten about it until she was looking through her stuff. She verified the complaint/concern was not placed on the grievance log and denied filing a self-reported incident to the State agency related to an incident of neglect. She verified in the email LPN #820 had stated Resident #52 had been lying in bowel movement and not changed for an hour after repeated requests to be changed, and STNA #856 assigned to care for Resident, #52 left the facility without changing her. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing revealed incontinence care was to be completed every two hours and/ or as needed if it was needed prior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held Resident Council Meetings monthly. She revealed on 11/29/22 several residents, including Resident #52, revealed they had not been receiving proper care including timely incontinence care. She revealed on 01/25/23 residents complained of being left soiled, including Resident #52. She revealed the facility had not had consistent management and it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting but felt the issues were not addressed as the same concerns continued monthly. Interview and observation on 02/08/23 at 8:32 A.M. revealed Resident #52 had her call light on, and a strong odor of urine and bowel movement was coming from her room. She had tears in her eyes and stated, it is happening again as her call light had been on since 7:45 A.M. as she needed changed as she was lying in a soiled mess. She revealed she had a bowel movement, and her skin was burning. Observation on 02/08/23 at 8:46 A.M. revealed the Administrator answered the resident's call light and Resident #52 explained she needed changed. The Administrator asked what nursing station she was assigned to (since her room was in the middle of the two nursing stations). The Administrator proceeded to the nursing station and left the resident's call light on. Observation on 02/08/23 at 9:14 A.M. revealed Agency STNA #862 answered Resident #52's call light and the resident again stated she needed changed. Agency STNA #862 revealed she would tell the resident's aide and proceeded to notify STNA #833. Observation on 02/08/23 at 9:22 A.M. revealed STNA #833 walked into Resident #52's room and told Resident #52 she had to collect breakfast trays and then would provide her incontinence care. Observation on 02/08/23 at 9:34 A.M. of incontinence care completed by STNA #833 and STNA #857 for Resident #52 revealed the resident had excoriation with redness on her peri area and excoriation with bleeding and redness to her buttocks. Resident #52's brief was heavily saturated with urine as well as a large brown dried ring on the resident's bottom sheet. The resident had also been incontinent of large amount of bowel movement. STNA #833 verified the above findings. Resident #52 stated she had not been changed since 5:30 A.M. STNA #833 revealed there was only one aide on the unit on night shift, and she was not able to get to Resident #52 prior. Review of a facility self-reported incident, dated 02/16/23 revealed the facility substantiated an incident of neglect, mistreatment, and abuse for Resident #52 regarding the incident that had occurred on 01/17/23 at 6:30 P.M. The SRI revealed Regional Director of Clinical Services #859 was notified by LPN #820 Resident #52 reported to LPN #820 she turned on her call light and STNA #856 had answered and stated she would be back to assist her. The SRI revealed LPN #820 noticed Resident #52's call light on again and requested STNA #856 to assist Resident #52. The SRI revealed at the end of the shift LPN #820 checked on Resident #52 and Resident #52 verbalized she had not been changed. Interview on 02/27/23 at 9:28 A.M. with Administrator revealed he was not aware of the allegation of neglect for Resident #52 on 01/17/23. He revealed Regional Director of Clinical Services #859 had received the allegation on 01/17/23 but had not reported it to him; therefore, he had not completed an SRI. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infection and skin irritation, and observe the residents skin condition. The policy did not include language to provide perineal care timely. 3. On 02/17/23 review of the facility staffing schedule revealed there were four nurses (one Registered Nurse (RN) and three LPN's) scheduled 7:00 A.M. to 7:00 P.M. and two nurses (two LPN's) scheduled 7:00 P.M. to 7:00 A.M. as two LPNs from agency did not show up per the Daily Assignment Sheet. The facility census was 85. On 02/18/23 at 8:05 A.M. interview with LPN #848 revealed she was scheduled 7:00 P.M. to 7:00 A.M. and they had two nurses that did not show up for their shift at 7:00 P.M. She revealed Agency LPN #993 was on 02/17/23 from 7:00 A.M. to 7:00 P.M. and came to her at approximately 10:30 P.M. to hand her the keys for the [NAME] unit. She revealed Agency LPN #993 stated she was only supposed to stay till 7:00 P.M. and had not passed any of the medications that were scheduled (HS - 8:00 P.M.) per the MAR for the residents residing on the unit. LPN #848 revealed she was unable to administer any of the medications on the [NAME] unit as she had her own unit to complete. She verified residents on the [NAME] unit did not receive their medications, were not assessed for pain, and had no monitoring of their oxygen saturation level on 02/17/23 scheduled for HS-8:00 P.M. She revealed the physician and/or responsible party was not notified of medications not being administered/assessments not being completed. She revealed she had attempted to contact Regional Director of Clinical Services #859 (acting Director of Nursing), Administrator, and Scheduler #826 by phone to update them regarding medications not being passed due to lack of staffing, but she did not receive a call back. On 02/18/23 at 9:02 A.M. and 10:55 A.M. interview with Scheduler #826 revealed her phone was broke and she was unable to receive any calls and/or messages. She revealed she let Regional Director of Clinical Nurse #859 know prior that her phone was not working and had provided her a different number to call her on regarding staffing issues. She revealed the staff on the floor were not provided this number. On 02/18/23 at 9:08 A.M. interview with Agency LPN #993 revealed she was scheduled 02/17/23 from 7:00 A.M. to 7:00 P.M. on the [NAME] unit. She revealed her relief at 7:00 P.M. did not show up. She revealed she had contacted Scheduler #826 and notified her that her relief did not show up but received no return call. She also called Regional Director of Clinical Nurse #859 but was unable to leave a message as her voicemail box was full. She [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, facility policy and procedure review, Ohio Department of Health's Gateway system for Self-Reported Incidents (SRIs), and interview the facility failed to ensure they implemented their policy regarding neglect and misappropriation. This affected three residents (#52, #53 and #55) out of three residents reviewed for abuse, neglect, and misappropriation and had the potential to affect all 84 residents residing in the facility. Findings include: 1. Record review for Resident #55 revealed an admitted [DATE] with diagnoses including congestive heart failure, diabetes, chronic kidney disease, morbid obesity, and hypertension. Review of the care plan dated 09/01/20 revealed Resident #55 had an alteration in elimination related to bowel and bladder incontinence. Interventions included check and change every two hours and as needed, monitor for skin redness and irritation, and provide incontinence care as needed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had intact cognition and required extensive assist of one staff with bed mobility and was totally dependent of two staff with transfers. She required extensive assist of two staff with toileting. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no pressure ulcers during the seven-day assessment reference period. Review of the care plan dated 01/24/23 revealed Resident #55 had actual impaired skin integrity from moisture associated skin damage (MASD) to her right thigh. Interventions included provide wound care per physician order and skin assessment per policy. Review of the Braden scale pressure ulcer risk assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #971 revealed Resident #55 was at high risk for pressure ulcers due to her sensory perception was very limited, constantly moist, bedfast, and problem with friction and shear. Review of the February 2023 physician's orders, revealed Resident #55 had an order to cleanse her left and right inner thighs, apply collagen to the wound base, and cover with a foam dressing every day shift due to excoriation dated 01/08/23. A new order was obtained on 02/07/23 to cleanse her left buttock with normal saline, apply alginate and a foam dressing due to skin compromise (new open area). Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired impaired skin to her left inner thigh from the friction of her brief. There were no measurements, and the treatment was to continue. Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired MASD to her right thigh area due to friction and body fluids. The treatment was to continue as ordered. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/06/23 at 10:15 A.M. with Resident #55 revealed she activated her call light and staff answered her call light on 02/06/23 at 8:00 A.M. She revealed she told staff that she needed changed, and they turned off her light and walked out of the room. She revealed she was still waiting the staff to come back. She was unable to name the staff as she stated the staff were all from agency, and stated she had different staff almost every day. Interview on 02/06/23 at 10:35 A.M. with Agency State tested Nursing Assistant (STNA) #854 revealed she was the aide assigned to Resident #55, and she had been on the unit alone for three hours. She revealed she had 27 residents and had not provided the residents (including Resident #55) incontinence care as she had just finished with breakfast trays. Interview and observation on 02/06/23 at 11:17 A.M. with Resident #55 revealed staff had not come back to provide incontinence care. She again stated she had asked at 8:00 A.M. She revealed the last time she was changed was on 02/06/23 at 2:00 A.M. She revealed staff always said they would be back after they answered her call light, but they never returned. Observation on 02/06/23 at 11:59 A.M. revealed Resident #55 yelled out as Agency STNA #854 walked by her room. Resident #55 stated to Agency STNA #854 that she was still waiting to be changed and stated she had been waiting since 8:00 A.M. Agency STNA #854 stated to Resident #55 that she was waiting for Agency LPN #852 to do her dressing change and she was going to change her at the same time. Agency STNA #854 also told to Resident #55 that she also had to finish changing two other residents down the hall and then she would get to her. Observation on 02/06/23 at 12:38 P.M. revealed Agency STNA #854 asked Agency LPN #852 to let her know when she was ready to change Resident #55's dressings as she was going to change her at the same time. Agency LPN #852 stated she was ready anytime. Agency STNA #854 then stated, well right now, I am going to chart and stuff. Agency STNA #853 who also was assigned Resident #55's unit came up to the nursing station at the same time and proceeded to remain at the nursing station from 12:38 A.M. to 12:45 P. M. on her personal phone and Agency STNA #854 continued to document. Observation revealed on 02/06/23 at 12:45 P.M. Agency STNA #854 stated to Agency LPN #852 oh well, trays are here now. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/06/23 at 1:25 P.M. revealed Agency LPN #852 asked Agency STNA #853 to assist her in doing Resident #55's incontinence care and wound care. While in the room, Resident #55 requested only Agency LPN #852 complete her incontinence care and wound care. Agency LPN #852 then proceeded to provide incontinence care. Observation revealed Resident #55's brief was heavily saturated in urine as Agency LPN #852 stated if she had to estimate, Resident #55 had urinated at least five times. Observation also revealed Resident #55 was incontinent of a moderate amount of bowel movement and parts of the bowel movement were dried to her bilateral inner thighs. Agency LPN #852 was asked to describe her skin integrity and she revealed her peri area and buttocks were excoriated with redness and bleeding. She revealed Resident #55 was tender to touch as Resident #55 stated ouch, ouch when provided incontinence care. Resident #55 then proceeded to say it was very sore and tender as she had not been changed since 2:00 AM. (almost 12 hours). Agency LPN #852 completed her wound dressing changes as ordered. She then noted a new open area to Resident #55's left buttock. Agency LPN #852 described the new open area as a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) that measured 1.0 centimeter (cm) in length by 1.0 cm in width, and she revealed she was unable to determine the depth as there was a large amount of bleeding. She revealed the area was surrounded by redness. Resident #55 then became upset and started to cry as Agency LPN #852 was informing her of the new area. Resident #55 again stated that she had not been changed since 2:00 A.M. and that she had asked at 8:00 A. M. and then also again after that, and nobody changed her. She revealed now she had another pressure ulcer and that she would never get healed. Interview on 02/06/23 at 2:15 P.M. with Resident #55's daughter revealed she had informed management staff multiple times regarding her mother not getting changed at least every two hours and that even after she brought up the concern, things had not improved. She revealed she was upset because her mother had a new pressure ulcer because the facility did not provide the care she needed. Review of nursing note dated 02/06/23 at 2:07 P.M. and completed by Agency LPN #852 revealed during wound care Resident #55 was found to have another small open area to her left buttock with moderate amount of blood. The area was approximately 1.0 cm in size. The wound was cleaned with normal saline, and a dressing was applied. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing (DON) and Administrator were notified of the incident of neglect regarding Resident #55. The DON revealed incontinence care was to be completed every two hours and as needed if it was needed prior. Review of SRI tracking number #232181 and dated 02/17/23 revealed a SRI with a date of discovery of 02/06/23 for neglect of Resident #55. The SRI revealed the facility substantiated neglect as Resident #55 was not provided timely incontinence care. Review of the SRI revealed no other investigation regarding the incident was completed. Interview on 02/27/23 from 1:52 P.M. to 1:55 P.M. with Regional Director of Operations #977 and Administrator verified they had not completed any other investigation regarding SRI tracking number 232181. (continued on next page)

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	365826	A. Building B. Wing	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19, revealed the facility would not tolerate abuse, neglect, and exploitation of the residents. The policy defines neglect as the failure of the facility, its employees or facility service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, and emotional distress. The administrator and/ or designee would notify the state agency of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident of the event no later than 24 hours from the time of the incident. The policy revealed once the administrator was notified an investigation of the allegation would be conducted. The policy revealed the investigation protocol would include the person investigating would interview the resident, accused, and all witnesses. The policy revealed documentation of evidence of the investigation would be documented. 2. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes, morbid obesity, and congestive heart failure. Review of the care plan dated 06/02/22 revealed Resident #52 had an alteration in elimination. She was incontinent of bowel and bladder. Interventions included incontinence care as needed and monitor skin for redness and irritation. Review of the care plan dated 06/02/22 revealed Resident #52 was at risk for impaired skin integrity due to morbid obesity. Interventions included barrier cream after each incontinent episode, skin assessment as ordered, and turn and reposition as ordered. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #52 had intact cognition. She required extensive assist of two staff with bed mobility. She was totally dependent on two staff with toileting and transfers. She was always incontinent of bowel and bladder. Review of an email dated 01/17/23 at 8:28 P.M. from LPN #820 to Regional Director of Clinical Services #859 revealed LPN #820 answered Resident #52's call light, and Resident #52 expressed that she was waiting to be changed. The email noted STNA #856 had answered Resident #52's call light on 01/17/23 at 6:30 P.M. and turned the call light off and stated she would return. The email noted LPN #820 stated she had asked STNA #856 to answer Resident #52's call light. The email noted she followed up with Resident #52 who stated STNA #856 had not provided incontinence care. The email revealed Resident #52 was lying in bowel movement for an hour, and STNA #856 left the facility without changing the resident. Review of the facility investigation dated 1/20/23 and completed by Regional Director of Clinical Services #859 revealed on 01/17/23 she had received a message by email from LPN #820 regarding Resident #52 not being changed timely by STNA #856. The investigation revealed on 01/18/23 Regional Director of Clinical Services #859 spoke with Former LPN/ Unit Manager #971, and he had returned information that she did get changed. The investigation revealed on 01/20/23 Regional Director of Clinical Services #859 interviewed Resident #52 and that she had said she got changed at shift change and she reported no further concern. Review of the Weekly Skin assessment dated [DATE] and completed by LPN #971 revealed Resident #52's skin was intact, and no issues were noted. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Braden scale pressure ulcer risk assessment dated [DATE] authored by LPN #971 revealed Resident #52 was at high risk for skin breakdown. Interview on 02/06/23 at 9:48 A.M. and on 02/07/23 at 11:02 A.M. with Resident #52 revealed it took five to six hours to get changed most the time. She revealed she would activate her call light and when staff answered her call light, she would ask to get changed and staff would say they would be back, but they did not return for several hours. She revealed on 02/05/23 she was not changed for over 12 hours even though she had asked several times. She revealed several weeks ago STNA #856 had answered her call light at approximately 6:30 P.M. and said she would be back but never returned. She revealed she notified LPN #820 and LPN #820 stated she would have STNA #856 change her. She revealed STNA #856 never changed her as she left the facility at the end of her shift. She revealed she did not end up getting changed until approximately 8:00 P.M. She revealed LPN #820 stated she would notify management of the concern, but they had never followed up with her regarding the incident. Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed she reported an incident she felt was neglect a few weeks ago as STNA #856 had answered Resident #52's call light and Resident #52 had asked to be changed, and STNA #856 stated she would be back. She revealed Resident #52 had also reported to her that she needed changed so she had instructed STNA #856 to change Resident #52, but she never changed her and left the facility. She revealed she reported the incident to Regional Director of Clinical Services #859 in writing. She revealed she had witnessed this occur multiple times especially from the agency staff as they would sit behind the nursing station and not assist the residents with incontinence care. Interview on 02/07/23 at 9:34 A.M. with Regional Director of Clinical Services #859 revealed she had never received an email and/ or anything in writing from any staff member regarding Resident #52 not being changed in a timely manner. Interview on 02/07/23 at 12:40 P.M. with Regional Director of Clinical Services #859 revealed she had just remembered that there had been an investigation that was completed regarding the allegation Resident #52 and LPN #820 had made on 01/17/23. She stated she had forgotten about it until she was looking through her stuff. She verified the complaint/ concern was not placed on the grievance log as well as she did not file a SRI regarding the allegations of neglect. She verified the email stated Resident #52 had been laying in bowel movement and not changed for an hour after repeated requests to be changed, and STNA #856, assigned to care for Resident #52, left the facility without changing her. Interview on 02/07/23 at 3:12 P.M. with the DON revealed incontinence care was to be completed every two hours and as needed if it was needed prior. Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held Resident Council Meetings monthly. She revealed on 11/29/22 several residents, including Resident #52, revealed they had not been receiving proper care including timely incontinence care. She revealed on 01/25/23 residents, including Resident #52, complained of being left soiled. She revealed the facility had not had consistent management and it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting but felt the issues were not addressed as the same concerns continued monthly. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 02/08/23 at 8:32 A.M. revealed Resident #52 had her call light on, and there was a strong odor of urine and bowel movement coming from her room. She had tears in her eyes and stated, it is happening again as her call light had been on since 7:45 A.M. as she needed changed as she was lying in a soiled mess. She revealed she had a bowel movement, and her skin was burning. Observation on 02/08/23 at 8:46 A.M. revealed the Administrator answered the resident's call light and Resident #52 explained she needed changed. The Administrator asked what nursing station Resident #52 was assigned to (since her room was in the middle of the two nursing stations). The Administrator proceeded to the nursing station and left the resident's call light on. Observation on 02/08/23 at 9:14 A.M. revealed Agency STNA #862 answered Resident #52's call light and the resident again stated she needed changed. Agency STNA #862 revealed she would tell the Resident #52's aide and proceeded to notify STNA #833. Observation on 02/08/23 at 9:22 A.M. revealed STNA #833 walked into Resident #52's room and told Resident #52 she had to collect breakfast trays and then would provide her incontinence care. Observation on 02/08/23 at 9:34 A.M. of incontinence care completed by STNA #833 and STNA #857 for Resident #52 revealed the resident had excoriation with redness on her peri area and excoriation with bleeding and redness to her buttocks. Resident #52's brief was heavily saturated with urine as well as a large brown dried ring on the resident's bottom sheet. The resident had also been incontinent of large amount of bowel movement. STNA #833 verified the above findings. Resident #52 stated she had not been changed since 5:30 A.M. STNA #833 revealed there was only one aide on the unit on night shift, and she was not able to get to Resident #52 prior. Review of the facility SRI tracking number #232168 and dated 02/16/23 revealed the facility substantiated neglect, mistreatment, and abuse for Resident #52 regarding an incident that had occurred on 01/17/23 at 6:30 P.M. The SRI revealed Regional Director of Clinical Services #859 was notified by LPN #820 that Resident #52 reported to LPN #820 that she turned on her call light and STNA #856 had answered and stated she would be back to assist her. The SRI revealed LPN #820 noticed Resident #52's call light on again and instructed STNA #856 to assist Resident #52. The SRI revealed at the end of the shift LPN #820 checked on Resident #52, and Resident #52 verbalized she had not been changed. Interview on 02/27/23 at 9:28 A.M. with Administrator revealed he was not aware of the allegation of neglect for Resident #52 on 01/17/23 as he revealed he was not aware of the incident until 02/07/23 when the incident was brought up during survey. He revealed Regional Director of Clinical Services #859 had received the allegation on 01/17/23 but had not reported it to him; therefore, he had not completed a SRI. 42730 3. Resident #53 was admitted the facility on 09/20/22 with diagnoses including multiple sclerosis, malignant neoplasm of prostate, and late-onset cerebellar ataxia. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #53 was alert and oriented to person, place, time. Resident #53 required one-staff physical extensive assist for activities of daily living (ADL). Interview on 02/21/23 at 11:17 A.M. with Resident #53 revealed he had $300.00 in his personal wallet and had $200.00 stolen. Resident #53 revealed the facility reimbursed him $200.00 after searching his room. Interview on 02/22/23 at 3:24 P.M. with the Social Work Director (SWD) #819 revealed Resident #53 reported missing $200.00 from his personal wallet. SWD #819 revealed the facility completed a complaint report, searched his room, and investigated. SWD #819 revealed the facility reimbursed Resident #53 the missing funds. Review of the facility document titled Complaint/Grievance Report, dated 02/06/23, revealed the facility received a concern communicated by Resident #53 of $200.00 missing from his wallet. Review of the document revealed an internal investigation was completed with Resident #53's funds being reimbursed. Review of the Ohio Department of Health's Gateway system revealed no SRI related to the allegation of misappropriation for Resident #53. Interview on 02/23/23 at 4:13 P.M. with the Administrator verified the above findings. Review of facility policy labeled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19, revealed the facility would not tolerate abuse, neglect, and exploitation of the residents. The policy defines neglect as the failure of the facility, its employees or facility service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, and emotional distress. The administrator and/ or designee would notify Ohio Department of Health of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident of the event no later than 24 hours from the time of the incident. The policy revealed once the administrator was notified an investigation of the allegation would be conducted. The policy revealed the investigation protocol would include the person investigating would interview the resident, accused, and all witnesses. The policy revealed documentation of evidence of the investigation would be documented. This deficiency represents non-compliance investigated under Complaint Number OH00140222.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, facility policy and procedure review, Ohio Department of Health's Gateway system for Self-Reported Incidents (SRIs), and interview the facility failed to ensure incidents of neglect and misappropriation were appropriately reported to the State Survey Agency. This affected three residents (#52, #53 and #55) out of three residents reviewed for abuse, neglect, and misappropriation. The facility census was 84. Findings include: 1. Record review for Resident #55 revealed an admitted [DATE] with diagnoses including congestive heart failure, diabetes, chronic kidney disease, morbid obesity, and hypertension. Review of the care plan dated 09/01/20 revealed Resident #55 had an alteration in elimination related to bowel and bladder incontinence. Interventions included check and change every two hours and as needed, monitor for skin redness and irritation, and provide incontinence care as needed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had intact cognition and required extensive assist of one staff with bed mobility and was totally dependent of two staff with transfers. She required extensive assist of two staff with toileting. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no pressure ulcers during the seven-day assessment reference period. Review of the care plan dated 01/24/23 revealed Resident #55 had actual impaired skin integrity from moisture associated skin damage (MASD) to her right thigh. Interventions included provide wound care per physician order and skin assessment per policy. Review of the Braden scale pressure ulcer risk assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #971 revealed Resident #55 was at high risk for pressure ulcers due to her sensory perception was very limited, constantly moist, bedfast, and problem with friction and shear. Review of the February 2023 physician's orders, revealed Resident #55 had an order to cleanse her left and right inner thighs, apply collagen to the wound base, and cover with a foam dressing every day shift due to excoriation dated 01/08/23. A new order was obtained on 02/07/23 to cleanse her left buttock with normal saline, apply alginate and a foam dressing due to skin compromise (new open area). Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired impaired skin to her left inner thigh from the friction of her brief. There were no measurements, and the treatment was to continue. Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired MASD to her right thigh area due to friction and body fluids. The treatment was to continue as ordered. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/06/23 at 10:15 A.M. with Resident #55 revealed she activated her call light and staff answered her call light on 02/06/23 at 8:00 A.M. She revealed she told staff that she needed changed, and they turned off her light and walked out of the room. She revealed she was still waiting the staff to come back. She was unable to name the staff as she stated the staff were all from agency, and stated she had different staff almost every day. Interview on 02/06/23 at 10:35 A.M. with Agency State tested Nursing Assistant (STNA) #854 revealed she was the aide assigned to Resident #55, and she had been on the unit alone for three hours. She revealed she had 27 residents and had not provided the residents (including Resident #55) incontinence care as she had just finished with breakfast trays. Interview and observation on 02/06/23 at 11:17 A.M. with Resident #55 revealed staff had not come back to provide incontinence care. She again stated she had asked at 8:00 A.M. She revealed the last time she was changed was on 02/06/23 at 2:00 A.M. She revealed staff always said they would be back after they answered her call light, but they never returned. Observation on 02/06/23 at 11:59 A.M. revealed Resident #55 yelled out as Agency STNA #854 walked by her room. Resident #55 stated to Agency STNA #854 that she was still waiting to be changed and stated she had been waiting since 8:00 A.M. Agency STNA #854 stated to Resident #55 that she was waiting for Agency LPN #852 to do her dressing change and she was going to change her at the same time. Agency STNA #854 also told to Resident #55 that she also had to finish changing two other residents down the hall and then she would get to her. Observation on 02/06/23 at 12:38 P.M. revealed Agency STNA #854 asked Agency LPN #852 to let her know when she was ready to change Resident #55's dressings as she was going to change her at the same time. Agency LPN #852 stated she was ready anytime. Agency STNA #854 then stated, well right now, I am going to chart and stuff. Agency STNA #853 who also was assigned Resident #55's unit came up to the nursing station at the same time and proceeded to remain at the nursing station from 12:38 A.M. to 12:45 P.M. on her personal phone and Agency STNA #854 continued to document. Observation revealed on 02/06/23 at 12:45 P.M. Agency STNA #854 stated to Agency LPN #852 oh well, trays are here now. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19, revealed the facility would not tolerate abuse, neglect, and exploitation of the residents. The policy defines neglect as the failure of the facility, its employees or facility service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, and emotional distress. The administrator and/ or designee would notify the state agency of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident of the event no later than 24 hours from the time of the incident. The policy revealed once the administrator was notified an investigation of the allegation would be conducted. The policy revealed the investigation protocol would include the person investigating would interview the resident, accused, and all witnesses. The policy revealed documentation of evidence of the investigation would be documented. 2. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes, morbid obesity, and congestive heart failure. Review of the care plan dated 06/02/22 revealed Resident #52 had an alteration in elimination. She was incontinent of bowel and bladder. Interventions included incontinence care as needed and monitor skin for redness and irritation. Review of the care plan dated 06/02/22 revealed Resident #52 was at risk for impaired skin integrity due to morbid obesity. Interventions included barrier cream after each incontinent episode, skin assessment as ordered, and turn and reposition as ordered. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #52 had intact cognition. She required extensive assist of two staff with bed mobility. She was totally dependent on two staff with toileting and transfers. She was always incontinent of bowel and bladder. Review of an email dated 01/17/23 at 8:28 P.M. from LPN #820 to Regional Director of Clinical Services #859 revealed LPN #820 answered Resident #52's call light, and Resident #52 expressed that she was waiting to be changed. The email noted STNA #856 had answered Resident #52's call light on 01/17/23 at 6:30 P.M. and turned the call light off and stated she would return. The email noted LPN #820 stated she had asked STNA #856 to answer Resident #52's call light. The email noted she followed up with Resident #52 who stated STNA #856 had not provided incontinence care. The email revealed Resident #52 was lying in bowel movement for an hour, and STNA #856 left the facility without changing the resident. Review of the facility investigation dated 1/20/23 and completed by Regional Director of Clinical Services #859 revealed on 01/17/23 she had received a message by email from LPN #820 regarding Resident #52 not being changed timely by STNA #856. The investigation revealed on 01/18/23 Regional Director of Clinical Services #859 spoke with Former LPN/ Unit Manager #971, and he had returned information that she did get changed. The investigation revealed on 01/20/23 Regional Director of Clinical Services #859 interviewed Resident #52 and that she had said she got changed at shift change and she reported no further concern. Review of the Weekly Skin assessment dated [DATE] and completed by LPN #971 revealed Resident #52's skin was intact, and no issues were noted. (continued on next page)

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	365826	A. Building B. Wing	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Braden scale pressure ulcer risk assessment dated [DATE] authored by LPN #971 revealed Resident #52 was at high risk for skin breakdown. Interview on 02/06/23 at 9:48 A.M. and on 02/07/23 at 11:02 A.M. with Resident #52 revealed it took five to six hours to get changed most the time. She revealed she would activate her call light and when staff answered her call light, she would ask to get changed and staff would say they would be back, but they did not return for several hours. She revealed on 02/05/23 she was not changed for over 12 hours even though she had asked several times. She revealed several weeks ago STNA #856 had answered her call light at approximately 6:30 P.M. and said she would be back but never returned. She revealed she notified LPN #820 and LPN #820 stated she would have STNA #856 change her. She revealed STNA #856 never changed her as she left the facility at the end of her shift. She revealed she did not end up getting changed until approximately 8:00 P.M. She revealed LPN #820 stated she would notify management of the concern, but they had never followed up with her regarding the incident. Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed she reported an incident she felt was neglect a few weeks ago as STNA #856 had answered Resident #52's call light and Resident #52 had asked to be changed, and STNA #856 stated she would be back. She revealed Resident #52 had also reported to her that she needed changed so she had instructed STNA #856 to change Resident #52, but she never changed her and left the facility. She revealed she reported the incident to Regional Director of Clinical Services #859 in writing. She revealed she had witnessed this occur multiple times especially from the agency staff as they would sit behind the nursing station and not assist the residents with incontinence care. Interview on 02/07/23 at 9:34 A.M. with Regional Director of Clinical Services #859 revealed she had never received an email and/ or anything in writing from any staff member regarding Resident #52 not being changed in a timely manner. Interview on 02/07/23 at 12:40 P.M. with Regional Director of Clinical Services #859 revealed she had just remembered that there had been an investigation that was completed regarding the allegation Resident #52 and LPN #820 had made on 01/17/23. She stated she had forgotten about it until she was looking through her stuff. She verified the complaint/ concern was not placed on the grievance log as well as she did not file a SRI regarding the allegations of neglect. She verified the email stated Resident #52 had been laying in bowel movement and not changed for an hour after repeated requests to be changed, and STNA #856, assigned to care for Resident #52, left the facility without changing her. Interview on 02/07/23 at 3:12 P.M. with the DON revealed incontinence care was to be completed every two hours and as needed if it was needed prior. Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held Resident Council Meetings monthly. She revealed on 11/29/22 several residents, including Resident #52, revealed they had not been receiving proper care including timely incontinence care. She revealed on 01/25/23 residents, including Resident #52, complained of being left soiled. She revealed the facility had not had consistent management and it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting but felt the issues were not addressed as the same concerns continued monthly. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 02/08/23 at 8:32 A.M. revealed Resident #52 had her call light on, and there was a strong odor of urine and bowel movement coming from her room. She had tears in her eyes and stated, it is happening again as her call light had been on since 7:45 A.M. as she needed changed as she was lying in a soiled mess. She revealed she had a bowel movement, and her skin was burning. Observation on 02/08/23 at 8:46 A.M. revealed the Administrator answered the resident's call light and Resident #52 explained she needed changed. The Administrator asked what nursing station Resident #52 was assigned to (since her room was in the middle of the two nursing stations). The Administrator proceeded to the nursing station and left the resident's call light on. Observation on 02/08/23 at 9:14 A.M. revealed Agency STNA #862 answered Resident #52's call light and the resident again stated she needed changed. Agency STNA #862 revealed she would tell the Resident #52's aide and proceeded to notify STNA #833. Observation on 02/08/23 at 9:22 A.M. revealed STNA #833 walked into Resident #52's room and told Resident #52 she had to collect breakfast trays and then would provide her incontinence care. Observation on 02/08/23 at 9:34 A.M. of incontinence care completed by STNA #833 and STNA #857 for Resident #52 revealed the resident had excoriation with redness on her peri area and excoriation with bleeding and redness to her buttocks. Resident #52's brief was heavily saturated with urine as well as a large brown dried ring on the resident's bottom sheet. The resident had also been incontinent of large amount of bowel movement. STNA #833 verified the above findings. Resident #52 stated she had not been changed since 5:30 A.M. STNA #833 revealed there was only one aide on the unit on night shift, and she was not able to get to Resident #52 prior. Review of the facility SRI tracking number #232168 and dated 02/16/23 revealed the facility substantiated neglect, mistreatment, and abuse for Resident #52 regarding an incident that had occurred on 01/17/23 at 6:30 P.M. The SRI revealed Regional Director of Clinical Services #859 was notified by LPN #820 that Resident #52 reported to LPN #820 that she turned on her call light and STNA #856 had answered and stated she would be back to assist her. The SRI revealed LPN #820 noticed Resident #52's call light on again and instructed STNA #856 to assist Resident #52. The SRI revealed at the end of the shift LPN #820 checked on Resident #52, and Resident #52 verbalized she had not been changed. Interview on 02/27/23 at 9:28 A.M. with Administrator revealed he was not aware of the allegation of neglect for Resident #52 on 01/17/23 as he revealed he was not aware of the incident until 02/07/23 when the incident was brought up during survey. He revealed Regional Director of Clinical Services #859 had received the allegation on 01/17/23 but had not reported it to him; therefore, he had not completed a SRI. 42730 3. Resident #53 was admitted the facility on 09/20/22 with diagnoses including multiple sclerosis, malignant neoplasm of prostate, and late-onset cerebellar ataxia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #53 was alert and oriented to person, place, time. Resident #53 required one-staff physical extensive assist for activities of daily living (ADL). Interview on 02/21/23 at 11:17 A.M. with Resident #53 revealed he had $300.00 in his personal wallet and had $200.00 stolen. Resident #53 revealed the facility reimbursed him $200.00 after searching his room. Interview on 02/22/23 at 3:24 P.M. with the Social Work Director (SWD) #819 revealed Resident #53 reported missing $200.00 from his personal wallet. SWD #819 revealed the facility completed a complaint report, searched his room, and investigated. SWD #819 revealed the facility reimbursed Resident #53 the missing funds. Review of the facility document titled Complaint/Grievance Report, dated 02/06/23, revealed the facility received a concern communicated by Resident #53 of $200.00 missing from his wallet. Review of the document revealed an internal investigation was completed with Resident #53's funds being reimbursed. Review of the Ohio Department of Health's Gateway system revealed no SRI related to the allegation of misappropriation for Resident #53. Interview on 02/23/23 at 4:13 P.M. with the Administrator verified the above findings. Review of facility policy labeled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19, revealed the facility would not tolerate abuse, neglect, and exploitation of the residents. The policy defines neglect as the failure of the facility, its employees or facility service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, and emotional distress. The administrator and/ or designee would notify Ohio Department of Health of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident of the event no later than 24 hours from the time of the incident. The policy revealed once the administrator was notified an investigation of the allegation would be conducted. The policy revealed the investigation protocol would include the person investigating would interview the resident, accused, and all witnesses. The policy revealed documentation of evidence of the investigation would be documented. This deficiency represents non-compliance investigated under Complaint Number OH00140222.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, facility policy and procedure review, Self-Reported Incident (SRI) with tracking number 232168, SRI with tracking number 232181, and interview the facility failed to investigate and/ or thoroughly investigate allegations of neglect. This affected two residents (#52, and #55) of three residents reviewed for abuse and neglect and had the potential to affect all 84 residents residing in the facility. Findings include: 1. Record review for Resident #55 revealed an admitted [DATE] with diagnoses including congestive heart failure, diabetes, chronic kidney disease, morbid obesity, and hypertension. Review of the care plan dated 09/01/20 revealed Resident #55 had an alteration in elimination related to bowel and bladder incontinence. Interventions included check and change every two hours and as needed, monitor for skin redness and irritation, and provide incontinence care as needed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had intact cognition and required extensive assist of one staff with bed mobility and was totally dependent of two staff with transfers. She required extensive assist of two staff with toileting. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no pressure ulcers during the seven-day assessment reference period. Review of the care plan dated 01/24/23 revealed Resident #55 had actual impaired skin integrity from moisture associated skin damage (MASD) to her right thigh. Interventions included provide wound care per physician order and skin assessment per policy. Review of the Braden scale pressure ulcer risk assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #971 revealed Resident #55 was at high risk for pressure ulcers due to her sensory perception was very limited, constantly moist, bedfast, and problem with friction and shear. Review of the February 2023 physician's orders, revealed Resident #55 had an order to cleanse her left and right inner thighs, apply collagen to the wound base, and cover with a foam dressing every day shift due to excoriation dated 01/08/23. A new order was obtained on 02/07/23 to cleanse her left buttock with normal saline, apply alginate and a foam dressing due to skin compromise (new open area). Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired impaired skin to her left inner thigh from the friction of her brief. There were no measurements, and the treatment was to continue. Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired MASD to her right thigh area due to friction and body fluids. The treatment was to continue as ordered. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/06/23 at 10:15 A.M. with Resident #55 revealed she activated her call light and staff answered her call light on 02/06/23 at 8:00 A.M. She revealed she told staff that she needed changed, and they turned off her light and walked out of the room. She revealed she was still waiting the staff to come back. She was unable to name the staff as she stated the staff were all from agency, and stated she had different staff almost every day. Interview on 02/06/23 at 10:35 A.M. with Agency State tested Nursing Assistant (STNA) #854 revealed she was the aide assigned to Resident #55, and she had been on the unit alone for three hours. She revealed she had 27 residents and had not provided the residents (including Resident #55) incontinence care as she had just finished with breakfast trays. Interview and observation on 02/06/23 at 11:17 A.M. with Resident #55 revealed staff had not come back to provide incontinence care. She again stated she had asked at 8:00 A.M. She revealed the last time she was changed was on 02/06/23 at 2:00 A.M. She revealed staff always said they would be back after they answered her call light, but they never returned. Observation on 02/06/23 at 11:59 A.M. revealed Resident #55 yelled out as Agency STNA #854 walked by her room. Resident #55 stated to Agency STNA #854 that she was still waiting to be changed and stated she had been waiting since 8:00 A.M. Agency STNA #854 stated to Resident #55 that she was waiting for Agency LPN #852 to do her dressing change and she was going to change her at the same time. Agency STNA #854 also told to Resident #55 that she also had to finish changing two other residents down the hall and then she would get to her. Observation on 02/06/23 at 12:38 P.M. revealed Agency STNA #854 asked Agency LPN #852 to let her know when she was ready to change Resident #55's dressings as she was going to change her at the same time. Agency LPN #852 stated she was ready anytime. Agency STNA #854 then stated, well right now, I am going to chart and stuff. Agency STNA #853 who also was assigned Resident #55's unit came up to the nursing station at the same time and proceeded to remain at the nursing station from 12:38 A.M. to 12:45 P. M. on her personal phone and Agency STNA #854 continued to document. Observation revealed on 02/06/23 at 12:45 P.M. Agency STNA #854 stated to Agency LPN #852 oh well, trays are here now. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/06/23 at 1:25 P.M. revealed Agency LPN #852 asked Agency STNA #853 to assist her in doing Resident #55's incontinence care and wound care. While in the room, Resident #55 requested only Agency LPN #852 complete her incontinence care and wound care. Agency LPN #852 then proceeded to provide incontinence care. Observation revealed Resident #55's brief was heavily saturated in urine as Agency LPN #852 stated if she had to estimate, Resident #55 had urinated at least five times. Observation also revealed Resident #55 was incontinent of a moderate amount of bowel movement and parts of the bowel movement were dried to her bilateral inner thighs. Agency LPN #852 was asked to describe her skin integrity and she revealed her peri area and buttocks were excoriated with redness and bleeding. She revealed Resident #55 was tender to touch as Resident #55 stated ouch, ouch when provided incontinence care. Resident #55 then proceeded to say it was very sore and tender as she had not been changed since 2:00 AM. (almost 12 hours). Agency LPN #852 completed her wound dressing changes as ordered. She then noted a new open area to Resident #55's left buttock. Agency LPN #852 described the new open area as a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) that measured 1.0 centimeter (cm) in length by 1.0 cm in width, and she revealed she was unable to determine the depth as there was a large amount of bleeding. She revealed the area was surrounded by redness. Resident #55 then became upset and started to cry as Agency LPN #852 was informing her of the new area. Resident #55 again stated that she had not been changed since 2:00 A.M. and that she had asked at 8:00 A. M. and then also again after that, and nobody changed her. She revealed now she had another pressure ulcer and that she would never get healed. Interview on 02/06/23 at 2:15 P.M. with Resident #55's daughter revealed she had informed management staff multiple times regarding her mother not getting changed at least every two hours and that even after she brought up the concern, things had not improved. She revealed she was upset because her mother had a new pressure ulcer because the facility did not provide the care she needed. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing (DON) and Administrator were notified of the incident of neglect regarding Resident #55. The DON revealed incontinence care was to be completed every two hours and as needed if it was needed prior. Review of SRI tracking number #232181 and dated 02/17/23 revealed a SRI with a date of discovery of 02/06/23 for neglect of Resident #55. The SRI revealed the facility substantiated neglect as Resident #55 was not provided timely incontinence care. Review of the SRI revealed no other investigation regarding the incident was completed. Interview on 02/27/23 from 1:52 P.M. to 1:55 P.M. with Regional Director of Operations #977 and Administrator verified they had not completed any other investigation regarding SRI tracking number 232181. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Braden scale pressure ulcer risk assessment dated [DATE] authored by LPN #971 revealed Resident #52 was at high risk for skin breakdown. Interview on 02/06/23 at 9:48 A.M. and on 02/07/23 at 11:02 A.M. with Resident #52 revealed it took five to six hours to get changed most the time. She revealed she would activate her call light and when staff answered her call light, she would ask to get changed and staff would say they would be back, but they did not return for several hours. She revealed on 02/05/23 she was not changed for over 12 hours even though she had asked several times. She revealed several weeks ago STNA #856 had answered her call light at approximately 6:30 P.M. and said she would be back but never returned. She revealed she notified LPN #820 and LPN #820 stated she would have STNA #856 change her. She revealed STNA #856 never changed her as she left the facility at the end of her shift. She revealed she did not end up getting changed until approximately 8:00 P.M. She revealed LPN #820 stated she would notify management of the concern, but they had never followed up with her regarding the incident. Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed she reported an incident she felt was neglect a few weeks ago as STNA #856 had answered Resident #52's call light and Resident #52 had asked to be changed, and STNA #856 stated she would be back. She revealed Resident #52 had also reported to her that she needed changed so she had instructed STNA #856 to change Resident #52, but she never changed her and left the facility. She revealed she reported the incident to Regional Director of Clinical Services #859 in writing. She revealed she had witnessed this occur multiple times especially from the agency staff as they would sit behind the nursing station and not assist the residents with incontinence care. Interview on 02/07/23 at 9:34 A.M. with Regional Director of Clinical Services #859 revealed she had never received an email and/ or anything in writing from any staff member regarding Resident #52 not being changed in a timely manner. Interview on 02/07/23 at 12:40 P.M. with Regional Director of Clinical Services #859 revealed she had just remembered that there had been an investigation that was completed regarding the allegation Resident #52 and LPN #820 had made on 01/17/23. She stated she had forgotten about it until she was looking through her stuff. She verified the complaint/ concern was not placed on the grievance log as well as she did not file a SRI regarding the allegations of neglect. She verified the email stated Resident #52 had been laying in bowel movement and not changed for an hour after repeated requests to be changed, and STNA #856, assigned to care for Resident #52, left the facility without changing her. Interview on 02/07/23 at 3:12 P.M. with the DON revealed incontinence care was to be completed every two hours and as needed if it was needed prior. Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held Resident Council Meetings monthly. She revealed on 11/29/22 several residents, including Resident #52, revealed they had not been receiving proper care including timely incontinence care. She revealed on 01/25/23 residents, including Resident #52, complained of being left soiled. She revealed the facility had not had consistent management and it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting but felt the issues were not addressed as the same concerns continued monthly. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 02/08/23 at 8:32 A.M. revealed Resident #52 had her call light on, and there was a strong odor of urine and bowel movement coming from her room. She had tears in her eyes and stated, it is happening again as her call light had been on since 7:45 A.M. as she needed changed as she was lying in a soiled mess. She revealed she had a bowel movement, and her skin was burning. Observation on 02/08/23 at 8:46 A.M. revealed the Administrator answered the resident's call light and Resident #52 explained she needed changed. The Administrator asked what nursing station Resident #52 was assigned to (since her room was in the middle of the two nursing stations). The Administrator proceeded to the nursing station and left the resident's call light on. Observation on 02/08/23 at 9:14 A.M. revealed Agency STNA #862 answered Resident #52's call light and the resident again stated she needed changed. Agency STNA #862 revealed she would tell the Resident #52's aide and proceeded to notify STNA #833. Observation on 02/08/23 at 9:22 A.M. revealed STNA #833 walked into Resident #52's room and told Resident #52 she had to collect breakfast trays and then would provide her incontinence care. Observation on 02/08/23 at 9:34 A.M. of incontinence care completed by STNA #833 and STNA #857 for Resident #52 revealed the resident had excoriation with redness on her peri area and excoriation with bleeding and redness to her buttocks. Resident #52's brief was heavily saturated with urine as well as a large brown dried ring on the resident's bottom sheet. The resident had also been incontinent of large amount of bowel movement. STNA #833 verified the above findings. Resident #52 stated she had not been changed since 5:30 A.M. STNA #833 revealed there was only one aide on the unit on night shift, and she was not able to get to Resident #52 prior. Review of the facility SRI tracking number #232168 and dated 02/16/23 revealed the facility substantiated neglect, mistreatment, and abuse for Resident #52 regarding an incident that had occurred on 01/17/23 at 6:30 P.M. The SRI revealed Regional Director of Clinical Services #859 was notified by LPN #820 that Resident #52 reported to LPN #820 that she turned on her call light and STNA #856 had answered and stated she would be back to assist her. The SRI revealed LPN #820 noticed Resident #52's call light on again and instructed STNA #856 to assist Resident #52. The SRI revealed at the end of the shift LPN #820 checked on Resident #52, and Resident #52 verbalized she had not been changed. Interview on 02/27/23 at 9:28 A.M. with Administrator revealed he was not aware of the allegation of neglect for Resident #52 on 01/17/23 as he revealed he was not aware of the incident until 02/07/23 when the incident was brought up during survey. He revealed Regional Director of Clinical Services #859 had received the allegation on 01/17/23 but had not reported it to him; therefore, he had not completed a SRI. Interview on 02/27/23 at 9:28 A.M. with Administrator revealed he was not aware of the allegation of neglect for Resident #52 on 01/17/23 as he revealed he was not aware of the incident until 02/07/23 when the incident was brought up during survey. He revealed Regional Director of Clinical Services #859 had received the allegation on 01/17/23 but had not reported it to him; therefore, he had not completed a SRI. Interview on 02/27/23 from 1:52 P.M. to 1:55 P.M. with Regional Director of Operations #977 and Administrator verified they had not completed any other investigation regarding SRI tracking number 232168 and/ or the incident of neglect that had occurred on 02/08/23 for Resident #52. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy labeled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 11/01/19 revealed the facility would not tolerate abuse, neglect and exploitation of the residents. The policy defines neglect as the failure of the facility, its employees or facility service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, and emotional distress. The administrator and/ or designee would notify Ohio Department of Health of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident of the event no later than 24 hours from the time of the incident. The policy revealed once the administrator was notified an investigation of the allegation would be conducted. The policy revealed the investigation protocol would include the person investigating would interview the resident, accused, and all witnesses. The policy revealed documentation of evidence of the investigation would be documented. This deficiency represents non-compliance investigated under Complaint Number OH00140222.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	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** 42730 Based on record review and staff interview the facility failed to ensure the state Ombudsman was notified of resident discharges. This affected one resident (#83) and had the potential to affect all 84 residents currently residing in the facility. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE] with diagnoses including weakness, fracture of left femur, and disorientation. Resident #83 discharged from the facility on 12/22/22. Review of the discharge return-not-anticipated, Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #83 had a memory problem, modified independence for tasks of daily living, had inattention, disorganized thinking, and required extensive assist for activities of daily living (ADL). Review of the progress note dated 12/22/22 at 10:46 A.M. revealed Resident #83 discharged from the facility with family. Review of Resident #83's medical record revealed no evidence that the state Ombudsman was notified of discharge. Interview on 02/27/23 at 2:50 P.M. with Regional Director of Operations (RDO) #977 revealed there were no documented notification of discharges to the state Ombudsman prior to January 2023. RDO #977 revealed due to multiple staff changes the facility had not been able to verify the state Ombudsman was notified of Resident #83's discharge.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview, and facility policy review the facility failed to ensure showers were completed per the care plans and resident's preferences. This finding affected four residents (#39, #45, #50 and #78) of five residents reviewed for showers. The facility census was 84. Findings include: 1. Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including multiple sclerosis, diabetes, quadriplegia, and spinal stenosis. Review of the care plan dated 11/22/21 revealed Resident #39 had an alteration in activities of daily living performance and participation related to multiple medical problems. The care plan revealed she was able to make her needs known. Interventions included encourage resident to participate while performing activities of daily living, anticipate needs and assist as needed, and may use essential oils per instructions on bottle for shower and bath upon resident request. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #39 had intact cognition. She required extensive assist of one staff with bed mobility. She was totally dependent of two staff with transfers and bathing. Review of the facility form labeled, Shower Documentation Survey Report V2, for January 2023, revealed Resident #39 had a shower on 01/19/23. There were no other documented showers/ baths documented for the month. Review of the facility form labeled, Shower Documentation Survey Report V2, for February 2023, revealed Resident #39 had a shower on 02/10/23. There were no other documented showers/ baths documented for the month. Interview on 02/16/23 at 11:09 A.M. with State tested Nursing Assistant (STNA) #810 revealed she felt many times showers were not able to be completed due to lack of staffing. Interview on 02/16/23 at 11:09 A.M. with STNA #810 revealed she felt many times showers were not able to be completed due to lack of staffing. Interview on 02/16/23 at 12:45 P.M. with STNA #833 revealed at times showers did not get completed because there was not enough staff. She revealed especially the residents that require two-staff assist, including Resident #39, it was difficult to complete showers due to lack of staffing. Interview on 02/16/23 at 12:49 P.M. with Resident #39 revealed she preferred to get a shower three times a week on Tuesday, Thursday, and Saturday but had not been receiving showers. She revealed they had always stated, there was not enough staff to give her a shower. She revealed at times she goes two weeks sometimes longer without a shower. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/27/23 at 10:06 A.M. with the Director of Nursing (DON) #2 verified she only had documentation that Resident #39 received a shower or bath on 01/19/23 and 02/10/23 from 01/01/23 to 02/18/23. She revealed she had no other documentation that Resident #39 was offered and/ or refused a shower and/ or bath and verified she was scheduled to have a shower twice a week. Review of undated facility form labeled, CV Shower Schedule revealed Resident #39 was to receive a shower every Tuesday and Saturday during evening/ night shift. 2. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, diabetes, altered mental status, adult failure to thrive, and spinal stenosis. Review of the care plan dated 10/28/22 revealed Resident #50 had an alteration in activities of daily living performance due to Parkinson's disease. The care plan revealed he was cognitively intact and able to make his needs know. Interventions included encourage resident participation while performing activities of daily living and break down tasks for the resident to perform. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #50 was cognitively intact. He required extensive assist of one staff with bed mobility. He was totally dependent of two staff with transfers and bathing. Review of the Bath and Skin Report, from 12/01/22 to 02/27/23, revealed Resident #50 had a bath and/ or shower on 12/28/22, 12/31/22, 01/02/23, and 01/25/23. Review of the facility form labeled, Shower Documentation Survey Report V2, for December 2022, revealed Resident #50 had a shower and/ or bath on 12/15/22 and 12/19/22. There was no other documented evidence showers/ baths were provided for the month. Review of the facility form labeled, Shower Documentation Survey Report V2, for January 2023, revealed Resident #50 had a shower and/ or bath on 01/19/23. There was no other documented evidence showers/ baths were provided for the month. Review of the facility form labeled, Shower Documentation Survey Report V2, for February 2023, revealed Resident #50 had a shower and/ or bath on 02/04/23, 02/09/23, 02/15/23, and 02/26/23. There was no other documented evidence showers/ baths were provided for the month. Review of undated facility form labeled, CV Shower Schedule revealed Resident #50 was to receive a shower every Sunday and Wednesday during the evening/ night shift. Interview on 02/16/23 at 11:09 A.M. with STNA #810 revealed she felt many times showers were not able to be completed due to lack of staffing. Interview on 02/21/23 at 9:22 A.M. with Resident #50 revealed he was supposed to get a shower twice a week and he revealed he did not get his showers as scheduled because there was not enough staff some days to give him one when he was scheduled. He revealed he had gone weeks in the past without a shower. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/27/23 at 10:06 A.M. with DON #2 verified she only had documentation that Resident #50 received a shower or bath from 12/01/22 to 02/27/23 on 12/15/22, 12/19/22, 12/28/22, 12/31/22, 01/02/23, 01/19/23, 01/25/23, 02/04/23, 02/09/23, 02/15/23, and 02/26/23. She verified Resident #50 had gone prolonged periods without a shower and/ or bath as she had no documented evidence he received a shower or bath from 12/01/22 to 12/18/22, from 12/20/22 to 12/27/22, and from 01/03/23 to 01/18/23. She verified he was to have a shower twice a week. 43063 3. Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including difficulty in walking, chronic pain syndrome, and heart failure. Review of the care plan dated 02/25/21 for Resident #45 revealed she was at risk for decline in activities of daily living related to weakness, chronic pain, and alteration in cardiovascular and respiratory status. Interventions included preventative skin care as needed. Review of the shower schedule revealed Resident #45 was to have showers on Monday and Saturday on dayshift. Review of Resident #45's shower sheets for January and February 2023 revealed she did not have showers on 01/07/23, 01/14/23, 01/21/23, 01/23/23, 02/04/23, 02/06/23, 02/11/23 and 02/20/23 as scheduled. Interview on 02/27/23 at 10:06 A.M. with DON #2 verified there were no showers or shower sheets on the days listed above. 34297 4. Review of Resident #78's medical record revealed he was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, muscle weakness, and other reduced mobility. Review of Resident #78's MDS 3.0 assessment dated [DATE] revealed he exhibited intact cognition and required one staff assist for showers. Review of Resident #78's activities of daily living care plan revealed an intervention dated 12/14/22 to encourage participation in activities of daily living during daily care. Review of Resident #78's nurse aide documentation revealed he received a bed bath on 02/12/23. No other documentation was provided, and he was not listed on the master shower schedule. Interview on 02/21/23 at 8:44 A.M. with Resident #78 indicated he did not receive showers and has not had one in a long time. Interview on 02/23/23 at 10:13 A.M. with Licensed Practical Nurse (LPN) #838 indicated she went to Resident #78's room on this date and asked him when he would like his showers completed. She confirmed the facility did not have evidence he had received showers in the last 30 days. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Giving a Bed bath, revised October 2010, (the facility did not have a policy for providing showers or bathing), revealed staff were to document the date and time the bed bath was performed. This deficiency represents non-compliance investigated under Complaint Numbers OH00140369 and OH00140222.

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, facility policy and procedure review, and interview the facility failed to ensure Resident #52 and Resident #55, who required staff assistance for activities of daily living care, received adequate and timely incontinence care. This resulted in Immediate Jeopardy and actual harm on 02/06/23 when Resident #55, who required extensive assist of two staff for activities of daily living care and was assessed to be always incontinent of bowel and bladder, went from 02/06/23 at 2:00 A.M. to 1:25 P.M. before being provided incontinence care after repeated requests. Resident #55 was observed to be saturated in urine and dried bowel movement on her bilateral thighs area resulting in the development of a Stage II pressure ulcer (partial thickness wound at the epidermis and dermis level) to her left buttock that was bleeding with excoriation and redness surrounding. The Immediate Jeopardy and actual harm continued on 02/08/23 when Resident #52, who required total dependence from two staff for incontinence care and was assessed to be always incontinent of bowel and bladder, went from 02/08/23 at 5:30 A.M. to 9:34 A.M. without incontinence care after repeated requests. Resident #52 was found saturated in urine and bowel movement with a dried brown ring on her bottom sheet resulting in excoriation with redness on her peri area and excoriation with bleeding and redness to her bilateral buttocks. On 02/16/23 at 4:57 P.M. the Administrator and Regional Director of Clinical Services #859 were notified Immediate Jeopardy began on 02/06/23 when staff failed to provide Resident #55 incontinence care after repeated requests resulting in the development of a Stage II pressure ulcer to her left buttock that was bleeding with excoriation and redness surrounding and on 02/08/23 when staff failed to provide Resident #52 incontinence care after repeated requests resulting in excoriation with bleeding and redness to her bilateral buttocks. In addition, concerns that did not rise to Immediate Jeopardy were identified related to the facility failure to ensure Resident #8, #10, and #26 were assisted with proper denture care and provided dentures for use prior to meals. This affected two residents (#52 and #55) reviewed for incontinence care, three residents (#8, #10 and #26) reviewed for oral/denture status and had the potential to affect 68 additional residents (#1, #2, #3, #4, #5, #7, #8, #9, #10, #11, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #24, #25, #26, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #60, #61, #62, #64, #66, #67, #68, #69, #72, #73, #74, #75, #76, #77, #78, and #80) who were assessed to be incontinent of bowel and/or bladder. The facility census was 84. The Immediate Jeopardy was removed on 02/22/23 when the facility implemented the following corrective actions: On 02/16/23 at 11:26 P.M. Resident #52 was assessed by Unit Manager/ LPN #974 for negative outcomes related to the lack of timely incontinence care. Resident #52 has a treatment in place to peri area which was ordered on 02/15/23 by Wound Nurse Practitioner (NP) #968. Resident was updated of new treatment regimen and verbalized understanding. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/16/23 at 11:42 P.M. Resident #55 was assessed by Regional Clinical Nurse #859 for negative outcomes related to the lack of timely incontinence care. Resident #55 refused to have skin assessed despite education and multiple attempts. Resident has treatment order in place to left buttocks which was ordered on 02/07/23 by Wound NP #968. Resident was updated of current treatment regimen to left buttock and verbalized understanding. On 02/16/23 at 7:00 P.M. all 68 additional residents who were identified to be incontinent were assessed by Unit Manager/ Licensed Practical Nurse (LPN) #975 and Unit Manager/ LPN #974 to ensure that timely and appropriate incontinence care was provided. On 02/16/23 at 8:00 P.M. the Administrator reviewed current staffing levels to ensure adequate staffing for the facility. On 02/17/23 at 10:30 A.M. residents who were interviewable were asked if they felt staff met their needs timely and if their call light was answered in a timely manner. Interviews were completed by the Administrator, Admissions #806, Environmental Director #842, Human Resources #821, Medical Records/Housekeeping #835, Licensed Social Worker (LSW) #819, Activities #803, and Dietary Manager #808. On 02/17/23 at 2:00 P.M. the Administrator, Director of Nursing, Scheduler #826, Unit Manager/ LPN #974, and Unit Manager/ LPN #975 were educated by Regional Director of Operations #977 on adequate staffing levels to provide timely and appropriate care. On 2/17/23 at 2:00 P.M. a staffing meeting was held by Administrator to review daily schedule and ensure adequate staffing for the facility. On 02/17/23 at 2:15 P.M. an Ad Hoc Quality Assurance Performance Improvement (QAPI) was completed including Medical Director #978 via phone. On 02/18/23 at 9:20 A.M. current staffing and schedules were reviewed by Scheduler #826, LSW #819, and Regional Nurse #976 to ensure facility was meeting adequate staffing. Beginning on 02/18/23 the facility implemented audits to be conducted by DON/designee to ensure all residents received timely and appropriate incontinence care, daily for four weeks then weekly for four weeks then ongoing as needed. Audits were verified as completed on 02/18,23, 02/19/23, 02/20/23, and 02/21/23. Beginning on 02/18/23 a plan for resident and/or responsible party interviews to be conducted by the Administrator/designee to ensure that all residents receive timely and adequate personal care. The interviews will be completed with five residents daily for four weeks and then five residents weekly for four weeks and then ongoing as needed. Interviews verified as completed on 02/18,23, 02/19/23, 02/20/23, and 02/21/23. Beginning on 02/18/23 a plan for audits to be conducted by the Administrator/designee to ensure sufficient staffing to maintain appropriate care for all residents, five times weekly for eight weeks and ongoing as needed. Audits verified as completed on 02/18/23, 02/19/23, 02/20/23, and 02/21/23. Staff education as part of the facility abatement plan was initiated on 02/16/23 and continued through 02/22/23. (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 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/16/23 at 9:00 P.M. the interdisciplinary management team (Administrator, Admissions #806, Environmental Director #842, Human Resources #821, Medical Records/Housekeeping #835, Licensed Social Worker (LSW) #819, Activities #803, Dietary Manager #808 with Regional Clinical Nurse #859 began education for staff including clinical topics on timely and appropriate incontinence care, the facility Quality of Life and Dignity policy, answering call lights timely and prevention of pressure ulcer development. Interview with staff on 02/21/23 from 5:05 A.M. to 5:48 A.M. revealed Agency LPN #989, #983, LPN #848, Agency STNA #988, #984, #985, and STNA #990 were not educated prior to working at the facility. On 02/21/23 at 7:45 A.M. Regional Nurse #976 and Administrator notified of staff not educated prior to start of shift. Interviews with staff on 02/22/23 from 9:59 A.M. to 10:12 A.M. revealed LPN #820 and Agency STNA #944 did not receive education prior to working at the facility. On 02/22/23 at 10:25 A.M. [NAME] President of Clinical Services #979 was notified of staff not being educated prior to shift. On 2/22/23 at 1:00 P.M. the facility implemented a plan to ensure a department head would be assigned to each shift change to ensure education was provided to each employee entering the facility prior to working their assignment. Interview on 02/22/23 from 2:02 P.M. to 2:10 P.M. LPN #820 and Agency STNA #944 received education. All findings will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations. Although the Immediate Jeopardy was removed on 02/22/23, 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 action and monitoring to ensure on-going compliance. Findings include: 1. Record review for Resident #55 revealed an admitted [DATE] with diagnoses including congestive heart failure, diabetes, chronic kidney disease, morbid obesity, and hypertension. Review of the care plan dated 09/01/20 revealed Resident #55 had an alteration in elimination related to bowel and bladder incontinence. Interventions included check and change every two hours and as needed, monitor for skin redness and irritation, and provide incontinence care as needed. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had intact cognition and required extensive assist of one staff with bed mobility and was totally dependent of two staff with transfers. She required extensive assist of two staff with toileting. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no pressure ulcers during the seven-day assessment reference period. Review of the care plan dated 01/24/23 revealed Resident #55 had actual impaired skin integrity from moisture associated skin damage (MASD) to her right thigh. Interventions included provide wound care per physician order and skin assessment per policy. Review of the Braden scale pressure ulcer risk assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #971 revealed Resident #55 was at high risk for pressure ulcers due to her sensory perception was very limited, constantly moist, bedfast, and problem with friction and shear. Review of the February 2023 physician's orders, revealed Resident #55 had an order to cleanse her left and right inner thighs, apply collagen to the wound base, and cover with a foam dressing every day shift due to excoriation dated 01/08/23. A new order was obtained on 02/07/23 to cleanse her left buttock with normal saline, apply alginate and a foam dressing due to skin compromise (new open area). Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired impaired skin to her left inner thigh from the friction of her brief. There were no measurements, and the treatment was to continue. Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired MASD to her right thigh area due to friction and body fluids. The treatment was to continue as ordered. Interview on 02/06/23 at 10:15 A.M. with Resident #55 revealed she activated her call light and staff answered her call light on 02/06/23 at 8:00 A.M. She revealed she told staff that she needed changed, and they turned off her light and walked out of the room. She revealed she was still waiting the staff to come back. She was unable to name the staff as she stated the staff were all from agency, and stated she had different staff almost every day. Interview on 02/06/23 at 10:35 A.M. with Agency State tested Nursing Assistant (STNA) #854 revealed she was the aide assigned to Resident #55, and she had been on the unit alone for three hours. She revealed she had 27 residents and had not provided the residents (including Resident #55) incontinence care as she had just finished with breakfast trays. Interview and observation on 02/06/23 at 11:17 A.M. with Resident #55 revealed staff had not come back to provide incontinence care. She again stated she had asked at 8:00 A.M. She revealed the last time she was changed was on 02/06/23 at 2:00 A.M. She revealed staff always said they would be back after they answered her call light, but they never returned. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 02/06/23 at 11:59 A.M. revealed Resident #55 yelled out as Agency STNA #854 walked by her room. Resident #55 stated to Agency STNA #854 that she was still waiting to be changed and stated she had been waiting since 8:00 A.M. Agency STNA #854 stated to Resident #55 that she was waiting for Agency LPN #852 to do her dressing change and she was going to change her at the same time. Agency STNA #854 also told to Resident #55 that she also had to finish changing two other residents down the hall and then she would get to her. Observation on 02/06/23 at 12:38 P.M. revealed Agency STNA #854 asked Agency LPN #852 to let her know when she was ready to change Resident #55's dressings as she was going to change her at the same time. Agency LPN #852 stated she was ready anytime. Agency STNA #854 then stated, well right now, I am going to chart and stuff. Agency STNA #853 who also was assigned Resident #55's unit came up to the nursing station at the same time and proceeded to remain at the nursing station from 12:38 A.M. to 12:45 P. M. on her personal phone and Agency STNA #854 continued to document. Observation revealed on 02/06/23 at 12:45 P.M. Agency STNA #854 stated to Agency LPN #852 oh well, trays are here now. Observation on 02/06/23 at 1:25 P.M. revealed Agency LPN #852 asked Agency STNA #853 to assist her in doing Resident #55's incontinence care and wound care. While in the room, Resident #55 requested only Agency LPN #852 complete her incontinence care and wound care. Agency LPN #852 then proceeded to provide incontinence care. Observation revealed Resident #55's brief was heavily saturated in urine as Agency LPN #852 stated if she had to estimate, Resident #55 had urinated at least five times. Observation also revealed Resident #55 was incontinent of a moderate amount of bowel movement and parts of the bowel movement were dried to her bilateral inner thighs. Agency LPN #852 was asked to describe her skin integrity and she revealed her peri area and buttocks were excoriated with redness and bleeding. She revealed Resident #55 was tender to touch as Resident #55 stated ouch, ouch when provided incontinence care. Resident #55 then proceeded to say it was very sore and tender as she had not been changed since 2:00 AM. (almost 12 hours). Agency LPN #852 completed her wound dressing changes as ordered. She then noted a new open area to Resident #55's left buttock. Agency LPN #852 described the new open area as a Stage II pressure ulcer that measured 1.0 centimeter (cm) in length by 1.0 cm in width, and she revealed she was unable to determine the depth as there was a large amount of bleeding. She revealed the area was surrounded by redness. Resident #55 then became upset and started to cry as Agency LPN #852 was informing her of the new area. Resident #55 again stated that she had not been changed since 2:00 A. M. and that she had asked at 8:00 A.M. and then also again after that, and nobody changed her. She revealed now she had another pressure ulcer and that she would never get healed. Interview on 02/06/23 at 2:15 P.M. with Resident #55's daughter revealed she had informed management staff multiple times regarding her mother not getting changed at least every two hours and that even after she brought up the concern, things had not improved. She revealed she was upset because her mother had a new pressure ulcer because the facility did not provide the care she needed. Review of nursing note dated 02/06/23 at 2:07 P.M. and completed by Agency LPN #852 revealed during wound care Resident #55 was found to have another small open area to her left buttock with moderate amount of blood. The area was about 1.0 cm in size. The wound was cleaned with normal saline, and a dressing was applied. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing revealed incontinence care was to be completed every two hours and/ or as needed if it was needed prior. (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 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infection and skin irritation, and observe the residents skin condition. The policy did not include language to provide perineal care timely. 2. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes, morbid obesity, and congestive heart failure. Review of the care plan dated 06/02/22 revealed Resident #52 had an alteration in elimination. She was incontinent of bowel and bladder. Interventions included incontinence care as needed and monitor skin for redness and irritation. Review of the care plan dated 06/02/22 revealed Resident #52 was at risk for impaired skin integrity due to morbid obesity. Interventions included barrier cream after each incontinent episode, skin assessment as ordered, and turn and reposition as ordered. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #52 had intact cognition. She required extensive assist of two staff with bed mobility. She was totally dependent of two staff with toileting and transfers. She was always incontinent of bowel and bladder. Review of an email dated 01/17/23 at 8:28 P.M. from LPN #820 to Regional Director of Clinical Services #859 revealed LPN #820 answered Resident #52's call light, and she had expressed that she was waiting to be changed. The email noted STNA #856 had answered her call light on 01/17/23 at 6:30 P.M. and turned her call light off and stated she would return. The email noted LPN #820 stated she had asked STNA #856 to answer Resident #52's call light. The email noted she followed up with Resident #52 who stated STNA #856 had not provided incontinence care. The email revealed Resident #52 was lying in bowel movement for an hour, and STNA #856 left the facility without changing the resident. Review of the Weekly Skin assessment dated [DATE] and completed by LPN #971 revealed Resident #52's skin was intact, and no issues were noted. Review of the Braden scale pressure ulcer risk assessment dated [DATE] authored by LPN #971 revealed Resident #52 was at high risk for skin breakdown. Interview on 02/06/23 at 9:48 A.M. and on 02/07/23 at 11:02 A.M. with Resident #52 revealed it took five to six hours to get changed most the time. She revealed she would activate her call light and when staff answered her call light, she would ask to get changed and staff would say they would be back, but they did not return for several hours. She revealed on 02/05/23 she was not changed for over 12 hours even though she had asked several times. She revealed several weeks ago an STNA #856 had answered her call light at approximately 6:30 P.M. and said she would be back but never returned. She revealed she notified LPN #820 and she stated she would have STNA #856 change her. She revealed STNA #856 never changed her as she left at the end of her shift. She revealed she did not end up getting changed until approximately 8:00 P.M. She revealed LPN #820 stated she would notify management of the concern, but they had never followed up with her regarding the incident. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed she reported an incident she felt was neglect a few weeks ago as STNA #856 had answered Resident #52's call light and Resident #52 had asked to be changed, and STNA #856 stated she would be back. She revealed Resident #52 had also reported to her that she needed changed so she had instructed STNA #856 to change Resident #52, but she never changed her and left the facility. She revealed she reported the incident to Regional Director of Clinical Services #859 in writing. She revealed she had witnessed this occur multiple times especially from the agency staff as they would sit behind the nursing station and not assist the residents with incontinence care. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing revealed incontinence care was to be completed every two hours and/ or as needed if it was needed prior. Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held Resident Council Meetings monthly. She revealed on 11/29/22 several residents, including Resident #52, revealed they had not been receiving proper care including timely incontinence care. She revealed on 01/25/23 residents complained of being left soiled, including Resident #52. She revealed the facility had not had consistent management and it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting but felt the issues were not addressed as the same concerns continued monthly. Interview and observation on 02/08/23 at 8:32 A.M. revealed Resident #52 had her call light on, and a strong odor of urine and bowel movement was coming from her room. She had tears in her eyes and stated, it is happening again as her call light had been on since 7:45 A.M. as she needed changed as she was lying in a soiled mess. She revealed she had a bowel movement, and her skin was burning. Observation on 02/08/23 at 8:46 A.M. revealed the Administrator answered the resident's call light and Resident #52 explained she needed changed. The Administrator asked what nursing station she was assigned to (since her room was in the middle of the two nursing stations). The Administrator proceeded to the nursing station and left the resident's call light on. Observation on 02/08/23 at 9:14 A.M. revealed Agency STNA #862 answered Resident #52's call light and the resident again stated she needed changed. Agency STNA #862 revealed she would tell the resident's aide and proceeded to notify STNA #833. Observation on 02/08/23 at 9:22 A.M. revealed STNA #833 walked into Resident #52's room and told Resident #52 she had to collect breakfast trays and then would provide her incontinence care. Observation on 02/08/23 at 9:34 A.M. of incontinence care completed by STNA #833 and STNA #857 for Resident #52 revealed the resident had excoriation with redness on her peri area and excoriation with bleeding and redness to her buttocks. Resident #52's brief was heavily saturated with urine as well as a large brown dried ring on the resident's bottom sheet. The resident had also been incontinent of large amount of bowel movement. STNA #833 verified the above findings. Resident #52 stated she had not been changed since 5:30 A.M. STNA #833 revealed there was only one aide on the unit on night shift, and she was not able to get to Resident #52 prior. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infection and skin irritation, and observe the residents skin condition. The policy did not include language to provide perineal care timely. 3. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including dementia, mild protein calorie malnutrition, hypertension, and congestive heart failure. Review of the Dental Progress Note dated 01/09/23 and authored by Dentist #863 revealed he completed a periodic exam for Resident #8. He revealed she had no natural teeth, and her dentures were well fitting. Review of the care plan dated 01/09/23 revealed Resident #8 was at risk for oral and dental health problems related to dentures. Interventions included coordinate arrangements for dental care, monitor and document signs of oral problems, and provide mouth care. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #8 had impaired cognition. She required total dependence of two staff with bed mobility and transfers. She was unable to ambulate. She required extensive assist of one staff with personal hygiene and limited assist of one staff with eating. She had no natural teeth. Review of the February 2023 Physician Orders revealed Resident #8 was on a mechanical soft diet. Interview on 02/06/23 at 3:50 P.M. with Resident #8's daughter revealed she had visited several times when her mother was eating, and the facility had not placed her dentures inside her mouth causing difficulty for Resident #8 to eat. Resident #8's daughter revealed she had brought this concern up many times to the administration, but it continued to occur. Observation on 02/07/23 at 8:55 A.M. revealed Resident #8 was in her bed with her breakfast tray in front of her. She was trying to bite into an English muffin and was having difficulty biting a piece off as she did not have dentures in her mouth. Observation revealed her dentures were in the bathroom in the denture cup. She then proceeded to set the English muffin back down without taking a bite and closed her eyes not attempting to eat any further. Interview on 02/07/23 with STNA #818 revealed she had provided Resident #8 her breakfast tray. She verified she had not provided Resident #8 her dentures prior to providing her tray and stated, Yes she should have had her dentures in for breakfast. 4. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, dementia, gastroesophageal reflux disease, and major depression. Review of the care plan dated 02/09/22 revealed Resident #26 was at risk for oral problems related to edentulous (no teeth) status. Interventions included monitor for signs of oral problems and provide mouth care as per activities of daily living personal hygiene. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Dental Progress Note dated 02/17/22 revealed Dentist #864 completed a periodic exam and noted Resident #26 had upper and lower dentures. She revealed the dentures fit well, and the resident was satisfied. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #26 had impaired cognition. He required extensive assist of one staff with bed mobility, and limited assist of one staff with personal hygiene. He was independent with set-up help for eating. He had no natural teeth. Review of the February 2023 Physician Orders revealed Resident #26 was on a regular mechanical soft diet. Observation and interview on 02/07/23 at 9:05 A.M. with Resident #26 revealed his breakfast tray was sitting on his over the bed table, and he was lying on his bed. He revealed he did not have his dentures in. He revealed staff did not offer his dentures when they had delivered his tray. He stated, I do not think they would even if I asked. He revealed the staff were always in a hurry, and he felt he received no assistance from staff with his care. He revealed it would be nice to have been offered his dentures as he felt he does eat better with his dentures in his mouth. Observation revealed his upper and lower dentures were in his bathroom in a denture cup. Interview on 02/07/23 at 9:14 A.M. with LPN #820 verified Resident #26's dentures were sitting in a denture cup in his bathroom. She revealed she thought he placed his own dentures in his mouth and usually was not a big breakfast eater anyway. 5. Record review for Resident #10 revealed an admitted [DATE] with diagnoses including psychosis, chronic obstructive pulmonary disease, hypertension, and Alzheimer's disease. Review of the Dental Progress Note dated 02/07/20 revealed Resident #10 had a comprehensive dental exam. She had upper and lower dentures, and the dentures fit well. Review of the care plan dated 05/25/22 revealed Resident #10 was edentulous and had upper and lower dentures. Interventions included coordinate arrangements for dental care, frequent mouth inspections, monitor for signs of oral and dental problems, and provide mouth care as per activities of daily living personal hygiene. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #10 had impaired cognition. She was totally dependent of two staff with bed mobility and transfers. She was totally dependent of one staff with personal hygiene and required extensive assist of one staff with eating. She had no natural teeth. Review of the February 2023 physician ordered revealed Resident #10 was on a pureed diet. Observation on 02/07/23 at 9:17 A.M. revealed Agency STNA #857 was feeding Resident #10 in her room. Agency STNA #857 revealed she had not attempted to put in Resident #10's dentures prior to assisting with feeding. She revealed she did not realize she had dentures. Observation revealed in Resident #10's bathroom there was a denture cup with dentures in it. Attempted to interview Resident #10 on 02/07/23 at 9:19 A.M. but unable due to cognitive ability. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the list of residents provided by the facility on 02/06/23 of residents that had dentures revealed it included Residents #8, #10, and #26. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing verified Residents #8, #10, and #26 had dentures, and staff should have assisted the residents with oral care including the assistance of providing dentures prior to breakfast. Review of the facility policy labeled, Dentures, Cleaning and Storing, dated October 2010, revealed the purpose of the policy was to cleanse and freshen the resident's mouth, clean the resident's dentures, and to prevent infections of the mouth. The policy revealed the resident was to be provided denture care before breakfast and at bedtime. The policy revealed to instruct and assist the resident as needed to rinse his or her mouth after each meal. The policy revealed encourage the resident to keep dentures in as much as possible as when dentures were left out the bone structure to the mouth changes and the gums shrink causing dentures to fit improperly. This deficiency represents non-compliance investigated under Complaint Number OH00140369, OH00140222, OH00139918, OH00139084 and OH00138338.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure adequate weight monitoring was completed for Residents #8 related to a diagnosis of congestive heart failure, and Residents #25, #69, and #76 related to bowel elimination; and failed to ensure Resident #236's physician orders were implemented for wound care to the right lateral foot as well as adequate assessment and monitoring of the right lateral foot and failed to ensure Resident #24's compression hose were implemented per the physician order. This affected one resident (#8) of three residents reviewed for weights, three residents (#25, #69 and #76) of three residents reviewed for bowel elimination, one resident (#236) of three residents reviewed for wounds, and one resident (#24) of one resident reviewed for edema. The facility census was 84. Findings include: 1. Record review revealed Resident #25 was admitted to the facility on [DATE] and was transferred to the hospital on 02/17/23. Diagnoses included diverticulosis of intestine, mild protein-calorie malnutrition, essential primary hypertension, dementia, Alzheimer's disease with early onset, and epilepsy. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #25 had severe cognitive impairment. Review of the physician's orders for Resident #25 revealed orders dated 01/04/22 for milk of magnesia 400 milligrams (mg) per 5 milliliters (ml), give 5 ml every 24 hours as needed (PRN) for constipation; bisacodyl suppository, one rectally every 24 hours PRN for constipation; and fleet enema 7-19 grams per 118 ml, insert one rectally every 24 hours PRN for constipation. Review of the care plan initiated 01/05/22 revealed Resident #25 was at risk for constipation and gastrointestinal issues related to diverticulosis. Interventions included to administer medications as ordered; monitor for constipation and causes; and monitor for any complications i.e., abdominal pain, abdominal distension, lack of bowel movements, and signs or symptoms of blood in stool, and update the physician as needed. Review of the nursing assistant documentation for bowel function, printed 02/22/23 with a 30-day look back period, revealed bowel function was documented for the period of 01/25/23 to 02/15/23. There was no documentation Resident #25 had a bowel movement after 02/07/23 and through 02/15/23. Review of the progress notes for February 2023 revealed Resident #25 had no documentation related to or of a bowel movement after 02/07/23 and before 02/17/23 when Resident #25 was transferred to the hospital. Review of the Treatment Administration Record (TAR) for February 2023 revealed no documentation related to bowel function. Review of the Medication Administration Record (MAR) for February 2023 revealed PRN orders for milk of magnesia, bisacodyl suppository, and fleets enema were not administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/22/23 at 10:39 A.M. with Licensed Practical Nurse (LPN) #830 confirmed nursing assistants record all bowel movements on the bowel function flow records and the electronic medical record (EMR) program would deliver a warning message to the nurse when any resident did not have a bowel movement recorded. Interview on 02/22/23 at 2:39 P.M. with LPN #830 verified there was a three-day bowel protocol for nurses to follow, and the EMR program alerted nurses when there were no bowel movements after the third day. Residents were questioned by the nurses about having a bowel movement, and then provide intervention when needed. The EMR program was not sending alerts and had not been for at least the past week or two, so nurses had to ask residents and document the responses in the progress notes. LPN #830 confirmed Resident #25 had no bowel function tracking completed after 02/07/23 and before 02/17/23, and no interventions were provided as ordered. Review of the facility bowel protocol, printed on 02/27/23, revealed if no bowel movement for three days administer milk of magnesia, the second step was to administer a Dulcolax suppository, and the third step was to administer a fleets enema. If there was no bowel movement for four days, administer a Dulcolax suppository followed by a fleets enema, and if no bowel movement for five days administer a fleets enema. Interview on 02/27/23 at 10:51 A.M. with Director of Nursing (DON) #2 revealed there was no written policy or procedure for bowel management. The protocol was set-up within the EMR system which was applied upon admission or when needed. The EMR system was set-up to identify when there was no bowel movement recorded after three days. DON #2 verified the bowel protocol printed on 02/27/23 was the facility's protocol for all residents and indicated the nurses were aware of the protocol as it was set-up in the EMR system. DON #2 confirmed if the protocol was not initiated on admission, then the nurses would need to contact the physician to obtain the orders, add them and follow the protocol. 2. Record review revealed Resident #69 was admitted to the facility on [DATE]. Diagnoses included surgical aftercare following surgery on digestive system, diabetes mellitus type two, dementia, Alzheimer's disease, down syndrome, and profound intellectual disabilities. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #69 had severe cognitive impairment. Review of the physicians orders for Resident #69 revealed no PRN medication orders for constipation or to manage bowel elimination. Review of the care plan initiated 02/06/23 revealed Resident #69 was at risk for constipation related to immobility. Interventions included to follow facility bowel protocol for bowel management and give laxatives as ordered by the physician as indicated PRN; and record bowel movement pattern each day, describe amount color and consistency. Review of the nursing assistant documentation for bowel function, printed 02/22/23 with a 30-day look back period, revealed bowel function was documented for the period of 01/26/23 to 02/21/23. There was no documentation Resident #69 had a bowel movement between 02/03/23 and 02/21/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes for February 2023 revealed on 02/04/23, Resident #69 was constipated during patient care and had a medium hard bowel movement. On 02/22/23, Resident #69 had a large bowel movement. There was no documentation Resident #69 had a bowel movement between 02/04/23 and 02/22/23. Review of the TAR for February 2023 revealed no documentation related to bowel function. Review of the MAR for February 2023 revealed no PRN interventions for bowel management. Interview on 02/22/23 at 2:39 P.M. with LPN #830 verified there was a three-day bowel protocol for nurses to follow, and the EMR program alerted nurses when there were no bowel movements after the third day. Residents were questioned by the nurses about having a bowel movement, and then provide intervention when needed. The EMR program was not sending alerts and had not been for at least the past week or two weeks, so nurses had to ask residents and document the responses in the progress notes. LPN #830 confirmed Resident #69 had no bowel function tracking completed after 02/04/23 and before 02/21/23, and no interventions were provided when needed. Review of the facility bowel protocol, printed on 02/27/23, revealed if no bowel movement for three days administer milk of magnesia, the second step was to administer a Dulcolax suppository, and the third step was to administer a fleets enema. If there was no bowel movement for four days, administer a Dulcolax suppository followed by a fleet's enema, and if no bowel movement for five days administer a fleets enema. Interview on 02/27/23 at 10:51 A.M. with DON #2 revealed there was no written policy or procedure for bowel management. The protocol was set-up within the EMR system which was applied upon admission or when needed. The EMR system was set-up to identify when there was no bowel movement recorded after three days. DON #2 verified the bowel protocol printed on 02/27/23 was the facility's protocol for all residents and indicated the nurses were aware of the protocol as it was set-up in the EMR system. DON #2 confirmed if the protocol was not initiated on admission, then the nurses would need to contact the physician to obtain the orders, add them and follow the protocol. 3. Record review revealed Resident #76 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, generalized anxiety disorder, benign prostatic hyperplasia (BPH), convulsions, depression, and metabolic encephalopathy. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #76 had severe cognitive impairment. Review of the physicians orders for Resident #76 revealed orders dated 08/10/22 for milk of magnesia 400 mg per 5 ml, give 5 ml every 24 hours PRN for constipation, nursing to administer if no bowel movement after three days; bisacodyl suppository, administer one rectally every 24 hours PRN for constipation on ensuing shift if still no bowel movement; fleet enema 7-19 grams per 118 ml, insert one rectally every 24 hours PRN for constipation, may administer if no bowel movement on the subsequent shift after suppository; and if no bowel movement after following steps one, two and three, notify physician of no bowel movement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan initiated 06/24/22 revealed Resident #69 had an alteration in elimination secondary to diagnosis of BPH and was incontinent of both bowel and bladder at times. Interventions included to administer medications as ordered; and note type, color, and amount of stool. Review of the nursing assistant documentation for bowel function, printed 02/22/23 with a 30-day look back period, revealed bowel function was documented for the period of 01/26/23 to 02/21/23. There was no documentation Resident #76 had a bowel movement between 02/06/23 and 02/21/23. Review of the progress notes for February 2023 revealed Resident #76 was constipated during patient care and had a medium hard bowel movement. On 02/20/23, Resident #76 had a small bowel movement and to alert there was no bowel movement after three days. On 02/22/23, Resident #76 had a large bowel movement. There was no documentation Resident #76 had a bowel movement prior to 02/20/23. Review of the TAR for February 2023 revealed if Resident #76 had no bowel movement after following steps one, two and three, notify physician of no bowel movement every 24 hours for constipation, which was not signed as completed. Review of the MAR for February 2023 revealed PRN orders for milk of magnesia, bisacodyl suppository, and fleet's enema were not administered. Interview on 02/22/23 at 10:39 A.M. with LPN #830 confirmed nursing assistants record all bowel movements on the bowel function flow records and the EMR program would deliver a warning message to the nurse when any resident did not have a bowel movement recorded. Interview on 02/22/23 at 2:39 P.M. with LPN #830 verified there was a three-day bowel protocol for nurses to follow, and the EMR program alerted nurses when there were no bowel movements after the third day. Residents were questioned by the nurses about having a bowel movement, and then provide intervention when needed. The EMR program was not sending alerts and had not been for at least the past week or two, so nurses had to ask residents and document the responses in the progress notes. LPN #830 confirmed Resident #76 had no bowel function tracking completed between 02/06/23 and 02/20/23, and no interventions were provided as ordered. Review of the facility bowel protocol, printed on 02/27/23, revealed if no bowel movement for three days administer milk of magnesia, the second step was to administer a Dulcolax suppository, and the third step was to administer a fleets enema. If there was no bowel movement for four days, administer a Dulcolax suppository followed by a fleet's enema, and if no bowel movement for five days administer a fleets enema. Interview on 02/27/23 at 10:51 A.M. with DON #2 revealed there was no written policy or procedure for bowel management. The protocol was set-up within the EMR system which was applied upon admission or when needed. The EMR system was set-up to identify when there was no bowel movement recorded after three days. DON #2 verified the bowel protocol printed on 02/27/23 was the facility's protocol for all residents and indicated the nurses were aware of the protocol as it was set-up in the EMR system. DON #2 confirmed if the protocol was not initiated on admission, then the nurses would need to contact the physician to obtain the orders, add them and follow the protocol. 34297 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #236's medical record revealed he was admitted on [DATE] with diagnoses including dementia, chronic obstructive pulmonary disease, and essential hypertension. Review of Resident #236's admission orders revealed an order dated 02/14/23 for Gentamicin sulfate external ointment (antibiotic) 0.1% (percent) apply to the right dorsal foot wound topically every day shift for wound care. Cleanse the wound with Hibiclens (antiseptic that fights bacteria), pat dry, apply Gentamicin ointment, cover with an adaptic and wrap with kerlix gauze daily. This order was not placed in the resident's EMR to be placed on the MAR or treatment TAR. Review of Resident #236's progress note dated 02/17/23 at 11:27 A.M. indicated he arrived from another facility and was not oriented. Review of Resident #236's progress note dated 02/17/23 at 10:58 P.M. indicated he had a wound site reported by the sending facility on the dorsal medial right foot with a dressing outdated and in place which was dry and in need of change at admission. He refused wound care, shower, hair, and oral care. The sister was aware. Review of Resident #236's progress note dated 02/20/23 at 1:14 P.M. indicated he refused all care including a skin assessment. The resident's record did not have evidence the right lateral foot wound was assessed, monitored, or provided care on 02/18/23, 02/19/23, 02/21/23, and 02/22/23. Observation on 02/21/23 at 10:15 A.M. revealed a bulky ace dressing on his right foot which was undated. He refused the interview, and he resides on the secured memory care unit (SMCU). Interview on 02/23/23 at 9:15 A.M. with Wound Nurse Practitioner (NP) #968 indicated she did not assess Resident #236 on 02/22/23 when she was in the building, and she was unaware he had a wound on his right foot. Telephone interview on 02/23/23 at 9:20 A.M. with Medical Director #978 indicated Resident #236 would often refuse treatments, medications, and care. He stated he was unaware Resident #236's medical record did not have orders for wound care and wound care should have been attempted at least daily per the previous nursing home's admission orders. Review of the Wound Care policy, revised 10/10, indicated the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. 39973 5. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including dementia, mild protein calorie malnutrition, hypertension, and congestive heart failure. Review of the TAR for January 2023 revealed Resident #8 was to have a daily weight obtained upon rising in the morning due to fluid retention and congestive heart failure. The TAR revealed the weight was to be obtained only by a mechanical lift. The documentation revealed daily weights were not obtained on 01/04/23, 01/05/23, 01/07/23, 01/10/23, 01/12/23, 01/13/23, 01/15/23, 01/16/23, 01/17/23, 01/19/23, 01/24/23, 01/25/23, 01/27/23, and 01/30/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #8 had impaired cognition. The resident required total dependence of two staff with bed mobility and transfers and was unable to ambulate. Her weight was 200 pounds, and she had weight loss. Review of the Nutritional assessment dated [DATE] and completed by Dietitian #866 revealed Resident #8 was on a mechanical soft diet with a supplement at dinner. She had a history of weight fluctuations and was to have a daily weight. Review of the facility form labeled, Complaint/ Grievance Report, dated 01/23/23, and completed by Licensed Social Worker (LSW) #819 revealed Cardiologist #950's progress note dated 01/19/19 was attached to the concern form that revealed Resident #8 was to be weighed every morning after urinating and before eating breakfast. The consult stated contact the physician if Resident #8's weight went up more than three pounds in one day or five pounds in one week. The concern form revealed under documentation of the investigation there was no response regarding the concern of daily weights not being obtained. Review of the February 2023 Physician Orders revealed Resident #8 had an order dated 07/29/21 to have a daily weight upon rising. Review of the TAR for February 2023 revealed Resident #8 was to have a daily weight upon rising in the morning due to fluid retention and congestive heart failure. The TAR revealed the weight was to be obtained only by a mechanical lift. The documentation revealed daily weights were not completed on 02/01/23, 02/02/23, 02/03/23, and 02/06/23. Review of the care plan last revised 02/02/23 revealed Resident #8 had the potential for alteration in nutrition and hydration related to medical diagnoses of dementia, expected weight loss due to fluid shift, and varied intake. Interventions included daily weights, assess, and report any signs of edema, and assist with meals. Observation and interview on 02/06/23 at 12:48 P.M. revealed Resident #8 was up in her wheelchair with a mechanical lift sling underneath her. Resident #8 was unable to report if staff had been weighed her prior to getting up and/or if she had any concerns regarding getting weighed due to her cognitive ability. Interview on 02/06/23 at 1:09 P.M. with Agency STNAs #853 and #854 revealed they worked for agency and that it their first day at the facility. They revealed they were assigned to care for Resident #8 and assisted her up in her chair but were never informed in report that she required a daily weight. Interview on 02/06/23 at 2:25 P.M. with Agency LPN #852 revealed she was the nurse on Resident #8's unit. She revealed STNA #853, STNA #854, and herself were from agency, and that it was their first day working at the facility. Agency LPN #852 revealed she was never informed in report that Resident #8 required a daily weight. Agency LPN #852 verified, after review of Resident #8's physician orders, that Resident #8 required a daily weight upon rising, and they had not obtained a weight prior to her getting up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/06/23 at 3:50 P.M. with Resident #8's daughter revealed Resident #8 was to have a daily weight as this was what her previous Cardiologist #950 had requested. She revealed she had provided the facility the consult as well as voiced her concern that Resident #8 was not getting weighed daily as ordered, but the facility continued to not follow the order. She revealed she had brought up the concern to several management staff including the Administrator. Interview on 02/07/23 at 3:12 P.M. with the DON verified daily weights were not being obtained for Resident #8. She revealed she was not aware Resident #8 required a daily weight as she had only worked at the facility for three weeks. She revealed she was unsure how it was communicated to staff which residents required a daily weight but would assume staff would get that information in report. Interview on 02/07/23 at 4:12 P.M. with LSW #819 revealed Resident #8's daughter had brought up in concern of her mother not getting weighted daily in the care conference on 01/23/23. He revealed Resident #8's daughter had brought in an old cardiologist consult as well as stated that Resident #8 had a current physician order for a daily weight that was not getting done. LSW #819 revealed he filled out a concern form regarding the concern Resident #8's daughter brought up, including attaching the Cardiologist #950's consult regarding the daily weight. He revealed he communicated the concern to the DON. Review of the facility policy labeled, Weight Assessment and Intervention, dated September 2008, revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable wight loss for the residents. The policy revealed weights would be recorded in the individual's medical record. There was nothing in the policy regarding the communication to staff to know when a resident required a daily weight. 43063 6. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnosis including congestive heart failure. Review of the physician's order dated 07/23/22 for Resident #24 revealed she was to have thrombo-embolic deterrent (TED) hose, stockings to reduce deep vein thrombosis, put on at 6:00 A.M. daily and taken off at 6:00 P.M. Review of the MAR and TAR for February 2023, revealed Resident #24 did not have her TED hose applied on 02/02/23, 02/03/23, 02/13/23, and 02/20/23. Observations on 02/21/23 at 12:28 P.M., 02/22/23 at 10:16 A.M., and 02/23/23 at 11:48 A.M. revealed Resident #24 did not have her TED hose on as ordered. Interview on 02/21/23 at 12:28 P.M. with Registered Nurse (RN) #448 verified TED hose were not on Resident #24 as ordered. Interview on 02/23/23 at 11:50 A.M. with STNA #857 verified Resident #24 did not have her TED hose on as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00139084.

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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** 39973 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure timely assessments and adequate interventions were implemented to prevent the development of pressure ulcers. Actual Harm occurred on 11/17/22 when Resident #66, who was diagnosed on [DATE] with a new right wrist and pubis fracture and required extensive assist with activities of daily living including bed mobility and transfers, developed an unstageable pressure ulcer (full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar) to the coccyx with a lack of evidence of adequate and effective interventions being in place prior to the development. This affected two residents (Resident #66 and #55) of three residents reviewed for pressure ulcers. The facility census was 84. Findings included: 1. Review of the medical record for Resident #66 revealed an admitted [DATE] with diagnoses including adjustment disorder with depressed mood, vascular dementia, hypertension, right wrist fracture, and pubis fracture. Review of the unsigned Admission Packet- V12 dated 09/21/22 revealed Resident #66's skin was intact. The admission packet included a Braden Scale pressure ulcer risk assessment that did not indicate if Resident #66 was at risk of developing pressure ulcers. The admission packet revealed the resident had slightly limited sensory perception and was occasionally moist. Review of the care plan dated from 09/21/22 to 11/18/22 revealed no care plan was in place for Resident #66 regarding risk for developing pressure ulcers and/or any interventions to prevent pressure ulcers including after she returned from the hospital on 10/29/22 following treatment for a fracture to her right wrist and pubis area. Review of the Braden Scale pressure ulcer risk assessments for Resident #66 from 09/22/22 to 01/31/23 revealed Resident #66 was not re-assessed again for her risk of developing a pressure ulcer including on 10/29/22 when she returned from the hospital with fractures to her right wrist and pubis area or when a significant change in status Minimum Data Set (MDS) 3.0 assessment was completed on 11/08/22. Review of the nursing note dated 10/28/22 at 3:16 P.M. and completed by Licensed Practical Nurse (LPN) #967 revealed Resident #66 had fallen and stated she felt she had broken her hip. The resident was transferred to the hospital. Review of the nursing note dated 10/29/22 at 10:00 A.M. and completed by LPN/ Unit Manager #809 revealed Resident #66 returned from the hospital on 10/28/22 at approximately 11:30 P.M. and was diagnosed with right wrist and pubis fractures. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #66 had impaired cognition. The assessment revealed the resident required extensive assistance of one staff for bed mobility, dressing, toileting, and personal hygiene. She required extensive assist of two staff with transfers. She was at risk for pressure ulcers and had no pressure ulcers noted at that time. Review of the nurses note dated 11/17/22 at 1:39 P.M. authored by LPN #965 revealed the LPN went in to give Resident #66 a total bed bath and noticed an unstageable wound on her coccyx area. The note revealed the LPN had the wound care nurse measure and treat the wound. The note revealed new treatment orders were obtained. Review of the Wound Weekly Observation Tool, dated 11/17/22, and completed by Former LPN/ Wound Nurse #966 revealed Resident #66 had an unstageable facility acquired pressure ulcer that was first identified on 11/17/22. The wound measured 5.6 centimeters (cm) in length by 4.8 cm in width and the depth was undetermined. The wound contained 75 percent slough (dead tissue that may have a yellow or white appearance) as well as necrotic (dead tissue that usually is black in nature). The area had a moderate amount of serosanguinous (clear drainage that may contain blood) drainage. The assessment revealed a treatment was ordered: cleanse wound with normal saline, pat dry, apply nickel thick Santyl (chemical topical agent used to debride/ remove dead tissue) to wound bed, cover with calcium alginate (dressing for moderately to heavily exudative wounds) and place bordered foam dressing every shift and as needed. Review of the care plan dated 11/18/22 revealed Resident #66 was at risk for impaired skin integrity secondary to fracture. Interventions included barrier cream, elevate heels, inspect skin during routine care, and lift sheet on chair and bed for positioning. Review of the Wound Progress Note dated 12/14/22 and completed by Wound Nurse Practitioner (NP) #968 revealed Resident #66 had a Stage IV (full thickness tissue loss with exposed bone, tendon or muscle, slough or eschar may be present on some parts of the wound bed, often include undermining and tunneling) wound to her sacrum area. The wound measured 2.8 cm in length, 2.5 cm in width, 1.2 cm in depth and was tunneling 1.8 cm at 12 o'clock. The area contained minimal slough. Review quarterly MDS 3.0 assessment dated [DATE] revealed Resident #66 had impaired cognition. She required total dependence of two staff with bed mobility. She required extensive assist of two staff with transfers, toileting, and dressing. She was unable to ambulate. She was at risk for unhealed pressure ulcers and had one unstageable pressure ulcer that was not present on admission. Review of the February 2023 physician's orders revealed Resident #66 had an order to cleanse her coccyx wound with normal saline, pat dry, apply nickel thick Santyl to wound bed, cut and place alginate to size of wound bed and cover with a border foam dressing every day and as needed, encourage side to side repositioning every two hours, and a low air loss mattress. Review of the care plan last revised 02/02/23 revealed Resident #66 had actual impaired skin integrity ulcer to her sacrum area. Interventions included encourage to turn and reposition every two hours as tolerated, low air loss mattress, wound care as ordered, and skin assessments per policy that was added 11/18/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/07/23 at 11:12 A.M. with Resident #66 revealed she had hurt her wrist and hip during a fall several months ago. She revealed she now had a pressure ulcer to her coccyx area. She was unable to provide any further details regarding her pressure ulcer due to cognitive impairment. Observation on 02/07/23 at 12:23 P.M. of wound care for Resident #66, completed by LPN/ Unit Manager #809 revealed the resident had a pressure ulcer to her coccyx/ sacrum area. LPN/ Unit Manager #809 revealed the wound was smaller in size as it started out as an unstageable the size of a 50-cent piece and now was the size of a dime. She described the wound bed with no slough and healthy tissue surrounding. Interview on 02/07/23 at 12:35 P.M. with LPN/ Unit Manger #809 verified Resident #66's wound was first identified on 11/17/22 as a facility acquired unstageable pressure ulcer. She verified the Wound Weekly Observation Tool dated 11/17/22 noted the wound to contained 75 percent slough as well as necrotic tissue. She stated, honestly, I do not know why it was not found at an earlier stage as it should have been. She verified the MDS 3.0 assessment dated [DATE] revealed Resident #66 required extensive assist from staff for transfers and bed mobility. She verified Resident #66 had returned from the hospital on 10/29/22 with fractures to her right wrist and pubis area. She verified a Braden scale pressure ulcer risk assessment was not completed on return from hospital on 10/29/22 nor on 11/08/22 when a significant change in condition MDS 3.0 assessment was completed. She revealed pressure ulcer risk assessments should be completed on admission, quarterly, and upon a change in condition. She verified a pressure ulcer risk assessment for Resident #66 was only completed on 09/21/22 and 01/31/23. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing verified a Braden Scale for pressure ulcer risk assessment was to be done on admission, quarterly, and upon a change in condition. She verified Resident #66 should have been assessed upon return from the hospital with a new fracture to right wrist and pubis area for risk of pressure ulcer development as this was a change in condition for her. She also verified a care plan should have been implemented upon return from the hospital for a potential for impaired skin integrity prior to her developing an unstageable pressure ulcer. Interview on 02/08/23 at 12:50 P.M. with Regional Director of Clinical Services #859 revealed she attempted to find additional wound consults completed by a physician and/or a nurse practitioner (NP) as she consulted the outside wound care provider but indicated the first Wound Progress Note completed by Wound NP #968 was dated 12/14/22 and was the first they had on file. She revealed she was unable to locate any further consults for Resident #66. Review of the facility policy labeled Prevention of Pressure Ulcer/ Injuries, dated July 2017, revealed the purpose of the policy was to provide information regarding the identification of pressure ulcers, injury risk factors, and interventions for specific risk factors. The policy revealed the residents care plan should identify risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The policy revealed risk assessments were to be completed on admission and upon any change in condition. The policy revealed the staff should inspect skin daily when performing activities of daily living personal care. 2. Record review for Resident #55 revealed an admitted [DATE] with diagnoses including congestive heart failure, diabetes, chronic kidney disease, morbid obesity, and hypertension. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan dated 09/01/20 revealed Resident #55 had an alteration in elimination related to bowel and bladder incontinence. Interventions included check and change every two hours and as needed, monitor for skin redness and irritation, and provide incontinence care as needed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had intact cognition and required extensive assist of one staff with bed mobility and was totally dependent of two staff with transfers. She required extensive assist of two staff with toileting. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no pressure ulcers during the seven-day assessment reference period. Review of the care plan dated 01/24/23 revealed Resident #55 had actual impaired skin integrity from moisture associated skin damage (MASD) to her right thigh. Interventions included provide wound care per physician order and skin assessment per policy. Review of the Braden scale pressure ulcer risk assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #971 revealed Resident #55 was at high risk for pressure ulcers due to her sensory perception was very limited, constantly moist, bedfast, and problem with friction and shear. Review of the February 2023 physician's orders, revealed Resident #55 had an order to cleanse her left and right inner thighs, apply collagen to the wound base, and cover with a foam dressing every day shift due to excoriation dated 01/08/23. A new order was obtained on 02/07/23 to cleanse her left buttock with normal saline, apply alginate and a foam dressing due to skin compromise (new open area). Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired impaired skin to her left inner thigh from the friction of her brief. There were no measurements, and the treatment was to continue. Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired MASD to her right thigh area due to friction and body fluids. The treatment was to continue as ordered. Interview on 02/06/23 at 10:15 A.M. with Resident #55 revealed she activated her call light and staff answered her call light on 02/06/23 at 8:00 A.M. She revealed she told staff that she needed changed, and they turned off her light and walked out of the room. She revealed she was still waiting the staff to come back. She was unable to name the staff as she stated the staff were all from agency, and stated she had different staff almost every day. Interview on 02/06/23 at 10:35 A.M. with Agency State tested Nursing Assistant (STNA) #854 revealed she was the aide assigned to Resident #55, and she had been on the unit alone for three hours. She revealed she had 27 residents and had not provided the residents (including Resident #55) incontinence care as she had just finished with breakfast trays. Interview and observation on 02/06/23 at 11:17 A.M. with Resident #55 revealed staff had not come back to provide incontinence care. She again stated she had asked at 8:00 A.M. She revealed the last time she was changed was on 02/06/23 at 2:00 A.M. She revealed staff always said they would be back after they answered her call light, but they never returned. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 02/06/23 at 11:59 A.M. revealed Resident #55 yelled out as Agency STNA #854 walked by her room. Resident #55 stated to Agency STNA #854 that she was still waiting to be changed and stated she had been waiting since 8:00 A.M. Agency STNA #854 stated to Resident #55 that she was waiting for Agency LPN #852 to do her dressing change and she was going to change her at the same time. Agency STNA #854 also told to Resident #55 that she also had to finish changing two other residents down the hall and then she would get to her. Observation on 02/06/23 at 12:38 P.M. revealed Agency STNA #854 asked Agency LPN #852 to let her know when she was ready to change Resident #55's dressings as she was going to change her at the same time. Agency LPN #852 stated she was ready anytime. Agency STNA #854 then stated, well right now, I am going to chart and stuff. Agency STNA #853 who also was assigned Resident #55's unit came up to the nursing station at the same time and proceeded to remain at the nursing station from 12:38 A.M. to 12:45 P. M. on her personal phone and Agency STNA #854 continued to document. Observation revealed on 02/06/23 at 12:45 P.M. Agency STNA #854 stated to Agency LPN #852 oh well, trays are here now. Observation on 02/06/23 at 1:25 P.M. revealed Agency LPN #852 asked Agency STNA #853 to assist her in doing Resident #55's incontinence care and wound care. While in the room, Resident #55 requested only Agency LPN #852 complete her incontinence care and wound care. Agency LPN #852 then proceeded to provide incontinence care. Observation revealed Resident #55's brief was heavily saturated in urine as Agency LPN #852 stated if she had to estimate, Resident #55 had urinated at least five times. Observation also revealed Resident #55 was incontinent of a moderate amount of bowel movement and parts of the bowel movement were dried to her bilateral inner thighs. Agency LPN #852 was asked to describe her skin integrity and she revealed her peri area and buttocks were excoriated with redness and bleeding. She revealed Resident #55 was tender to touch as Resident #55 stated ouch, ouch when provided incontinence care. Resident #55 then proceeded to say it was very sore and tender as she had not been changed since 2:00 AM. (almost 12 hours). Agency LPN #852 completed her wound dressing changes as ordered. She then noted a new open area to Resident #55's left buttock. Agency LPN #852 described the new open area as a Stage II pressure ulcer that measured 1.0 centimeter (cm) in length by 1.0 cm in width, and she revealed she was unable to determine the depth as there was a large amount of bleeding. She revealed the area was surrounded by redness. Resident #55 then became upset and started to cry as Agency LPN #852 was informing her of the new area. Resident #55 again stated that she had not been changed since 2:00 A. M. and that she had asked at 8:00 A.M. and then also again after that, and nobody changed her. She revealed now she had another pressure ulcer and that she would never get healed. Interview on 02/06/23 at 2:15 P.M. with Resident #55's daughter revealed she had informed management staff multiple times regarding her mother not getting changed at least every two hours and that even after she brought up the concern, things had not improved. She revealed she was upset because her mother had a new pressure ulcer because the facility did not provide the care she needed. Review of nursing note dated 02/06/23 at 2:07 P.M. and completed by Agency LPN #852 revealed during wound care Resident #55 was found to have another small open area to her left buttock with moderate amount of blood. The area was about 1.0 cm in size. The wound was cleaned with normal saline, and a dressing was applied. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing revealed incontinence care was to be completed every two hours and/ or as needed if it was needed prior. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infection and skin irritation, and observe the residents skin condition. The policy did not include language to provide perineal care timely. This deficiency represents non-compliance investigated under Complaint Number OH00139084.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34297 Based on observation, record review, interview, and facility policy review the facility failed to ensure Resident #23's physician was notified in a timely manner for cigarette burns to his fingers; failed to ensure Resident #23 was assessed and monitored for cigarette burns to his fingers; failed to ensure Resident #43 and Resident #81 were assessed for safe smoking; failed to ensure Resident #53's bed was in the lowest position to avoid the possibility of an injury if he sustained a fall and failed to document Resident #53's fall without injury on the incident and accident log. This finding affected three residents (#23, #43 and #81) of nine residents who smoke and one resident (#53) of three residents for falls. The facility census was 84. Findings include: 1. Review of Resident #23's medical record revealed he was readmitted on [DATE] with diagnoses including end stage renal disease, diabetes, and muscle wasting. Review of Resident #23's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he exhibited intact cognition. Review of Resident #23's Smoking Care Plan dated 04/28/22 revealed he was at risk of injury related to his smoking status and was able to smoke with supervision only. Review of Resident #23's Smoking Assessment form dated 12/13/22 revealed he was safe to smoke without supervision. Review of Resident #23's progress note dated 02/19/23 indicated he was smoking outside when he burned his left finger with hot ash. He stated when he pulled the hot ash off his finger, it had blistered. The blister was noted to be broken at this time and the area was cleansed and triple antibiotic ointment was applied. The physician would need to be called for new orders. Review of Resident #23's progress note dated 02/21/23 indicated he was interviewed regarding a burn on his finger during smoking and he stated he had some Band-Aid glue on his finger, and the hot ash fell from the cigarette and stuck to the glue. It had blistered and the nurse practitioner was notified, and a treatment was put in place. Review of Resident #23's Wound Assessment form dated 02/21/23 indicated he reported a burn to his left second finger which was acquired on 02/19/23 and the burn measured 1.0 cm (centimeter) length by 0.5 cm width by 0 cm depth and was scabbed. Interview on 02/21/23 at 10:07 A.M. with Resident #23 indicated he burned his left pointer finger and middle finger on 02/17/23 around 2:00 P.M. when he was outside smoking with staff supervision. He stated the hot ash from the cigarette stuck to his fingers and burned his fingers and he was unaware right away because of diabetic neuropathy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/21/23 at 10:10 A.M. of Resident #23's left pointer finger revealed a reddened wound from approximately the knuckle to the nail bed on his inner left lateral pointer finger and a reddened area to his medial right middle finger. The resident's left two fingers did not have a dressing in place at the time of the observation. Interview on 02/22/23 at 3:35 P.M. with Director of Nursing (DON) #2 confirmed she talked to Resident #23 on 02/21/23 concerning the cigarette burns on his left hand, called the Certified Nurse Practitioner (CNP) to report the burns and obtained physician orders to treat the burns two days after the resident reported he burned himself while smoking. Review of the Change in a Resident's Condition or Status, policy dated 12/16, indicated the facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. 2. Review of Resident #43's medical record revealed he was readmitted to the facility on [DATE] with diagnoses including muscle weakness, diabetes, and vascular dementia. Review of Resident #43's MDS 3.0 assessment dated [DATE] revealed he exhibited moderate cognitive impairment. Review of Resident #43's smoking care plan dated 10/13/22 indicated he was a half a pack a day smoker since 1968. Review of Resident #43's medical record revealed his smoking assessment was dated 02/21/23 which indicated he required supervision for smoking per the facility policy and he required supervision at all times for smoking. Observation on 02/21/23 at 9:30 A.M. with Licensed Practical Nurse (LPN) #838 revealed Resident #43 was walking down the hall toward the smoking area with a cigarette in his hand. When questioned, he stated he was going outside to smoke. Interview on 02/21/23 at 11:09 A.M. with LPN #838 indicated she had observed Resident #43 smoking recently, but she could not remember the date. She confirmed Resident #43 did not have a smoking assessment to determine if he could safely smoke to prevent accidents while smoking. Interview on 02/21/23 at 11:04 A.M. with State tested Nursing Assistant (STNA) #818 confirmed she had observed Resident #43 smoking during her shift on 02/17/23 with supervision. Review of the Smoking Policy and Procedure, revised 08/08/22, indicated residents that have a preference to smoke during their stay at the facility would be assessed by nursing upon admission and quarterly thereafter. 43063 3. Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including muscle weakness and schizoaffective disorder, bipolar type. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #81's assessments dated from 01/20/23 to 02/16/23 revealed there was no smoking assessment performed to ensure his safety while smoking. Review of the care plan dated 01/20/23 for Resident #81 revealed he smoked about a pack of cigarettes per day. Interventions included to complete a smoking evaluation per facility guidelines, not to leave unattended while smoking, to provide a smoking apron, and assist to put it on and for him to follow the facility smoking policy. Observation on 02/21/23 at 8:55 A.M. revealed Resident #81 handing a cigarette to Resident #43 from a pack of cigarettes he had in his room. Interview on 02/21/23 at 9:15 A.M. with Resident #81 verified he was able to keep his own cigarettes and lighter in his room and then go to the smoking area whatever time he wished. Observation on 02/22/23 at 4:30 P.M. revealed Resident #81 exiting the common area and/or dining room adjacent to the kitchen, to the outside courtyard for a smoke break. Resident #81 was observed not wearing an apron and unsupervised. Resident #81 was observed smoking and lighting a cigarette without the assistance of staff. Interview on 02/23/23 at 2:57 P.M. with the DON #2 verified Resident #81 did not have a smoking assessment in his medical record. Review of the facility policy titled, Cuyahoga Falls Rehabilitation and Nursing Center Smoking Policy and Procedure, revised 08/08/22, stated residents that have a preference to smoke during their stay will be assessed by nursing upon admission and quarterly thereafter. Also, residents who smoke are not permitted to keep smoking supplies in their rooms. 42730 4. Resident #53 was admitted the facility on 09/20/22 with diagnoses including multiple sclerosis, malignant neoplasm of prostate, and late-onset cerebellar ataxia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #53 was alert and oriented to person, place, time. Resident #53 required one-staff physical extensive assist for activities of daily living (ADL). Review of the care plan initiated 09/20/22 revealed Resident #53 was at risk for falls and potential for injury with interventions that included, but not limited to, bed in low position, keep table within reach, and keep commonly used articles within easy reach such as water, call light, remote control, and telephone. Review of the progress note dated 02/04/23 at 10:18 A.M. located in Resident #53 Electronic Medical Record (EMR), revealed he was found on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note dated 02/20/23 at 7:55 A.M., located in Resident #53 EMR, revealed he was observed lying on the floor next to his bed on left side. Resident #53's head was the same direction as the head of the bed. Resident #53's head was rested on the bottom base of tray table and partially under his torso. Review of the progress note dated 02/21/23 at 6:03 P.M. located in Resident #53 EMR, revealed he had a fall out of bed with no injury while reaching for something on his table. Review of the progress note revealed it was a follow-up to the fall that occurred on 02/20/23. Review of the incident log dated 02/24/22 to 02/24/23 revealed Resident #53 had a fall documented on 02/20/23. Further review of the incident log revealed no others falls documented for Resident #53. Observation on 02/23/23 at 2:24 P.M. revealed Resident #53 lying in bed, with the bed not in the lowest position. Interview on 02/23/23 at 2:24 P.M. with STNA #446 revealed Resident #53 was alert and oriented but was a fall risk. STNA #466 revealed Resident #53's bed was to be in the lowest position due to recent falls. STNA #466 verified Resident #53's bed was not in the lowest position. Interview on 02/27/23 at 10:50 A.M. with MDS Registered Nurse (RN) #824 confirmed Resident #53 had a care planned intervention of bed in the lowest position due to fall risk. Interview on 02/27/23 at 10:54 A.M. with DON #2 verified that all incidents of falls were to be documented on the incident log. Review of the facility document titled Managing Falls and Fall Risk, revised December 2007, revealed the facility had a policy in place that, based on previous evaluations and current data, the staff would identify interventions related to the resident specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of the document revealed the facility did not implement the policy. This deficiency represents non-compliance investigated under Complaint Number OH00139918.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, and facility policy review the facility failed to ensure oxygen orders were in place for Resident #11, oxygen tubing was dated, and an oxygen sign was posted per acceptable standards of nursing practice for Residents #11 and #76, and oxygen equipment was maintained in a sanitary manner for Resident #24. This affected three residents (#11, #24 and #76) of four residents reviewed for respiratory care. The census was 84. Findings include: 1. Record review revealed Resident #11 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), mild intermittent asthma, anxiety, major depressive disorder, and essential primary hypertension. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had severe cognitive impairment. Review of the physician's orders for Resident #11 revealed hospice services were added on 02/07/23 and no orders for oxygen administration. Observation on 02/21/23 at 10:08 A.M. revealed Resident #11 had an oxygen concentrator in the room with a nasal cannula setting on top of the concentrator, and the concentrator was turned on. Resident #11 was not in the area. Observation on 02/22/23 at 8:17 A.M. revealed Resident #11 reclined in a bedside chair with a nasal cannula in place and the oxygen concentrator turned on and set at 1.5 liters per minute (LPM). Observation and interview on 02/22/23 at 8:22 A.M. with Licensed Practical Nurse (LPN) #830 verified Resident #11 was in the bedside chair with oxygen being administered at 1.5 LPM via a nasal cannula. LPN #830 readjusted the oxygen rate to 2 LPM after stating the oxygen was to be at 2 LPM. LPN #830 indicated Resident #11 used the oxygen at night and while in bed for comfort only and it was not needed when out of the room. Interview on 02/22/23 8:25 A.M. confirmed Resident #11 had no orders for oxygen administration. Review of the physician orders for Resident #11 revealed an order dated 02/22/23 at 9:00 A.M. for oxygen at 2 LPM via nasal cannula as needed (PRN) for shortness of breath or comfort. Observation on 02/22/23 at 4:18 P.M. revealed Resident #11 was in a bedside chair with oxygen being administered at 2 LPM via a nasal cannula. The oxygen tubing was not dated and there was no posted oxygen safety sign. Interview at the time of the observation with LPN #830 verified there was no oxygen safety sign posted, and the oxygen tubing was not dated. LPN #830 stated Resident #11's nasal cannula was new when it was placed by hospice services who initiated the oxygen administration which was about two weeks ago, so it had not been changed since that time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Oxygen Administration, revised October 2010, revealed to verify there was a physician's order, to review the physician's orders or facility protocol for oxygen administration, and a No Smoking/Oxygen in Use sign was necessary. 2. Record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, generalized anxiety disorder, convulsions, depression, and metabolic encephalopathy. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #76 had severe cognitive impairment. Review of the physician's orders for Resident #76 revealed an order dated 02/13/23 for oxygen at 2 LPM via nasal cannula PRN for shortness of breath or comfort. Observation on 02/22/23 at 4:18 P.M. revealed Resident #76 had an oxygen concentrator in the room with no posted oxygen safety sign. Interview at the time of the observation with LPN #830 verified there was no oxygen safety sign posted as required. Review of the facility policy, Oxygen Administration, revised October 2010, revealed a No Smoking/Oxygen in Use sign was necessary. 43063 3. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including respiratory failure and congestive heart failure. Review of the physician's order dated 04/17/22 for Resident #24 revealed she was to have her oxygen tubing and nasal cannula changed every week on Sunday on night shift. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2023, revealed Resident #24 did not have oxygen tubing changed on 01/08/23. Observations on 02/21/23 at 9:32 A.M. and 12:28 P.M revealed Resident #24 had a nasal cannula on, and oxygen tubing attached to the oxygen concentrator. There was no date noted on the tubing to show when staff had last changed the tubing or cannula. Interview on 02/21/23 at 12:28 P.M. with Registered Nurse (RN) #448 verified Resident #24's oxygen tubing was undated. Interview on 02/21/23 at 12:30 P.M. with Resident #24 revealed she knew the oxygen tubing and cannula was to be changed weekly and had to ask staff to change it. Resident #24 also stated nursing would leave the tubing in her bedside drawer for her to change it herself. Review of the facility policy titled, Oxygen Administration, revised October 2010, revealed staff should record in the resident's medical record the date and time the procedure was performed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review, interview, and facility policy review the facility failed to monitor and assess Resident #43 following dialysis treatments. This finding affected one resident (#43) of one resident reviewed for dialysis. Findings include: Review of Resident #43's medical record revealed he was readmitted on [DATE] with diagnoses including diabetes, vascular dementia, and unspecified chronic kidney disease. Review of Resident #43's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he exhibited moderate cognitive impairment, and he received dialysis services. Review of Resident #43's physician orders revealed an order dated 01/03/23 for dialysis services Tuesday, Thursday, and Saturday at 1:15 P.M. Review of Resident #43's medical record and progress notes from 01/24/23 to 02/21/23 revealed no evidence post dialysis monitoring and assessments were completed on 01/24/23, 02/02/23, 02/16/23 and 02/18/23. Interview on 02/22/23 at 3:45 P.M. with Director of Nursing (DON) #2 confirmed Resident #43 was not monitored and assessed for complications including monitoring the blood pressure, the dialysis catheter site and the catheter dressing after four dialysis treatments from 01/24/23 to 02/21/23. Review of the Hemodialysis Access Care policy, revised 09/10, indicated the medical nurse should document in the resident's medical record every shift as follows: location of catheter, condition of dressing, any part of the report from the dialysis nurse post-dialysis being given and observations post-dialysis.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety 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** 39973 Based on observation, record review, review of staffing (schedules, daily staffing assignment sheets, and employee punch detail), review of a facility concern log, review of resident council minutes, review of the facility Staffing policy and procedure, review of the Facility Assessment, and interviews the facility failed to maintain sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This resulted in Immediate Jeopardy and actual harm on 02/06/23 when there was insufficient staff to ensure Resident #55 who was dependent on staff for care went from 2:00 A.M. to 1:25 P.M. without incontinence care even after repeated requests resulting in the development of a Stage II pressure ulcer (partial thickness wound at the epidermis and dermis level) to her left buttock that was bleeding with excoriation and redness surrounding. The Immediate Jeopardy and actual harm continued 02/08/23 when Resident #52, who required total dependence from two staff for incontinence care and was assessed to be always incontinent of bowel and bladder, went from 5:30 A.M. to 9:34 A.M. without incontinence care after repeated requests for care were made. Resident #52 was found saturated in urine and bowel movement with a dried brown ring on her bottom sheet resulting in excoriation with redness on her peri area and excoriation with bleeding and redness to her bilateral buttocks. The Immediate Jeopardy continued 02/17/23 when 15 residents, Resident #13, #17, #19, #21, #31, #33, #46, #49, #56, #60, #68, #72, #73, #76 and #235, who resided on the [NAME] unit did not receive medication administration, pain assessments or oxygen saturation monitoring due to a lack of staff onsite to provide care. A staffing concern (that did not rise to an Immediate Jeopardy level) occurred on 02/06/23 when the facility failed to ensure Agency Licensed Practical Nurse (LPN) #852 had access to the Electronic Medical Administration Record (EMAR) to administer medications resulting in a significant medication error for Resident #34 as the resident did not receive her seizure medication timely. A staffing concern (that did not rise to an Immediate Jeopardy level) also occurred when the facility did not ensure showers were completed per the care plan and resident's preferences for Residents #39, #45, #50 and #78 due to lack of staff. This affected three residents (#52, #55 and #68) reviewed for incontinence care, one resident (#34) observed during medication administration, 15 residents (13, #17, #19, #21, #31, #33, #46, #49, #56, #60, #68, #72, #73, #76 and #235) residing on the [NAME] unit, four residents (#39, #45, #50 and #78) reviewed for showers, eight residents interviewed and/or who had voiced staffing concerns (#83, #21, #82, #186, #34, #185, #61 and #8) and had the potential to affect all 84 residents residing in the facility. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/16/23 at 4:57 P.M. the Administrator and Regional Director of Clinical Services #859 were notified Immediate Jeopardy began on 02/06/23 when a lack of staff resulted in situations of neglect of resident care, including timely incontinence care and medication administration. The Immediate Jeopardy continued on 02/08/23 related to a lack of staff to provide timely incontinence care and on 02/17/23 when there were not enough licensed staff on duty to ensure medications and assessments were completed for residents on the [NAME] unit. The Immediate Jeopardy was removed on 02/22/23 when the facility implemented the following corrective actions: On 02/16/23 at 6:55 P.M. an audit was completed by Unit Manager/ Licensed Practical Nurse (LPN) #974 to ensure that all staff required to use the electronic medical records for medication administration had access. This was verified as completed 02/16/23. On 02/16/23 at 11:42 P.M. Resident #55 was assessed by Regional Clinical Nurse #859 for negative outcomes related to the lack of timely incontinence care. Resident #55 refused to have skin assessed despite education and multiple attempts. Resident has treatment order in place to left buttocks which was ordered on 02/07/23 by Wound NP #968. Resident was updated of current treatment regimen to left buttock and verbalized understanding. This was verified as completed 02/16/23. On 02/16/23 at 11:26 P.M. Resident #52 was assessed by Unit Manager/ LPN #974 for negative outcomes related to the lack of timely incontinence care. Resident #52 has a treatment in place to peri area which was ordered on 02/15/23 by Wound Nurse Practitioner (NP) #968. Resident was updated of new treatment regimen and verbalized understanding. On 02/16/23 at 7:00 P.M. a skin assessment was completed on all residents by Unit Manager/ LPN #975 and Unit Manager/ LPN #974, and Regional Clinical Nurse #859 to ensure that timely and appropriate incontinence care was provided, and residents are free from neglect of care needs by staff. On 02/16/23 at 8:00 P.M. facility current staffing levels were reviewed by the Administrator to ensure adequate staffing for the facility. On 02/17/23 at 8:30 A.M. facility staffing levels were reviewed by Administrator to ensure sufficient staffing to meet resident needs. On 02/17/23 at 9:00 A.M. an audit was completed by Unit Manager/ LPN #974 to ensure that all staff required to use the electronic medical records for medication administration had access. On 02/17/23 at 10:30 A.M. all residents who can be interviewed were questioned on if they have experienced abuse, neglect, exploitation, or misappropriation while in the facility, and if they are receiving timely personal care. Interviews were completed by Administrator, Admissions #806, Environmental Director #842, Human Resources #821, Medical Records/Housekeeping #835, Licensed Social Worker (LSW) #819, Activities #803, and Dietary Manager #808. On 02/17/23 at 1:40 P.M. Resident #34 was assessed by Unit Manager/ LPN #974 for negative outcomes related to not receiving a seizure medication in the appropriate time frame. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/17/23 at 1:30 P.M. A medication error report was completed by Unit Manager/ LPN #975 including physician notification and family notification for Resident #34. On 02/17/23 at 1:48 P.M. an audit was completed by Regional Nurse #976 on all residents receiving seizure medication to ensure all medications were administered timely. On 02/17/23 at 2:00 P.M. the Administrator, Director of Nursing, Scheduler #826, Unit Manager/ LPN #974, and Unit Manager/ LPN #975 were educated by Regional Director of Operations #977 on adequate staffing levels to provide timely and appropriate care. On 02/17/23 at 2:00 P.M. a staffing meeting was held by the Administrator to review daily schedule and ensure adequate staffing for the facility. On 02/17/23 at 2:15 P.M. an Ad Hoc Quality Assurance and Performance Improvement (QAPI) was completed including Medical Director #978 via phone. On 02/18/23 at 9:20 A.M. current staffing and schedule were reviewed by Scheduler #826, LSW #819, and Regional Nurse #976 to ensure facility was meeting adequate staffing. On 02/18/23 at 1:00 P.M. Scheduler #826 and [NAME] President (VP) of Clinical Services #977 reviewed schedules for 02/18/23-02/20/23. On 02/18/23 at 1:12 P.M. Scheduler #826 sent weekend schedule to Administrator, Regional Nurse #976, VP of Clinical Services #979, Regional Director of Operations #977, VP of Operations #980, and Human Resources #821 to ensure corporate team had access to facility schedules. On 02/18/23 at 2:15 P.M. Regional Nurse #976 posted on-call list and phone numbers at each nurses' station to ensure all staff have contact numbers for any clinical or staffing concerns. The on-call contact list included: Regional Nurse #976, VP of Clinical Services #979, Regional Director Operations #977, and VP of Operations #980. Beginning on 02/18/23 a plan for audits to be conducted by DON/designee daily to ensure all residents receive timely and appropriate incontinence care and medications were given per physician order and electronic medical record access for all required employees for four weeks then weekly for four weeks then ongoing as needed. Audits verified as completed on 02/18/23, 02/19/23, 02/20/23, and 02/21/23. Beginning on 02/18/23 a plan for resident and/or responsible party interviews to be conducted by the Administrator/designee daily to ensure that all residents remain free from neglect and are receiving adequate and timely personal care. The interviews will be completed with five residents daily for four weeks and then five residents weekly for four weeks then ongoing as needed. Audits verified as completed on 02/18,23, 02/19/23, 02/20/23, and 02/21/23. Beginning on 02/18/23 a plan for audits to be conducted by the Administrator/designee to ensure sufficient staffing to maintain appropriate care for all residents, 5 times weekly for 8 weeks and ongoing as needed. Audits verified as completed on 02/18/23, 02/19/23, 02/20/23, and 02/21/23. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Staff education as part of the facility abatement plan was initiated on 02/16/23 and continued through 02/22/23: On 02/16/23 at 9:00 P.M. the interdisciplinary management team (Administrator, Admissions #806, Environmental Director #842, Human Resources #821, Medical Records/Housekeeping #835, Licensed Social Worker (LSW) #819, Activities #803, Dietary Manager #808 with Regional Clinical Nurse #859 began education for staff including clinical topics on timely and appropriate incontinence care, the facility Quality of Life and Dignity policy, answering call lights timely and prevention of pressure ulcer development. Interview with staff on 02/21/23 from 5:05 A.M. to 5:48 A.M. revealed Agency LPN #989, #983, LPN # 848, Agency STNA #988, #984, #985, and STNA #990 were not educated prior to working at the facility. On 02/21/23 at 7:45 A.M. Regional Nurse #976 and Administrator notified of staff not educated prior to start of shift. Interviews with staff on 02/22/23 from 9:59 A.M. to 10:12 A.M. revealed LPN #820 and Agency STNA # 944 did not receive education prior to working at the facility. On 02/22/23 at 10:25 A.M. Regional Director of Operation #977 was notified of staff not being educated prior to shift. On 2/22/23 at 1:00 P.M. the facility implemented a plan to ensure a department head would be assigned to each shift change to ensure education was provided to each employee entering the facility prior to working their assignment. Interview on 02/22/23 from 2:02 P.M. to 2:10 P.M. LPN #820 and Agency STNA #944 received education. All findings will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations. Although the Immediate Jeopardy was removed on 02/22/23, 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 action and monitoring to ensure on-going compliance. Findings include: 1. Record review for Resident #55 revealed an admitted [DATE] with diagnoses including congestive heart failure, diabetes, chronic kidney disease, morbid obesity, and hypertension. Review of the care plan dated 09/01/20 revealed Resident #55 had an alteration in elimination related to bowel and bladder incontinence. Interventions included check and change every two hours and as needed, monitor for skin redness and irritation, and provide incontinence care as needed. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had intact cognition and required extensive assist of one staff with bed mobility and was totally dependent of two staff with transfers. She required extensive assist of two staff with toileting. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers but had no pressure ulcers during the seven-day assessment reference period. Review of the care plan dated 01/24/23 revealed Resident #55 had actual impaired skin integrity from moisture associated skin damage (MASD) to her right thigh. Interventions included provide wound care per physician order and skin assessment per policy. Review of the Braden scale pressure ulcer risk assessment dated [DATE] and completed by Licensed Practical Nurse (LPN) #971 revealed Resident #55 was at high risk for pressure ulcers due to her sensory perception was very limited, constantly moist, bedfast, and problem with friction and shear. Review of the February 2023 physician's orders, revealed Resident #55 had an order to cleanse her left and right inner thighs, apply collagen to the wound base, and cover with a foam dressing every day shift due to excoriation dated 01/08/23. A new order was obtained on 02/07/23 to cleanse her left buttock with normal saline, apply alginate and a foam dressing due to skin compromise (new open area). Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired impaired skin to her left inner thigh from the friction of her brief. There were no measurements, and the treatment was to continue. Review of the Weekly Observation Tool dated 02/01/23 and completed by LPN/ Unit Manger #809 revealed Resident #55 had facility acquired MASD to her right thigh area due to friction and body fluids. The treatment was to continue as ordered. Interview on 02/06/23 at 10:15 A.M. with Resident #55 revealed she activated her call light and staff answered her call light on 02/06/23 at 8:00 A.M. She revealed she told staff that she needed changed, and they turned off her light and walked out of the room. She revealed she was still waiting the staff to come back. She was unable to name the staff as she stated the staff were all from agency, and stated she had different staff almost every day. Interview on 02/06/23 at 10:35 A.M. with Agency State tested Nursing Assistant (STNA) #854 revealed she was the aide assigned to Resident #55, and she had been on the unit alone for three hours. She revealed she had 27 residents and had not provided the residents (including Resident #55) incontinence care as she had just finished with breakfast trays. Interview and observation on 02/06/23 at 11:17 A.M. with Resident #55 revealed staff had not come back to provide incontinence care. She again stated she had asked at 8:00 A.M. She revealed the last time she was changed was on 02/06/23 at 2:00 A.M. She revealed staff always said they would be back after they answered her call light, but they never returned. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 02/06/23 at 11:59 A.M. revealed Resident #55 yelled out as Agency STNA #854 walked by her room. Resident #55 stated to Agency STNA #854 that she was still waiting to be changed and stated she had been waiting since 8:00 A.M. Agency STNA #854 stated to Resident #55 that she was waiting for Agency LPN #852 to do her dressing change and she was going to change her at the same time. Agency STNA #854 also told to Resident #55 that she also had to finish changing two other residents down the hall and then she would get to her. Observation on 02/06/23 at 12:38 P.M. revealed Agency STNA #854 asked Agency LPN #852 to let her know when she was ready to change Resident #55's dressings as she was going to change her at the same time. Agency LPN #852 stated she was ready anytime. Agency STNA #854 then stated, well right now, I am going to chart and stuff. Agency STNA #853 who also was assigned Resident #55's unit came up to the nursing station at the same time and proceeded to remain at the nursing station from 12:38 A.M. to 12:45 P. M. on her personal phone and Agency STNA #854 continued to document. Observation revealed on 02/06/23 at 12:45 P.M. Agency STNA #854 stated to Agency LPN #852 oh well, trays are here now. Observation on 02/06/23 at 1:25 P.M. revealed Agency LPN #852 asked Agency STNA #853 to assist her in doing Resident #55's incontinence care and wound care. While in the room, Resident #55 requested only Agency LPN #852 complete her incontinence care and wound care. Agency LPN #852 then proceeded to provide incontinence care. Observation revealed Resident #55's brief was heavily saturated in urine as Agency LPN #852 stated if she had to estimate, Resident #55 had urinated at least five times. Observation also revealed Resident #55 was incontinent of a moderate amount of bowel movement and parts of the bowel movement were dried to her bilateral inner thighs. Agency LPN #852 was asked to describe her skin integrity and she revealed her peri area and buttocks were excoriated with redness and bleeding. She revealed Resident #55 was tender to touch as Resident #55 stated ouch, ouch when provided incontinence care. Resident #55 then proceeded to say it was very sore and tender as she had not been changed since 2:00 AM. (almost 12 hours). Agency LPN #852 completed her wound dressing changes as ordered. She then noted a new open area to Resident #55's left buttock. Agency LPN #852 described the new open area as a Stage II pressure ulcer that measured 1.0 centimeter (cm) in length by 1.0 cm in width, and she revealed she was unable to determine the depth as there was a large amount of bleeding. She revealed the area was surrounded by redness. Resident #55 then became upset and started to cry as Agency LPN #852 was informing her of the new area. Resident #55 again stated that she had not been changed since 2:00 A. M. and that she had asked at 8:00 A.M. and then also again after that, and nobody changed her. She revealed now she had another pressure ulcer and that she would never get healed. Interview on 02/06/23 at 2:15 P.M. with Resident #55's daughter revealed she had informed management staff multiple times regarding her mother not getting changed at least every two hours and that even after she brought up the concern, things had not improved. She felt the facility never had enough staff on to meet her needs as she had been at the facility multiple times and had witnessed her mother request assistance and the staff stated she had to wait as there was not enough staff to get to her. She revealed she was upset because her mother had a new pressure ulcer because the facility did not provide the care she needed. Review of nursing note dated 02/06/23 at 2:07 P.M. and completed by Agency LPN #852 revealed during wound care Resident #55 was found to have another small open area to her left buttock with moderate amount of blood. The area was about 1.0 cm in size. The wound was cleaned with normal saline, and a dressing was applied. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing revealed incontinence care was to be completed every two hours and/ or as needed if it was needed prior. Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infection and skin irritation, and observe the residents skin condition. The policy did not include language to provide perineal care timely. 2. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes, morbid obesity, and congestive heart failure. Review of the care plan dated 06/02/22 revealed Resident #52 had an alteration in elimination. She was incontinent of bowel and bladder. Interventions included incontinence care as needed and monitor skin for redness and irritation. Review of the care plan dated 06/02/22 revealed Resident #52 was at risk for impaired skin integrity due to morbid obesity. Interventions included barrier cream after each incontinent episode, skin assessment as ordered, and turn and reposition as ordered. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #52 had intact cognition. She required extensive assist of two staff with bed mobility. She was totally dependent of two staff with toileting and transfers. She was always incontinent of bowel and bladder. Review of an email dated 01/17/23 at 8:28 P.M. from LPN #820 to Regional Director of Clinical Services #859 revealed LPN #820 answered Resident #52's call light, and she had expressed that she was waiting to be changed. The email noted STNA #856 had answered her call light on 01/17/23 at 6:30 P.M. and turned her call light off and stated she would return. The email noted LPN #820 stated she had asked STNA #856 to answer Resident #52's call light. The email noted she followed up with Resident #52 who stated STNA #856 had not provided incontinence care. The email revealed Resident #52 was lying in bowel movement for an hour, and STNA #856 left the facility without changing the resident. Review of the Weekly Skin assessment dated [DATE] and completed by LPN #971 revealed Resident #52's skin was intact, and no issues were noted. Review of the Braden scale pressure ulcer risk assessment dated [DATE] authored by LPN #971 revealed Resident #52 was at high risk for skin breakdown. Interview on 02/06/23 at 9:48 A.M. and on 02/07/23 at 11:02 A.M. with Resident #52 revealed it five to six hours to get changed most the time. She revealed she would activate her call light and when staff answered her call light, she would ask to get changed and staff would say they would be back, but they did not return for several hours. She revealed on 02/05/23 she was not changed for over 12 hours even though she had asked several times. She revealed several weeks ago an STNA #856 had answered her call light at approximately 6:30 P.M. and said she would be back but never returned. She revealed she notified LPN #820 and she stated she would have STNA #856 change her. She revealed STNA #856 never changed her as she left at the end of her shift. She revealed she did not end up getting changed until approximately 8:00 P.M. She revealed LPN #820 stated she would notify management of the concern, but they had never followed up with her regarding the incident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 02/07/23 at 8:31 A.M. with LPN #820 revealed she reported an incident she felt was neglect a few weeks ago as STNA #856 had answered Resident #52's call light and Resident #52 had asked to be changed, and STNA #856 stated she would be back. She revealed Resident #52 had also reported to her that she needed changed so she had instructed STNA #856 to change Resident #52, but she never changed her and left the facility. She revealed she reported the incident to Regional Director of Clinical Services #859 in writing. She revealed she had witnessed this occur multiple times especially from the agency staff as they would sit behind the nursing station and not assist the residents with incontinence care. Interview on 02/07/23 at 3:12 P.M. with the Director of Nursing revealed incontinence care was to be completed every two hours and/ or as needed if it was needed prior. Interview on 02/07/23 at 4:30 P.M. with Activities #803 revealed she held Resident Council Meetings monthly. She revealed on 11/29/22 several residents, including Resident #52, revealed they had not been receiving proper care including timely incontinence care. She revealed on 01/25/23 residents complained of being left soiled, including Resident #52. She revealed the facility had not had consistent management and it was hard as she filled out individual grievance reports to voice residents' concerns after the resident council meeting but felt the issues were not addressed as the same concerns continued monthly. Interview and observation on 02/08/23 at 8:32 A.M. revealed Resident #52 had her call light on, and a strong odor of urine and bowel movement was coming from her room. She had tears in her eyes and stated, it is happening again as her call light had been on since 7:45 A.M. as she needed changed as she was lying in a soiled mess. She revealed she had a bowel movement, and her skin was burning. Observation on 02/08/23 at 8:46 A.M. revealed the Administrator answered the resident's call light and Resident #52 explained she needed changed. The Administrator asked what nursing station she was assigned to (since her room was in the middle of the two nursing stations). The Administrator proceeded to the nursing station and left the resident's call light on. Observation on 02/08/23 at 9:14 A.M. revealed Agency STNA #862 answered Resident #52's call light and the resident again stated she needed changed. Agency STNA #862 revealed she would tell the resident's aide and proceeded to notify STNA #833. Observation on 02/08/23 at 9:22 A.M. revealed STNA #833 walked into Resident #52's room and told Resident #52 she had to collect breakfast trays and then would provide her incontinence care. Observation on 02/08/23 at 9:34 A.M. of incontinence care completed by STNA #833 and STNA #857 for Resident #52 revealed the resident had excoriation with redness on her peri area and excoriation with bleeding and redness to her buttocks. Resident #52's brief was heavily saturated with urine as well as a large brown dried ring on the resident's bottom sheet. The resident had also been incontinent of large amount of bowel movement. STNA #833 verified the above findings. Resident #52 stated she had not been changed since 5:30 A.M. STNA #833 revealed there was only one aide on the unit on night shift, and she was not able to get to Resident #52 prior. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility policy labeled, Perineal Care, dated October 2010, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infection and skin irritation, and observe the residents skin condition. The policy did not include language to provide perineal care timely. 3. On 02/17/23 review of the facility staffing schedule revealed there was four nurses (one Registered Nurse (RN) and three LPN's) scheduled 7:00 A.M. to 7:00 P.M. and two nurses (two LPN's) scheduled 7:00 P.M. to 7:00 A.M. as two LPNs from agency did not show up per the Daily Assignment Sheet. The facility census was 85. On 02/18/23 at 8:05 A.M. interview with LPN #848 revealed she was scheduled 7:00 P.M. to 7:00 A.M. and they had two nurses that did not show up for their shift at 7:00 P.M. She revealed Agency LPN #993 was on 02/17/23 from 7:00 A.M. to 7:00 P.M. and came to her at approximately 10:30 P.M. to hand her the keys for the [NAME] unit. She revealed Agency LPN #993 stated she was only supposed to stay till 7:00 P.M. and had not passed any of the medications that were scheduled (HS - 8:00 P.M.) per the MAR for the residents residing on the unit. LPN #848 revealed she was unable to administer any of the medications on the [NAME] unit as she had her own unit to complete. She verified residents on the [NAME] unit did not receive their medications, were not assessed for pain and had no monitoring of their oxygen saturation level on 02/17/23 scheduled for HS-8:00 P.M. She revealed the physician and/or responsible party was not notified of medications not being administered/assessments not being completed. She revealed she had attempted to contact Regional Director of Clinical Services #859 (acting Director of Nursing), Administrator, and Scheduler #826 by phone to update them regarding medications not being passed due to lack of staffing, but she did not receive a call back. On 02/18/23 at 9:02 A.M. and 10:55 A.M. interview with Scheduler #826 revealed her phone was broke and she was unable to receive any calls and/or messages. She revealed she let Regional Director of Clinical Nurse #859 know prior that her phone was not working and had provided her a different number to call her on regarding staffing issues. She revealed the staff on the floor were not provided this number. On 02/18/23 at 9:08 A.M. interview with Agency LPN #993 revealed she was scheduled 02/17/23 from 7:00 A.M. to 7:00 P.M. on the [NAME] unit. She revealed her relief at 7:00 P.M. did not show up. She revealed she had contacted Scheduler #826 and notified her that her relief did not show up but received no return call. She also called Regional Director of Clinical Nurse #859 but was unable to leave a message as her voicemail box was full. She verified she did not administer any medications that were scheduled at HS- 8:00 P.M. on the [NAME] unit as she was only scheduled till 7:00 P.M. and was also busy completing her other assigned work including documentation. She revealed she left the facility at approximately 10:58 P.M. and had given the keys and report which included that she did not administer the HS medications on the [NAME] unit on 02/17/23. On 02/18/23 from 9:25 A.M. to 9:32 A.M. revealed Resident #13, #17, #19, #21, #31, #33, #46, #49, #56, #60, #68, #72, #73, #76 and #235, who resided on the [NAME] unit that did not receive their medications were cognitively impaired and unable to be interviewed. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/18/23 at 10:21 A.M. and 11:09 A.M. interview with Regional Nurse #976 revealed she spoke with Regional Director of Clinical Nurse #859 who stated that she had gone out of state and was in a remote area and unable to receive phone calls. Regional Nurse #976 verified Regional Director of Clinical Nurse #859 was the acting Director of Nursing for the facility and stated she placed a notice at the nursing station to contact MDS/Registered Nurse (RN) #824 of any nursing concerns. Regional Nurse #976 verified she was unable to locate the notice/ posting at the nursing stations regarding to contact MDS/ RN #826. She revealed she spoke with the Administrator who denied getting any phone calls. She revealed she had just found out about Scheduler #826's phone not working and was unable to receive calls. On 02/18/23 at 10:58 A.M. interview with RN #981 revealed she worked on 02/17/23 from 7:00 A.M. to 12:45 A.M. on 02/18/23. She revealed she had only been scheduled to work from 7:00 A.M. to 7:00 P.M. but her relief did not show up. She revealed she had contacted Regional Director of Clinical Services #859, and Administrator multiple times and left multiple messages until finally when she attempted to reach Regional Director of Clinical Services #859 the mailbox stated it was full. She revealed they did not return her call so that she could notify them of the insufficient staffing at the facility as two nurses did not show up to replace Agency LPN #993 or herself. The following residents were affected by the lack of available staff on 02/17/23 to provide care, including medication administration and assessments as ordered to prevent incidents of neglect: a. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, acute respiratory failure with hypoxia, major depression, and moderate protein-calorie malnutrition. Review of the February 2023 Medication Administration Record (MAR) for Resident #13 revealed she had an order that included: Remeron 7.5 mg (antidepressant) by mouth at bedtime (MAR indicated to be given HS 8:00 P.M.). She also had an order for the nurse to assess her pain level at night. The MAR revealed the Remeron 7.5 mg was not administered, and pain level was not assessed on 02/17/23. b. Review of medical record for Resident #68 revealed an admitted [DATE] with diagnoses including dementia, anxiety, and major depression. Review of February 2023 MAR for Resident #68 revealed she was to have her pain level assessed at night. The MAR revealed her pain level was not assessed on 02/17/23. c. Review of medical record for Resident #21 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, insomnia, hypertension, and asthma. Review of the February 2023 MAR for Reside [TRUNCATED]

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, interviews, and facility policy review the facility failed to ensure Resident #335, who had a diagnosis of paranoid schizophrenia received appropriate treatment, including the administration of anti-psychotic medications to ensure the resident maintained the highest practicable mental and psychosocial well-being. Actual Harm occurred on [DATE] when Resident #335 was transferred and admitted for in-patient psychiatric care with increased hallucinations and suicidal ideation, a deterioration in the resident's mental well-being. Prior to the hospitalization , the facility failed to ensure the psychoactive medication, Clozaril (anti-psychotic medication used to treat mental/mood disorders including schizophrenia) was administered as ordered. The resident was hospitalized until [DATE]. This affected one resident (#335) of six residents reviewed for medication administration. The facility census was 84. Findings include: Review of the medical record revealed Resident #335 was admitted on [DATE] with diagnoses including paranoid schizophrenia and major depressive disorder. Review of Resident #335's census documentation revealed the resident was transferred to the hospital on [DATE]. The resident was readmitted to the facility on [DATE]. Review of the psychiatric progress note, dated [DATE] by Nurse Practitioner (NP) #450 revealed a chief complaint of increased suicidal ideation and thinking people are demons. The resident was disoriented, had delusions, and had auditory and visual hallucinations. NP #450 provided a new order to increase the resident's Clozaril to 200 milligrams (mg) twice daily. Review of the physician's orders for Resident #335 revealed an order (dated [DATE]) for Clozaril (Clozapine) 200 mg, one tablet twice a day for behaviors. On [DATE], the order for 200 mg twice daily was discontinued. A new order was provided by NP #450 to administer 275 mg twice daily for hallucinations. Resident #335 also had an order (dated [DATE]) to obtain Clozapine levels every Monday for therapeutic drug level monitoring and an order (dated [DATE]) to assess Resident #335's behaviors every shift. Review of the care plan, dated [DATE] revealed Resident #335 received anti-psychotic medications and had a diagnosis of schizophrenia. The plan reflected the order, dated [DATE] to increase Clozaril per NP #450 to decrease hallucinations. Interventions included to administer medications as ordered. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #335 had intact cognition. The MDS assessment noted the resident had received anti-psychotic medications six of seven days during the assessment reference period and the medications were received on a daily routine basis. The assessment also noted the resident had delusions. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for [DATE], revealed Clozaril 200 mg was not administered as ordered at bedtime on [DATE], [DATE], [DATE], [DATE], [DATE] or in the morning on [DATE], [DATE], [DATE] or [DATE]. The Clozapine levels were drawn as ordered. Resident #335 was noted to have behaviors at night on [DATE] and [DATE] as well as on day shift on [DATE]. Review of the MAR for February 2023 revealed Clozaril 25 mg, Clozaril 50 mg and Clozaril 200 mg (total of 275 mg) were not administered in the morning on [DATE] or [DATE] or at bedtime on [DATE] or [DATE]. Resident #335 was noted to have behaviors on day shift on [DATE] and at night on [DATE]. Review of the laboratory results, dated [DATE] revealed the resident's Clozapine serum level was 60 nanograms/milliliter (ng/mL) and Norclozapine serum was 40 ng/mL with a combined total of 100 ng/mL (normal/therapeutic ,d+[DATE] ng/mL), which revealed it was not at a therapeutic level. The laboratory data reference stated patients dosed with 400 mg Clozapine daily for four weeks were most likely to exhibit a therapeutic effect when the sum of Clozapine and Norclozapine concentrations were at least 450 ng/mL. Review of the resident's nursing progress notes revealed on [DATE] at 11:09 P.M. Clozaril 200 mg was not given due to staff not being able to locate the medication. On [DATE] at 1:44 P.M. social services met with the resident and he stated he wanted to die and life was not worth living. Resident #335 was noted to have delusions of a curse being placed on him. He did confirm to social services that he had suicidal thoughts and was going to ask staff to give him a razor blade. Social services was able to de-escalate him and nursing was updated. On [DATE] at 8:01 P.M. Clozaril was not administered due to being on order. On [DATE] at 4:20 A.M. Clozaril was not administered due to being on order. On [DATE] at 5:54 A.M. Clozaril was not administered and stated it was not applicable. On [DATE] at 8:44 P.M. Clozaril was not administered due to being on order. On [DATE] at 5:59 P.M. Clozaril was not administered due to being on order. On [DATE] at 12:59 P.M. nursing updated the medical doctor of missed medication and noted it was okay to medication is filled by pharmacy. On [DATE] at 7:33 P.M. it was noted Resident #335 was having behaviors and stated he was stressed and was requesting psych services. Nursing stated the previous shift notified the physician of the behavior. On [DATE] at 7:59 P.M. Clozaril was not administered due to medication not being available and the Clozapine serum level was faxed to the pharmacy. The note revealed nursing would administer the medication as soon as it was delivered. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:00 P.M. Licensed Practical Nurse (LPN) #989 noted another nurse had made her aware that Resident #335 had been without his antipsychotic medications for days. LPN #989 updated the pharmacy and the pharmacy representative stated they needed the updated Clozapine levels to release the medication. LPN #989 stated Resident #335 appeared confused, speech unclear and garbled. On [DATE] at 11:31 A.M. another resident reported to nursing staff Resident #335 had been having hallucinations with seeing animals and demons. Nursing staff placed him near the nurses station for monitoring. On [DATE] at 4:19 P.M. Resident #335 was having increased hallucinations. NP #450 was updated and provided a new order to increase Clozaril dosage from 200 mg twice daily to 275 mg twice daily to attempt to reduce hallucinations. On [DATE] at 8:48 P.M. Clozaril was not administered due to being on order. On [DATE] at 5:01 A.M. Clozaril was not administered due to being on order. On [DATE] at 11:25 P.M. a nursing note revealed at 10:50 P.M. Resident #335 spoke to the nurse and stated he was going to hell because he sinned. He stated he wished to die and then attempted to cut open his skin with his fingernail. He stated he had a plan to kill himself and was going to slit his wrist with a razor blade if he got one. Nursing placed the resident in the lobby where he was observed having hallucinations and attempted to scratch his arm until he died . The on-call Nurse Practitioner was called and provided an order to send the resident to the hospital for suicidal ideation and hallucinations. On [DATE] at 11:26 P.M. it was noted the Clozaril bedtime dose was not available. Review of a discharge form, dated [DATE] from the psychiatric hospitalization at Akron City Hospital revealed Resident #335 was admitted on [DATE] for behavioral health. His primary diagnosis was hallucinations. A behavioral health psycho-social assessment, dated [DATE] revealed the resident was admitted directly from the emergency department due to suicidal ideation, thoughts of self-harm, hallucinations, and delusional thought content. The assessment revealed the resident had been non compliant with medications for three to four days prior to admission. Review of the Department of Psychiatry History and Physical revealed the resident had not taken his Clozapine for the previous two days prior to hospitalization . He was noted to be depressed, had decreased energy, suicidal ideation, anxiety, hallucinations, and delusions. Interview on [DATE] at 3:08 P.M. with NP #450 revealed he saw Resident #335 on a monthly basis. He stated it was problematic Resident #335's Clozaril medication was not given as ordered as the medication needed to be titrated to be at a therapeutic level. NP #450 revealed for Clozaril to be therapeutic, it needed consistent dosing. The NP would not verify the psychiatric hospitalization for Resident #335 was caused by the facility not administering the medications as ordered, however, the NP indicated it would cause a worsening of symptoms. NP #450 revealed if he would have been made aware of Resident #335 missing the doses listed above, he would've restarted the medication at different dose to re-titrate the medication. Interview on [DATE] at 3:30 P.M. with Director of Nursing (DON) #2 verified Resident #335 did not receive his Clozaril as ordered by NP #450 for the dates listed above. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Administering Medications, revised [DATE], revealed medications must be administered in accordance with the orders. This deficiency represents non-compliance investigated under Complaint Numbers OH00139918, OH00138866, OH00138859 and OH00138338.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review, and facility policy review the facility failed to ensure monthly pharmacy reviews were completed and/ or pharmacy recommendations were addressed for five residents (#7, #23, #28, #52, and #76) out of five residents reviewed for unnecessary medications. The facility census was 84. Findings include: 1. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including atrial fibrillation, diabetes, congestive heart failure (CHF), major depression, and morbid obesity. Review of the care plan dated 06/02/22 revealed Resident #52 had an alteration in cardiac function related to atrial fibrillation, CHF, and ischemic cardiomyopathy. Interventions included medications as ordered and monitor labs and report to physician as needed. Review of the Note to Attending Physician/ Prescriber, dated 08/26/22 and completed by Pharmacy Consultant #476, revealed she recommended to consider obtaining a digoxin level now and every six months as Resident #52 was on digoxin. The pharmacy recommendation revealed Medical Director/ Primary Care Physician #978 agreed with the recommendation on 09/22. (The date was ineligible as could only read month and year but not the day). Review of the lab work in Resident #52's medical record dated from 08/26/22 to 02/27/23 revealed no digoxin levels were obtained. Review of the February 2023 Physician Orders for Resident #52 revealed she continued to receive Digoxin 250 microgram (mcg) one tablet by mouth at bedtime due to atrial fibrillation. She had no orders for a Digoxin level on her physician orders. Review on 02/27/23 at 10:06 A.M. with Director of Nursing (DON) #2 of Resident #52's medical record from 03/01/22 to 02/21/23 revealed the record had no evidence the pharmacy reviewed for medication and physician order irregularities for the months of 03/22, 04/22, 05/22, 06/22, 07/22, 09/22, and 10/22. Interview on 02/27/23 at 10:07 A.M. with DON #2 confirmed Resident #52's medical record did not have evidence pharmacy completed their monthly review of her medical record for seven months. She also verified Resident #52 had a pharmacy recommendation on 08/26/22 to obtain a Digoxin level now and every six months and Medical Director/ Primary Care Physician #978 had agreed to the recommendation (09/22). She verified in her medical record there was no evidence a digoxin level was completed. 43063 2. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including bipolar disorder, anxiety, and depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. Review of Resident #7's medical record did not reveal evidence that pharmacy reviewed her medications monthly to ensure the medical record did not have any medication irregularities ordered by the physician. Interview on 02/27/23 at 10:06 A.M. with DON #2 confirmed Resident #7's medical record only had monthly pharmacy recommendations for the months of 03/22, 04/22, 05/22, 06/22, 07/22, 09/22 or 10/22. 41526 3. Record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, chronic pain syndrome, anxiety disorder, multi-system degeneration of the autonomic nervous system, and essential primary hypertension. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #28 had severe cognitive impairment. Review on 02/27/23 at 10:06 A.M. with DON #2 of Resident #28's medical record from 03/01/22 to 02/21/23 revealed the record had no evidence the pharmacy reviewed the medication regimen monthly for irregularities for the months of March 2022 through July 2022 and September 2022 through November 2022. Interview at the time of the review with DON #2 confirmed Resident #28's medical record had no evidence the pharmacy completed the monthly medication regimen reviews as required. 4. Record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, generalized anxiety disorder, benign prostatic hyperplasia (BPH), convulsions, depression, and metabolic encephalopathy. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #76 had severe cognitive impairment. Review on 02/27/23 at 10:06 A.M. with DON #2 of Resident #76's medical record from 03/01/22 to 02/21/23 revealed the record had no evidence the pharmacy reviewed the medication regimen monthly for irregularities for the months of March 2022 through October 2022. Interview at the time of the review with DON #2 confirmed Resident #76's medical record had no evidence the pharmacy completed the monthly medication regimen reviews as required. Review of the facility policy labeled, Medication Regimen Reviews, dated April 2007, revealed the consultant pharmacist would perform a medication regimen review for every resident in the facility monthly. The policy revealed the consultant pharmacist would document his and/ or her findings and recommendations on the regimen review report as well as provide a written report to the physician with the identified irregularity. The policy revealed nothing regarding ensuring if the physician was in agreement with the recommendation to ensure the orders was transcribed and followed through. 34297 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #23's medical record revealed he was admitted on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease, diabetes, and major depressive disorder. Review of Resident #23's MDS 3.0 assessment dated [DATE] revealed he exhibited intact cognition. Review on 02/27/23 at 10:06 A.M. with DON #2 of Resident #23's medical record from 03/01/22 to 02/21/23 revealed the record had no evidence the pharmacy actually reviewed for medication and physician order irregularities for the months of 03/22, 04/22, 05/22, 06/22, 07/22, 09/22 and 10/22. Interview on 02/27/23 at 10:07 A.M. with DON #2 confirmed Resident #23's medical record did not have evidence pharmacy completed their monthly review of his medical record for seven months.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, facility policy and procedure review, and interview the facility failed to ensure Resident #34 was free from a significant medication error. This affected one resident (#34) of four sampled residents. The facility census was 84. Findings include: Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including epilepsy (seizures), multiple sclerosis, anxiety, hypertension, and altered mental status. Review of the nursing note dated 12/28/22 at 11:40 A.M. and completed by Licensed Practical Nurse (LPN) #820 revealed staff had called her down to the nursing station where Resident #34 was observed in her wheelchair bent over leaning to the side. She had a seizure that lasted four minutes. Review of care plan last revised 12/29/22 revealed Resident #34 had a seizure disorder related to epilepsy. She had a seizure observed on 12/28/22. Interventions included give medications as ordered, ask resident about presence of aura prior to seizure, and provide post seizure treatment including turn to side, and take vitals after seizure. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #34 had impaired cognition. Review of the current (February 2023) physician orders for Resident #34 revealed she had an order dated 12/28/22 for Brivaracetam 100 milligram (mg) (anticonvulsant) tablet by mouth every morning and at bedtime due to seizures. Review of the February 2023 Medication Administration Record (MAR) for Resident #34 revealed she had an order for Brivaracetam 100 mg tablet by mouth every morning and at bedtime due to seizures. She was to receive the medication at 8:00 A.M. and 8:00 P.M. Interview on 02/06/23 at 9:06 A.M. with Resident #34's daughter revealed when Resident #34 does not receive her seizure medication in a timely manner she was likely then to have a seizure. She revealed the nurses were to administer the medications at exact times every day to prevent her from having seizures as she had discussed this many times with administration. Interview and observation on 02/06/23 at 9:33 A.M. with Resident #34 revealed she was lying in her bed without any seizure activity. She revealed she had not received her morning medications today, 02/06/23, but the nurse should be coming. Observation and interview on 02/06/23 at 9:36 A.M. revealed Agency LPN #852 was sitting behind the nursing station. Agency LPN #852 was asked by this surveyor if she was going to be administering medications and she stated she was unable at this time as the facility had not provided her with a log in to get into the resident's electronic medical records. She revealed she had notified management of the facility on 02/06/23 at approximately 8:30 A.M. but was unsure who she had notified. She revealed she was waiting for them to come back and provide her the log in. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/06/23 at 10:15 A.M. of medication administration with Agency LPN #852 revealed Resident #34 had an order to receive Brivaracetam 100 mg tablet by mouth every morning due to seizures. Agency LPN #852 revealed she was not administering Resident #34's Brivaracetam as it was scheduled for 8:00 A.M. and the facility had not provided her a log in for the electronic medical record until after 9:30 A.M. She revealed she could not start passing her medications then until after 9:30 A.M. and since the medication was ordered for 8:00 A.M. she was past the time that allowed her to administer as she only could administer one hour prior and one hour after the ordered time. She revealed the medication was for seizures but when asked if Resident #34 had active seizures she revealed she was unsure as she did not get that in report. She revealed she was unsure what the policy at the facility was when medications were late as she stated she was from agency so just went by what she felt was right and not give medications if they were past the scheduled time. She did not state she would notify the physician of omitting the seizure medication. She revealed she had arrived at the facility at 7:00 A.M. as scheduled and usually a facility had the log in available at the front desk for agency staff, but this was the first day she was at this facility and was unsure of their process. She revealed she had looked for a member of management but was told that they usually do not arrive until between 8:00 A.M. to 8:30 A.M. She revealed she finally was able to speak with a management employee on 02/06/23 at approximately 8:30 A.M. as everyone she had asked prior was also from agency but was unsure who it was and explained she did not have a log in and was unable to start her medication administration pass. She revealed she did not receive her log in until after 9:30 A.M. despite Resident #34's medication being due at 8:00 A.M. Interview on 02/06/23 at 10:45 A.M. with Director of Nursing (DON) revealed she had not known Agency LPN #852 did not received a log in in a timely manner. She revealed if a seizure medication was late, the nurse should have notified the physician right away and received orders to administer the medication and not just omit a seizure medication. She verified missing a seizure medication would increase Resident #34's risk to have a seizure. She revealed she would have the nurse contact the physician to get an order to administer her seizure medication. Interview on 02/06/23 at 11:06 A.M. with LPN/ Unit Manager #809 revealed she arrived at the facility on 02/06/23 at 8:30 A.M. and was notified by Agency LPN #852 that she had not received a log in to start her medication pass. She revealed she had to take care of another resident regarding a change in condition, so she was unable to get the log in but had delegated Scheduler #826 to provide Agency LPN #852 her log in. She revealed she was not aware Agency LPN #852 was not provided her log in until after 9:30 A.M. and was not able to start her medication pass until after that time. She revealed she had notified Resident #34's Nurse Practitioner (NP) #969 and received an order to give Resident #34 her Brivaracetam late. Observation and interview on 02/06/23 at 11:10 A.M. of Agency LPN #852 revealed she administered Resident #34 her Brivaracetam 100 mg tablet. She verified she administered the medications three hours and ten minutes past the scheduled time. Review of the nursing note dated 02/06/23 at 1:03 P.M. and completed by LPN/ Unit Manager #809 revealed she was informed by Agency LPN #852 that she was unable to give Resident #34 her seizure medication because it was outside scheduled time. LPN/ Unit Manager #809 notified NP #969 and received permission to give medication late. This deficiency represents non-compliance investigated under Complaint Number OH00140222, OH00139918, OH00138859, OH00138866, and OH00138338.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review, interview, and facility policy review the facility failed to ensure all medications were secured in an appropriate manner and discarded when expired. This finding affected seven residents (#6, #20, #39, #40, #45, #62 and #64) of seven residents reviewed for medication storage. Findings include: 1. Review of Resident #62's medical record revealed she was admitted on [DATE] with diagnoses including anxiety disorder, hyperlipidemia, and major depressive disorder. Review of Resident #62's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she exhibited intact cognition. Review of Resident #62's physician orders revealed an order dated [DATE] to apply nystatin-triamcinolone cream (antifungal) under bilateral breasts and groin topically every shift for fungal infection. Review of Resident #40's medical record revealed he was readmitted to the facility on [DATE] with diagnoses including diabetes, unspecified dementia, and Alzheimer's disease. Review of Resident #40's MDS 3.0 assessment dated [DATE] exhibited severe cognitive impairment. Observation on [DATE] at 7:00 A.M. revealed a full tube of Resident #62's nystatin anti-fungal medication was lying on the Buckeye nursing station desk. Further observation revealed Resident #40, who was exhibited severe cognitive impairment was sitting near the nursing station in a wheelchair. Interview on [DATE] at 7:04 A.M. with Licensed Practical Nurse (LPN) #444 confirmed the nystatin cream was lying on the desk and unsecured. 43063 2. Review of the medical for Resident #6 revealed an admitted [DATE] with diagnoses including dementia and vertigo (a condition that affects your balance and makes you feel dizzy). Review of Resident #6's physician's orders revealed she had an order dated [DATE] for Meclizine 12.5 milligrams (mg) every eight hours as needed for vertigo. Review of the Medication Administration Record (MAR) for [DATE] revealed Resident #6 had received Meclizine 12.5 mg (antihistamine) on [DATE] and [DATE]. Review of the MAR for February 2023 revealed Resident #6 had received Meclizine 12.5 mg on [DATE], [DATE] and [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 3:40 P.M. with Registered Nurse (RN) #447 of the Brandywine Medication Cart revealed a bottle of Meclizine 12.5 mg that had an expiration date of [DATE]. RN #447 verified the medication was expired and should not be given. Review of the facility policy titled, Administering Medications, revised [DATE], revealed the expiration date on the medication label must be checked prior to administering. 3. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including diabetes mellitus, congestive heart failure, and chronic kidney disease. Review of Resident #20's physician's orders revealed she had an order dated [DATE] for Lantus Solution 100 unit/milliliter, inject 20 units subcutaneously at bedtime for hyperglycemia. This order was discontinued on [DATE]. On [DATE], Resident #20 received a new order for Lantus Solution 100 unit/milliliter, inject 25 units subcutaneously at bedtime for hyperglycemia. Review of the MAR for [DATE], [DATE], and February 2023 revealed Resident #20 received her Lantus as ordered. Observation on [DATE] at 3:40 P.M. with RN #447 of the Brandywine Medication Cart revealed Resident #20's Lantus Solution to be dated [DATE] when opened. RN #447 verified the medication was expired after 28 days of opening and should not be given. Review of the facility policy titled, Administering Medications, revised [DATE], revealed the expiration date on the medication label must be checked prior to administering. 4. Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including allergic rhinitis and hypertension. She was discharged to the hospital on [DATE]. Review of Resident #39's physician's orders revealed she had an order dated [DATE] for Zyrtec 10 mg (antihistamine), take one in the morning for allergies. Review of the MAR for February 2023, revealed Resident #39 received Zyrtec 10 mg as ordered from [DATE] through [DATE]. Observation on [DATE] at 3:15 P.M. with RN #448 of the Cascade Cart revealed the Allergy Relief Cetrizine Hydrochloride (Zyrtec) 10 mg had an expiration date of [DATE]. RN #448 verified the medication was expired and should not be given. Review of the facility policy titled, Administering Medications, revised [DATE], revealed the expiration date on the medication label must be checked prior to administering. 5. Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including diabetes mellitus. She had a hospital stay from [DATE] until [DATE]. Review of Resident #45's physician's orders revealed she had an order dated [DATE] for Insulin Lispro Injection Solution (Humalog) (medication for high blood sugar), inject four units subcutaneously with meals. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR for February 2023 revealed Resident #45 received Insulin Lispro injection, four units, three times a day from [DATE] until [DATE] at lunch. Observation on [DATE] at 3:15 P.M. with RN #448 of the Cascade Cart revealed Resident #45's Insulin Lispro to be dated [DATE] when opened. RN #448 verified the Insulin Lispro should have been discarded on [DATE]. RN #448 verified Resident #45 had been receiving the Insulin Lispro. Review of the facility policy titled, Administering Medications, revised [DATE], revealed the expiration date on the medication label must be checked prior to administering. 6. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including diabetes mellitus, depression, and anxiety. Review of physician's orders for February 2023 revealed there were no order for Nystop topical powder (prescription antifungal powder). Observation on [DATE] at 8:51 A.M. of Resident #64's room revealed Nystop topical powder sitting opened on her tray table. Upon inspection, Resident #64's name was not on the bottle. Interview on [DATE] at 9:17 A.M. with Director of Nursing (DON) #2 verified Resident #64 did not have an order for Nystop topical powder. DON #2 also verified the prescription medication should not have been in the room. Review of the facility policy titled, Administering Medications, revised [DATE], revealed medications must be administered in accordance with the orders.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, personnel file review and job description review and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. In addition, the facility administration failed to ensure staffing data accurately reflected the staff on duty at all times and availability of management including the Administrator and/or nursing. This affected four residents (#52, #55, #59 and #68) reviewed for incontinence care, one resident (#34) observed during medication administration, 15 residents (13, #17, #19, #21, #31, #33, #46, #49, #56, #60, #68, #72, #73, #76 and #235) residing on the [NAME] unit, four residents (#39, #45, #50 and #78) reviewed for showers, eight residents interviewed and/or who had voiced staffing concerns (#83, #21, #82, #186, #34, #185, #61 and #8) and had the potential to affect all 84 residents residing in the facility. Findings include: 1. During the annual, complaint and extended survey, observations, record reviews and interviews resulted in concerns including but not limited to situations of neglect, lack of personal care/incontinence and staffing resulting in Immediate Jeopardy. The facility failed to ensure residents were provided adequate and timely personal care to prevent incidents of neglect. The facility failed to maintain sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure Resident #52 and Resident #55, who required staff assistance for activities of daily living care, received adequate and timely incontinence care. These concerns resulted in Immediate Jeopardy and actual harm on 02/06/23 when there was insufficient staff to ensure Resident #55 who was dependent on staff for care went from 2:00 A.M. to 1:25 P.M. without incontinence care even after repeated requests resulting in the development of a Stage II pressure ulcer (partial thickness wound at the epidermis and dermis level) to her left buttock that was bleeding with excoriation and redness surrounding. The Immediate Jeopardy and actual harm continued 02/08/23 when Resident #52, who required total dependence from two staff for incontinence care and was assessed to be always incontinent of bowel and bladder, went from 5:30 A.M. to 9:34 A.M. without incontinence care after repeated requests for care were made. Resident #52 was found saturated in urine and bowel movement with a dried brown ring on her bottom sheet resulting in excoriation with redness on her peri area and excoriation with bleeding and redness to her bilateral buttocks. A staffing concern (that did not rise to an Immediate Jeopardy level) occurred on 02/06/23 when the facility failed to ensure Agency Licensed Practical Nurse (LPN) #852 had access to the Electronic Medical Administration Record (EMAR) to administer medications resulting in a significant medication error for Resident #34 as the resident did not receive her seizure medication timely. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A staffing concern (that did not rise to an Immediate Jeopardy level) occurred when the facility did not ensure showers were completed per the care plan and resident's preferences for Residents #39, #45, #50 and #78 due to lack of staff. A situation of neglect (that did not rise to an Immediate Jeopardy level) occurred on 02/25/23 when Resident #59 was assisted out of bed on 02/25/23 at approximately 8:00 A.M. and went to the dining room. Resident #59 was incontinent of bowel while up in his wheelchair and went back to his unit to be changed. He reported to State tested Nursing Assistant (STNA) #857 and STNA #475 that he needed changed and was told by STNA #475 that she had already cleaned him up before he had gotten up in his wheelchair and told him to roll back that way despite being incontinent of bowel movement. STNA #475 verified she told Resident #59 this as she stated the workload was heavy and she had another resident that needed care. STNA #857 verified she witnessed STNA #475 and Resident #59's interaction and revealed she then assisted Resident #59 with incontinence care and changed him on 02/25/23 at approximately 9:00 A.M. She confirmed he was incontinent of bowel and urine. Resident #59 revealed he was furious that STNA #475 was not going to change him despite being incontinent of bowel as she had done this on prior occasions as well. He stated that was the reason he left the facility without notifying staff was because he was not staying at a facility that treated him in that manner. 2. A situation of Immediate Jeopardy continued on 02/17/23 when 15 residents, Resident #13, #17, #19, #21, #31, #33, #46, #49, #56, #60, #68, #72, #73, #76 and #235, who resided on the [NAME] unit did not receive medication administration, pain assessments or oxygen saturation monitoring due to a lack of staff onsite to provide care. On 02/18/23 at 8:05 A.M. interview with Licensed Practical Nurse (LPN) #848 revealed she was scheduled 7:00 P.M. to 7:00 A.M. and two nurses did not show up for their shift at 7:00 P.M. She revealed Agency LPN #993 worked on 02/17/23 from 7:00 A.M. to 7:00 P.M. and came to her at approximately 10:30 P.M. to hand her the keys for the [NAME] unit. She revealed Agency LPN #993 stated she was only supposed to stay till 7:00 P.M. and had not passed any of the medications that were scheduled HS [bedtime]- 8:00 P.M. per the Medication Administration Record (MAR) for the residents residing on the unit. LPN #848 revealed she was unable to administer any of the medications on the [NAME] unit as she had her own unit to complete. She verified residents on the [NAME] unit did not receive their medications, were not assessed for pain, and had no monitoring of their oxygen saturation level on 02/17/23 scheduled for HS-8:00 P.M. She revealed the physicians and/or responsible parties were not notified of medications not being administered/assessments not being completed. She revealed she had attempted to contact Regional Director of Clinical Services #859 (Acting Director of Nursing), Administrator, and Scheduler #826 by phone to update them regarding medications not being passed due to lack of staffing, but she did not receive a call back. On 02/18/23 at 9:02 A.M. and 10:55 A.M. interview with Scheduler #826 revealed her phone was broken, and she was unable to receive any calls and/or messages. She revealed she let Regional Director of Clinical Nurse #859 know prior that her phone was not working and provided her a different number to call her on regarding staffing issues. She revealed the staff on the floor were not provided this number. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/18/23 at 9:08 A.M. interview with Agency LPN #993 revealed she was scheduled 02/17/23 from 7:00 A.M. to 7:00 P.M. on the [NAME] unit. She stated her relief at 7:00 P.M. did not show up. She revealed she contacted Scheduler #826 and notified her that her relief did not show up but received no return call. She also called Regional Director of Clinical Nurse #859 but was unable to leave a message as her voicemail box was full. She verified she did not administer any medications that were scheduled at HS- 8:00 P.M. on the [NAME] unit as she was only scheduled till 7:00 P.M. and was also busy completing her other assigned work including documentation. She revealed she left the facility at approximately 10:58 P.M. and gave the keys and report which included that she did not administer the HS-8:00 P.M. medications on the residents on the [NAME] unit on 02/17/23. 3. Interview on 02/06/23 at 9:10 A.M. with the Ombudsman #454 revealed she held a resident/ family council once a month to discuss concerns at the facility, but it was difficult to ensure follow through of the concerns as the facility had majority agency staff that were not consistent as well as multiple changes in management including the Administrator and DON. She revealed often the same concerns continued to be presented including concerns with lack of staff to meet the resident's needs, and concerns that the facility had majority agency staff with no consistency. Interview on 02/06/23 at 10:23 A.M. with STNA #853 revealed the facility smelled really bad due to lack of incontinence care but she was unable to determine which resident room the smells came from since she was just starting her shift. STNA #853 revealed there were multiple residents that needed incontinence care. Interview on 02/06/23 at 10:25 A.M. with Resident #83 revealed there was never enough staff in the facility to assist with care needs. Resident #83 revealed she needed to attend her therapy session but could not leave her room due to staff not knowing where to get her another oxygen tank. Resident #83 revealed her oxygen tank for utilization of her wheelchair was empty and the staff present was unsure where to get another one. Interview on 02/06/23 at 10:35 A.M. with STNA #854 revealed there was not enough staff to meet the needs of the residents. STNA #854 stated she covered 27 residents, seven of those residents required a Hoyer lift (mechanical lift) for transfers, and she was working alone for three hours. STNA #854 revealed incontinent residents had not been changed. Interview on 02/06/23 at 5:00 P.M. with Residents #21 and #82 revealed there was never enough staff to assist with their needs. Interview on 02/07/23 at 3:10 P.M. with the DON revealed she witnessed staff not going into resident rooms timely and answering call lights. The DON revealed the facility was staffed based on the census and resident needs but due to staff reporting off and staff not showing up, agency staff was utilized to get staff in the building. The DON verified incontinence care was to be completed every two hours including for Residents #52 and #55. Interview on 02/08/23 at 2:00 P.M. with LPN #820 revealed the facility was always short on staff. LPN #820 revealed there were currently one nurse and one aide assigned to her unit. LPN #820 revealed there were approximately 27 to 28 residents on the unit. Interview revealed residents lacked incontinence care and call lights were not answered timely. Interview revealed weekend staffing was worse. LPN #820 revealed there was barely staff on 02/04/23. LPN #820 revealed she could only verify three staff members. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/08/23 at 3:50 P.M. with Staff Scheduler (SS) #826 revealed she could not verify and reconcile staff scheduled versus staff that actually worked their designated shift. SS #826 revealed staff scheduled were responsible for signing off and highlighting their own name on the staff assignment sheet. Interview on 02/21/23 at 12:49 P.M. with Resident #39 revealed she felt there was never enough staff as they do not answer her call light in a timely manner. She revealed many times she had to wait several hours. Review of the staffing schedules, daily staffing assignment sheets, and employee punch reports dated January and February 2023 with SS #826 could not be verified for accuracy. In addition, review of the facility concerns log and resident council minutes from November 2022 through January 2023 revealed a lack of evidence resident concerns were being addressed and resolved by administrative staff. Review of the concern log dated November 2022 to January 2023 revealed multiple concerns including but not limited to, staffing, patient care, and treatment, and staff turnover. The concern log, dated 11/08/22 for Resident #34 revealed her call light was being turned off without addressing her need. Resident #34's mother called into the facility and staff assisted with care. Review of grievance concern dated 12/21/22 revealed Resident #186 had a concern regarding receiving her medications late. Review of concern form dated 12/29/22 revealed concerns from Resident Council regarding staff and management continuously leaving and the continuity of care. Review of concern form dated 01/13/23 revealed Resident #185's daughter was concerned regarding staff turnover. Review of concern form dated 01/17/23 revealed Resident #61's family member had a concern regarding her patient care. Review of concern form dated 01/23/23 revealed Resident #76's family was concerned regarding her patient care including assisting with meals. Review of concern form dated 01/23/23 revealed Resident #8's daughter had patient care concerns as Resident #8 was to be weighed every morning after urinating and before eating breakfast. The concern form revealed under documentation of the investigation there was no response regarding the concern with weights not being obtained. Review of concern form dated 01/25/23 Resident Council meeting residents voiced concerns aides were treating them terribly and care was not being met. The form revealed call lights were not being answered and they were being left soiled. The form revealed the DON responded on the grievance form on 01/30/23 that she interviewed residents and in-serviced staff. The form also revealed nursing rounds would be done daily by supervisors to ensure residents needs were met. (continued on next page)

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	365826	A. Building B. Wing	03/01/2023

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Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Resident Council Meeting minutes dated 11/29/22 to 01/25/23 revealed multiple topics of concern related to staff not giving proper care, respect, too many agency staff, and staff turnover. Review of Resident Council Meeting dated 11/29/22 revealed residents voiced concerns that aides were not giving proper care or respect. Review of Resident Council Meeting dated 12/28/22 revealed residents had voiced concern that management was always leaving. Review of Resident Council Meeting dated 01/25/23 revealed evening night nurses and aides very disrespectful and not doing their jobs. The minute's revealed residents were frustrated and discouraged. 4. Interview on 02/06/23 at 3:24 P.M. with Staff Scheduler (SS) #826 revealed she staffed the facility based on the census and not the acuity needs. SS #826 revealed the facility staffed five nurses and seven aides during day shift. SS #826 revealed when staff called off or did not show up, she contacted staffing agencies to determine who could staff the quickest. Interview on 02/07/23 at 3:10 P.M. with the Director of Nursing revealed the facility was staffed based on the census and resident needs but due to reporting off and no shows, agency was utilized to get staff in the building. The Director of Nursing verified copies of employee punch detail report, staff schedules, and daily staff assignments provided to the State Agency (SA) were inaccurate. Interview on 02/08/23 at 10:42 A.M. with STNA #833 revealed she did not work on 02/04/23 although the employee punch report listed her name. Interview on 02/08/23 at 2:00 P.M. with LPN #820 revealed the facility was always short staffed. LPN #820 revealed there was currently one nurse and one aide assigned to her unit. LPN #820 revealed there was approximately 27 to 28 residents on the unit. Interview revealed weekend staffing was worse. LPN #820 revealed there was barely staff on 02/04/23. Interview on 02/08/23 at 3:50 P.M. with SS #826 revealed she could not verify and reconcile staff scheduled versus staff worked. SS #826 revealed staff scheduled were responsible for signing off and highlighting their own name on the staff assignment sheet. Review of the staffing schedules, daily staffing assignment sheets, and employee punch reports dated January and February 2023 with SS #826 could not be verified for accuracy. SS #826 revealed she had never heard of LPN #097, although he was listed on the employee punch report dated 02/04/23. Review of the Administrator's personnel file revealed a hire date of 12/12/22. Review of undated facility Job Description for the Administrator revealed he was responsible for the management of the facility. The primary purpose was to direct the day-to-day functions of the facility in accordance with federal, state, and local standards, guidelines, and regulations of the nursing facility. The description revealed the executive director was delegated the administrative authority, responsibility, and accountability necessary for carrying out the assigned duties including clinical and administrative activities of the facility. The Administrator signed the job description on 12/12/22. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated Job Description for the Director of Nursing revealed the primary purpose of the position was to plan, develop, and direct the overall operation of the nursing services department in accordance with federal, state, and local standards, guidelines, and regulations that govern the facility and to ensure the highest degree of the quality care was maintained at all times. The description revealed the Director of Nursing must possess the ability to plan, organize, implement, and interpret the programs, goals, objectives, policies, and procedures that were necessary for providing quality care. The description revealed the Director of Nursing worked beyond normal working hours and on weekends and holidays when necessary, including on call 24 hours per day seven days a week. This deficiency represents non-compliance investigated under Complaint Numbers OH00140222 and OH00140369.

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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 34297 Based on record review, interview, and facility policy review the facility failed to conduct the quarterly quality assurance committee meetings at least quarterly and as needed to coordinate and evaluate activities under the QAPI (Quality Assurance and Performance Improvement) program. This finding had the potential to affect 84 residents residing in the facility. Findings include: The facility did not have evidence QAPI meetings were conducted at least quarterly with the Administrator, Director of Nursing (DON), the Medical Director, and all department heads. Interview on 02/27/23 at 10:30 A.M. with the Administrator indicated he was new to the building and could not find evidence quarterly QAPI meetings were conducted at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. Review of the QAPI policy, revised 04/14, revealed the facility shall develop, implement, and maintain an ongoing, facility-wide QAPI program that buildings on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review, interview, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidance the facility failed to ensure Resident #236's contact isolation precautions were implemented per the physician orders and failed to ensure Resident #64's reverse isolation precautions were implemented per the care plan. This affected one resident (#236) of six residents reviewed for isolation precautions and had the potential to affect all 24 residents residing on the [NAME] Hills unit including Residents #11, #12, #13, #17, #18, #19, #21, #22, #27, #28, #31, #33, #46, #49, #56, #60, #68, #69, #72, #73, #76, #79, #235 and #236 as well as one resident (#64) of one reviewed for reverse isolation precautions on the Cascade Unit. Findings include: 1. Review of Resident #236's facility pre-admission progress note dated 02/14/23 at 10:25 A.M. indicated the wound certified nurse practitioner (CNP) was in the facility to provide wound care. A culture of the wound results revealed methicillin resistant Staphylococcus aureus (MRSA) bacterial infection in the right foot wound. Resident #236's resides on the [NAME] Hills unit. Review of Resident #236's medical record revealed he was admitted on [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease, and major depressive disorder. Observation on 02/22/23 at 9:50 A.M. with Director of Nursing (DON) #2 of Resident #236's room revealed a personal protective equipment (PPE) cart was located outside the door but no signage was placed on the door to indicated he was in contact isolation precautions due to MRSA in his right foot wound and wound care being completed by nursing staff. Interview on 02/22/23 at 9:54 A.M. with DON #2 confirmed Resident #236's room did not have the appropriate signage on his door confirming he was in contact isolation precautions due to MRSA in his foot wound, and the resident's medical record did not have a physician order for contact isolation precautions as required. She indicated she placed the resident in contact isolation precautions on this date per the facility policy and physician orders. Observation and interview on 02/23/23 at 12:15 P.M. with Licensed Practical Nurse (LPN) #445 confirmed Resident #236's door did not have the appropriate signage indicating he was on contact isolation precautions, so staff were aware of what precautions including what type of PPE to use when providing resident care. Interview on 02/27/23 at 12:07 P.M. with DON #2 confirmed contact isolation precautions were discontinued for Resident #236 on 02/25/23 due to the discontinuation of his antibiotics. Twenty-four residents reside on the [NAME] Hills unit including Residents #11, #12, #13, #17, #18, #19, #21, #22, #27, #28, #31, #33, #46, #49, #56, #60, #68, #69, #72, #73, #76, #79, #235 and #236. Review of the CDC Guidelines, dated 02/28/19, recommends the use of contact precautions in patients known to be colonized or infected with epidemiologically important multi drug-resistant organisms including MRSA. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Contact PPE policy, revised 01/12, indicated transmission-based precautions would be used whenever measures more stringent that Standard Precautions were needed to prevent or control the spread of infection. 43063 2. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including sepsis, diabetes mellitus, and hypertension. Review of the care plan dated 01/12/23 revealed Resident #64 had impaired immunity and required contact isolation due to Carbapenem Resistant Acinetobacter Baumannii (highly antibiotic-resistant bacteria for which few treatment options exist). The goal was for the resident not to display any complications related to immune deficiency. As the resident was at risk for contracting infections due to an impaired immune system, interventions included to keep the environment clean and people with infections away and to use universal precautions as appropriate. Observation on 02/23/23 at 11:54 A.M. and 2:27 P.M. revealed Resident #64 had no isolation cart with PPE or signage identifying she was on contact isolation. Interview on 02/23/23 at 1:36 P.M. with Registered Nurse (RN) #824 verified she had been given documentation from DON #1 from the CDC that Resident #64 needed to be on contact isolation for Carbapenem Resistant Acinetobacter Baumannii. RN #824 verified it was an oversight of nursing that they did not get the order from the physician to start contact isolation. Interview on 02/23/23 2:29 P.M. with the DON #2 verified Resident #64 should've been on contact isolation precautions. Review of the facility policy titled, Isolation-Categories of Transmission-Based Precautions, revised January 2012 revealed the facility would implement signs to alert staff, have staff wear disposable gowns while in the room and dispose of before leaving the room, wear gloves while caring for the resident and after removing gloves perform hand hygiene.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure new admissions were educated on influenza vaccines, offered and/or provided influenza vaccines during the influenza season. This finding affected four residents (#236, #285, #286, and #288) of six residents reviewed for immunizations. Findings include: 1. Review of Resident #236's medical record revealed he was admitted on [DATE] with diagnoses including major depressive disorder and mild cognitive impairment of unknown or uncertain etiology. Review of Resident #236's immunization record revealed his last influenza vaccine was 09/16/20. His medical record did not reveal evidence he or his representative were offered or educated on the influenza vaccine following admission. 2. Review of Resident #285's medical record revealed she was admitted on [DATE] with diagnoses including anxiety disorder, diabetes, and atherosclerotic heart disease. Review of Resident #285's immunization record revealed she did not receive the influenza vaccine from 10/01/22 to 02/17/23 prior to admission. Her medical record did not reveal evidence she was offered or educated on the influenza vaccine following admission. 3. Review of Resident #286's medical record revealed she was admitted on [DATE] with diagnoses including schizophrenia, major depressive disorder, and adult failure to thrive. Review of Resident #286's immunization record revealed she did not receive the influenza vaccine from 10/01/22 to 02/08/23 prior to admission. Her medical record did not reveal evidence she was offered or educated on the influenza vaccine following admission. 4. Review of Resident #288's medical record revealed she was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, heart failure, and muscle weakness. Review of Resident #288's immunization record revealed she did not receive the influenza vaccine from 10/01/22 to 02/17/23 prior to admission. Her medical record did not reveal evidence she was offered or educated on the influenza vaccine following admission. Interview on 02/23/23 at 1:23 P.M. with Director of Nursing (DON) #2 confirmed Residents #236, #285, #286 or #288's medical record did not have evidence they were offered or educated on the influenza vaccine since admission. Review of the Influenza Vaccine policy, revised 08/16, indicated the facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives). Between 10/01 and 03/31 of each year, the influenza vaccine shall be offered to residents and employees unless the vaccine was medically contraindicated, or the resident or employee had already been immunized.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review, interview, and facility policy review the facility failed to ensure new admissions were tested for COVID-19 per the Centers for Disease Control (CDC) Guidelines. This finding affected three residents (#285, #286 and #288) of six residents reviewed for immunizations and had the potential to affect all twelve residents residing on the Brandywine Falls unit including Residents #6, #14, #20, #26, #53, #61, #77, #285, #286, #287, #288, and #289. Findings include: 1. Review of Resident #285's medical record revealed she was admitted on [DATE] with diagnoses including anxiety disorder, chronic kidney disease and hyperlipidemia. Resident #285 resides on the Brandywine Falls unit. Review of Resident #285's medical record did not have evidence she received COVID-19 testing upon admission, 48 hours later and 96 hours later (on day 0, 2 and 4). 2. Review of Resident #286's medical record revealed she was admitted on [DATE] with diagnoses including malignant neoplasm of the sigmoid colon, adult failure to thrive and schizophrenia. Resident #285 resides on the Brandywine Falls unit. Review of Resident #286's medical record did not have evidence she received COVID-19 testing upon admission, 48 hours later and 96 hours later (on day 0, 2 and 4). 3. Review of Resident #288's medical record revealed she was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, heart failure, and muscle wasting. Resident #285 resides on the Brandywine Falls unit. Review of Resident #288's medical record did not have evidence she received COVID-19 testing upon admission, 48 hours later and 96 hours later (on day 0, 2 and 4). Interview on 02/23/23 at 1:23 P.M. with Director of Nursing (DON) #2 indicated she did not have evidence COVID-19 testing was completed for Residents #285, #286 and #288 following admission and per the CDC guidelines. She confirmed the COVID-19 county positivity level was red or high. Twelve residents reside on the Brandywine Falls unit including Residents #6, #14, #20, #26, #53, #61, #77, #285, #286, #287, #288, and #289. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Coronavirus (COVID-19) Policy and Procedure Policy, dated 12/02/22, indicated facilities were directed to the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease Pandemic guidance under managing admissions and residents who leave the facility for information on testing of residents who were newly admitted or readmitted to the facility and those who leave the facility for greater than 24 hours. Admissions in counties where Community Transmission levels were high should be tested upon admission (admission testing at lower levels of Community Transmission was at the discretion of the facility). Testing was recommended at admission and, if negative, again in 48 hours after the first negative test, and if negative, again 48 hours after the second negative test. They should also be advised to wear source control for the 10 days following their admission.