STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365834	A. Building B. Wing	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent Healthcare and Rehabilitation.	1290 Fairchild Avenue Kent, OH 44240

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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	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** 36307 Based on record review, review of nursing staff schedules, review of the facility Abuse, Neglect and Misappropriation policy and procedure, review of facility medication error reports, review of a facility self-reported incident (SRI), staff interviews and interview with Medical Director #578 the facility failed to prevent a situation of neglect when there were no licensed nursing staff on duty in the facility to meet the total care needs of all facility residents. This resulted in Immediate Jeopardy beginning on 03/05/22 at approximately 8:30 P.M. when no licensed nurse (licensed practical nurse (LPN) or registered nurse (RN)) was on duty to provide for the routine care, monitoring, medication administration, assessments, response to urgent resident needs and/or treatments for all 52 residents residing in the facility. The facility remained without a licensed nurse from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and then was again without a licensed nurse on 03/07/22 from 1:00 A.M. to 7:00 A.M. The lack of licensed nurse in the facility to provide nursing care resulted in a situation of neglect and actual or the potential for actual harm for residents related to the lack of administration of medications, wound care, supervision, enteral nutrition administration and/or treatment/management of chronic and/or acute disease processes/diagnoses for the residents for which only a licensed nurse was qualified to provide. This had the potential to affect all 52 residents. On 03/09/22 at 11:10 A.M. the Administrator, Regional Clinical Support Nurse #579, and the Interim Director of Nursing (IDON) were notified Immediate Jeopardy began on 03/05/22 at 8:30 P.M. when the facility failed to ensure a licensed nurse was on duty and present in the facility to provide for the routine care, monitoring, medication administration, assessments, response to urgent resident needs and treatments for all 52 residents residing in the facility. There was no licensed nurse on duty from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and again on 03/07/22 at 1:00 A.M. until 7:00 A.M. leaving residents without access to a licensed nurse to meet their total care needs. The Immediate Jeopardy was removed on 03/09/22 when the facility implemented the following corrective actions: On 03/08/22 the facility identified all residents had the potential to be affected related to the lack of licensed nurse on duty and in the facility. Beginning 03/08/22 the facility indicated they would attempt to schedule an additional licensed nurse for each 12-hour shift. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/08/22 at 12:27 P.M. Medical Director #578 was notified by Regional Clinical Support Nurse #579 regarding the staffing concern from 03/05/22 for 7:00 P.M. to 7:00 A.M. and from 03/07/22 from 1:00 A.M. to 7:00 A.M. including resident missed medications, treatments, enteral feedings and blood glucose checks. On 03/08/22 the Administrator was educated by Regional Clinical Support Nurse #579 regarding communication via an immediate phone call to the Regional Support Team regarding any open nurse shift positions due to call-offs that are unable to be filled in a timely manner, nurse no shows, etc to meet the care needs of the residents including medication administration. On 03/08/22 the Administrator, Human Resource #580 and Scheduler/STNA #539 were educated by Regional Clinical Support Nurse #579 regarding conducting staffing meetings two times daily to review any call-offs and ensure adequate coverage is obtained as needed to meet the care needs of the residents including medication administration. On 03/08/22 at 2:02 P.M. all 18 facility nurses were educated via blast text through OnShift regarding the importance of safe staffing to foster safe resident care, proper procedure for nurse call-offs, and to immediately notify the Interim DON if an oncoming nurse does not report to work as scheduled and there is no coverage. Nurses were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 5:15 P.M. all 18 State tested Nursing Assistant (STNA) staff were educated via blast text through OnShift regarding if there is not a nurse in the building to immediately notify the Administrator, and then the Interim DON if there isn't an immediate response from the Administrator. STNAs were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 6:55 P.M. the Interim DON's phone number was posted at all nursing stations. On 03/08/22 the facility implemented a plan to hold a staffing meeting with the Administrator, HR Director #580 and Scheduler/STNA #539 in attendance to review scheduled nursing staff for the day to ensure there was always a licensed nursing staff member on duty to meet the care needs of the residents including medication administration. The daily posted staffing would be reviewed during the meeting to ensure an adequate number of nurses were scheduled for the day. The staffing meeting would occur two times daily Monday through Friday for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. Beginning 03/08/22 the facility implemented a plan for the Interim DON/designee to verify via a telephone call to facility on the off shift (7:00 P.M. to 7:00 A.M. (nights and weekends) all scheduled nurses had arrived for their scheduled shifts to ensure there was always licensed staff in the facility to meet the care needs of the residents including medication administration. This will occur daily for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. Between 03/09/22 and 03/10/22 the facility completed medication error reports for each resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 the facility Interdisciplinary (IDT) team, including the Activity Director, Admission Director, Nurse Scheduler, Administrator, Receptionist, Maintenance Director, and Therapy Director completed Ambassador rounds for all residents to conduct psycho-social wellness checks with no negative outcomes identified at that time. On 03/09/22 at 8:42 A.M. Human Resource Director #580 made telephone contact with 35 nurse and STNA staff members who did not respond in OnShift to the text blasts from 03/08/22 at 2:02 P.M. and 5:15 P.M. and verbally educated them on those texts to complete the education. On 03/09/22 at 7:30 P.M. all 36 nursing (RN, LPN and STNA) staff members were educated via telephone contact and in person by Human Resources Director #580 and Scheduler/STNA #539 on staffing guidelines regarding sufficient nursing staff required on each shift to meet the needs of the residents in the facility with notification to the IDON, ADON, and nursing scheduler for assistance if unable to schedule sufficient staff. The staff were also educated regarding the facility's proper call-off procedure. On 03/09/22 one on one education was provided by Regional Clinical Support Nurse #579 to Licensed Practical Nurse (LPN) #507 who was the only nurse on duty on 03/05/22 at 7:00 P.M. and 03/07/22 at 1:00 A. M. who left the facility without having adequate coverage regarding her obligation to ensure adequate licensed nursing staff always remain in the facility to meet the care needs of the residents including administration of medications. On 03/09/22 the facility implemented a plan for the IDON and/or Regional Support team to cover open nurse shifts until a DON was in place to meet the care needs of the residents including medication administration. Results of all audits will be reviewed in QAPI for tracking and trending purposes. Although the Immediate Jeopardy was removed on 03/09/22, 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. Review of the facility staffing schedules, assignments sheets and punch detail revealed on 03/05/22 from 7:00 A.M. to 7:00 P.M. there were two nurses, LPN #507 and LPN #576 on duty for the entire 12 hour shift and one nurse LPN #506 on duty for 8 hours from 7:00 A.M. to 3:00 P.M. to provide care for the 52 residents residing in the nursing facility. Review of a nurse/STNA schedule for 03/05/22 as well as the attendance punch records for 03/05/22, revealed LPN #507 punched in at 8:30 A.M. and punched out at 8:30 P.M. The facility schedule reflected on 03/05/22 there were two nurses, facility LPN #577 and agency LPN #581, scheduled for the shift beginning at 7:00 P.M. However, interview and record review revealed facility LPN #577 never arrived for his shift. Agency LPN #581 arrived at 7:00 P.M. but left at 7:26 P.M. because she did not want to be the only nurse in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility schedule reflected on 03/06/22 there were two nurses, facility LPN #507 and facility LPN #505 scheduled for the entire 12 hour shift from 7:00 A.M. to 7:00 P.M. Facility LPN #577 and agency LPN #582 were scheduled for the shift beginning at 7:00 P.M. Interview and record review revealed LPN #577 never arrived to start the 7:00 P.M. shift. Agency LPN #582 arrived at 7:00 P.M. but was unable to punch in or gain access to the facility electronic medical record (EMR) system with her agency badge and password. LPN #582 got frustrated because she could not do anything, called her agency, and left the facility at approximately 7:30 P.M. Review of the facility attendance punch records indicated LPN #505 remained in the facility until 03/07/22 at 12:00 A.M. and LPN #507 remained in the facility on 03/07/22 until 1:00 A.M. However, no nurse(s) arrived to replace them. And LPN #507 left the facility after working 18 hours. Review of a facility self-reported incident (SRI), tracking number 218870 created on 03/10/22 a 3:52 P.M. revealed the facility reported an allegation of neglect/mistreatment to the State agency. The SRI revealed during the evening of 03/05/22 from 8:30 P.M. to 7:00 A.M. (03/06/22) and 03/07/22 from 1:00 A.M. to 7:00 A.M. the facility did not have a nurse in the building. The facility identified 52 residents affected by the incident. A narrative summary of the incident revealed a staff nurse called off prompting the agency nurse to leave the facility. The SRI noted as a result of the incident, on 03/08/22 the facility medical director and physicians were notified of the staffing concerns from 03/05/22 at 8:30 P.M. to 03/06/22 at 7:00 A.M. and from 03/07/22 from 1:00 A.M. to 7:00 A.M. including missed medications, wound treatments, enteral (tube feedings) and blood glucose checks. In addition, resident responsible parties were also notified of the missed medications and blood glucose checks. The facility substantiated the allegation of neglect. Record review revealed Medication/Treatment Incident Reports were completed on 03/10/22 for all 52 residents in the facility as a result of there being no nurse in the facility on 03/05/22 from 8:30 P.M. to 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. The reports indicated all 52 residents in the facility during that time failed to receive their prescribed medications. The reports further indicated each resident's physician as well as the Medical Director were notified of the incident on 03/08/22 and responsible parties were notified on 03/09/22. On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 03/06/22 at 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 7:00 A.M. STNA #520 revealed when she arrived to work at 11:00 P.M. on 03/05/22 quite a few of the residents were asking for pain medication. STNA #520 revealed the same thing happened on Sunday, 03/06/22. STNA #520 revealed there was no licensed nurse working in the facility and she and two other aides, STNA #566 and STNA #574 were working to keep all the residents' safe, clean and dry and to prevent any falls. STNA #520 indicated she contacted both the Administrator and Scheduler #539 multiple times on 03/05/22 from 11:00 P.M. until 12:00 A.M. The scheduler responded and indicated they knew about the staffing situation, and they were making phone calls. At the end of her shift on 03/06/22 at 7:00 A.M. STNA #520 revealed she left written messages regarding the staffing situation in the mailboxes of the Administrator and Scheduler. STNA #520 revealed the Administrator and Scheduler called her for a conference call on Monday, 03/07/22 to discuss the staffing situation and asked her to be patient and understanding regarding the staffing and they were working on it and it would not be an overnight fix. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M., residents were complaining they did not receive their medications, some residents were complaining of pain and some residents were panicking because there was no nurse in the facility. STNA #566 also stated Sunday night (03/06/22) was the same and the residents only got their first round of night meds (prior to 1:00 A.M. on 03/07/22). STNA #566 stated she did not know what to do. She stated the medication cart keys were locked in the medication carts and in the morning on 03/07/22 the 7:00 A.M. nurses, who arrived on duty could not open the carts to get the keys and had to get someone to open the medication carts. On 03/09/22 at 1:16 P.M. interview with STNA #518 revealed she worked the 3:00 P.M. to 11:00 P.M. shift on 03/05/22 and 03/06/22. STNA #518 revealed there was no nurse in the facility on 03/05/22 after 8:30 P.M. and she was aware there was no nurse in the facility on 03/07/22 after 1:00 A.M. She stated she personally spoke with the scheduler on 03/05/22 at approximately 7:30 P.M. and was told they were working on getting a nurse and to do the best they could. STNA #518 revealed the situation was the same on 03/06/22 when no nurses arrived for the 7:00 P.M. shift but LPN #505 and LPN #507 stayed over until 12:00 A.M. and 1:00 A.M. , respectively. LPN #507 came and found her at 11:00 P.M. and indicated her replacement had shown up at approximately 7:00 P.M. but left almost immediately after discovering she would be the only nurse. On 03/09/22 at 1:36 P.M. interview with STNA #575 revealed during shift change at 7:00 P.M. on 03/06/22, an agency nurse (LPN #581) showed up but she had no log-in information for the facility electronic medical record system. STNA #575 indicated the nurse called the agency and then left because there was nothing she could do. The facility nurse, LPN #507 was sick and dizzy and called the Administrator on 03/05/22 at 8:30 P.M. STNA #575 revealed LPN #507 did not receive a return call (from the Administrator) and eventually locked up the narcotic keys and left. STNA #575 revealed we took care of the residents and put them to bed. She stated some were requesting their medications, but we were STNAs and could not do anything but take care of them. On 03/09/22 at 2:05 P.M. interview with LPN #576 revealed she was an agency nurse who was scheduled to work on 03/05/22 from 7:00 A.M. to 7:30 P.M. at the facility. She stated she had worked at the facility in the past and this was the second or third time she had experienced staffing problems. She indicated she was assigned two halls when she arrived at the facility at 7:00 A.M., the 300 Hall (secured dementia unit) and the 400 Hall with two STNAs to assist her. LPN #576 indicated on 03/05/22 the relief nurse LPN #577 called off at 5:14 P.M. and the agency relief nurse LPN #581 arrived at 7:00 P.M. but indicated that she was not staying because she did not want to be the only nurse in the facility. LPN #576 revealed she called the Administrator at 7:15 P.M. regarding LPN #581's staffing concerns and again at 7:26 P.M. when LPN #581 decided she was not staying because it was unsafe, and she left. LPN #576 indicated she counted the narcotics in the medication carts with LPN #507 and left the facility at 8:00 P.M. LPN #507 was still in the facility when she left. LPN #576 indicated on 03/05/22 when she left the facility, there was only one nurse, LPN #507 along with three STNAs (#520, #566 and #574) remaining in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 at 3:40 P.M. interview with Scheduler/STNA #539 revealed she had worked at the facility since July 2021. She stated she schedules staffing for the facility a month out and posts the entire month at least two weeks before, usually on the 18th of the month. She posts the schedule so if staff want to pick up extra shifts, they know what shifts are available. She also sends out mass texts via the On Shift System for facility staff and enters information into staffing agency portals or emails them directly to let them know of the availability of shifts and facility staffing needs. Scheduler/STNA #539 revealed she typically staffs three nurses for the 7:00 A.M. to 7:00 P.M. shift and two nurses for the 7:00 P.M. to 7:00 A.M. shift and tries to get a medication pass nurse for 7:00 P.M. to 11:00 P.M. and then drops to two nurses at 11:00 P.M. Schedule/STNA #539 revealed when she received the call off notification from LPN #577, she immediately started making attempts to replace him with another licensed nurse. She stated she contacted the Administrator and was working with her using On Shift, texting people, offering bonuses but got a lot of no. She stated she also posted to all of the agencies and still got no response. Scheduler/STNA #539 indicated she continued to try to get staffing for the facility and went to bed with the phone still making phone calls and worrying about the STNAs left to work in the facility with no licensed nurse as well as the residents. On 03/10/22 at 12:58 A.M. interview with LPN #507 revealed she was scheduled to work at the facility on 03/05/22 from 7:00 A.M. to 7:30 P.M. with another staff nurse (LPN #506) scheduled from 7:00 A.M. to 3:00 P.M. and an agency nurse (LPN #576) scheduled for the 7:00 A.M. to 7:30 P.M. shift. LPN #507 indicated LPN #506 left at 3:00 P.M. and she assumed care for the residents on the 100 hall and 200 hall by herself, which was difficult for one nurse. Agency LPN #576 was assigned to care for residents on the 300 Hall and the secured dementia unit. At 7:00 P.M., both LPN #507 and Agency LPN #576 were waiting for their relief staff to arrive. LPN #507 indicated she was sick and barely making it to the end of the shift. She had a headache, vomiting, diarrhea and was dizzy. LPN #507 revealed she sent messages to the scheduler (regarding staffing) with no response. She also called the Administrator at approximately 7:30 P.M. and told her she was sick and couldn't stay. The Administrator's response was, can you hang in for a little longer-about an hour? LPN #507 revealed Agency LPN #576 left at 7:30 P.M. and she (LPN #507) stayed until 8:30 P.M. as the only nurse in the facility and was trying to hang on. LPN #507 revealed at that time no one had told her an oncoming nurse had called off. LPN #507 indicated she stayed for another hour (until approximately 8:00 P.M.-8:30 P.M.), and no one came. LPN #507 stated she sent four messages to the scheduler with no response. LPN #507 revealed she locked the keys in the medication room and placed the medication room key in the office and told the Administrator where they were in a hidden location. During the interview, LPN #507 revealed she returned to the facility on [DATE] at 7:00 A.M. and worked until 03/07/22 at 1:00 A.M. (although she was scheduled to leave on 03/06/22 at 7:30 P.M.). LPN #507 revealed it was like [NAME]-[NAME] all over again. Facility LPN #577 who was scheduled to come in on 03/06/22 at 7:00 P.M. did not show up and she was told he had quit. An agency nurse, LPN #582 did arrive to the facility at 11:00 P.M. but did not stay because she had no access to anything, was unable to scan her badge to administer medications and stated she was not staying because she felt it was unsafe. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	a. On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 03/06/22 at 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 03/07/22 at 7:00 A.M. STNA #520 revealed when she arrived at work on 03/05/22 at 11:00 P.M. Resident #122 was crying in pain and needed pain medication. STNA #520 indicated Resident #122 was one of many residents complaining of pain and the STNA felt bad because there was no nurse working and she could not administer medications to the residents. STNA #520 revealed she tried to offer other interventions for pain that were ineffective, and Resident #122 was in pain throughout the whole night on 03/06/22 and 03/07/22. On 03/21/22 at 1:55 P.M. the surveyor attempted to interview Resident #122. The resident was unable to communicate in sentences/conversation but nodded her head yes and no. Resident #122 indicated she was in pain throughout the night when she did not get her pain medication on the above dates. She was unable to verbalize anything specific to the pain but nodded yes to generalized pain. Resident #122 also nodded yes to being anxious about having no nurse in the facility and acknowledged it had not occurred again since those dates. b. On 03/08/22 at 11:48 A.M. interview with Resident #108 revealed she did not receive any medications or her pain medication on Saturday (03/05/22) night because there was no nurse. The resident reported she was having pain which she described as being intolerable. The resident revealed she repeatedly asked STNA #566 that night if the nurse was there to give her pain medication. On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M., Resident #108 immediately voiced complaints of pain and stated she did not receive her bedtime medications or pain medications (Tylenol Extra Strength). STNA #566 indicated Resident #108 was in pain throughout the whole night (03/05/22 to 03/06/22) but there was no nurse working in the facility to administer pain medications to the resident. On 03/21/22 at 2:05 P.M. during a follow up interview with Resident #108 the resident again voiced concerns she discovered there were no nurses in the facility when she went to the nurses' station to check on her medications. Resident #108 revealed she became very frustrated and anxious because she did not get her anxiety medication or her pain medication. In addition, she stated she also did not get her Melatonin and was unable to sleep the entire night. She stated that she had a rough night. She indicated she takes Tylenol every night which is effective in managing her pain, she did not get any of her medications and was anxious about what would happen if there was an emergency in the facility. c. On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 7:00 A.M. STNA #520 revealed when she arrived to work at 11:00 P.M. on 03/05/22, Resident #124 was asking if there was a nurse. STNA #520 indicated Resident #124 was one of many residents requesting medications and the STNA felt bad because there was no nurse working in the facility and she could not administer medications. STNA #520 indicated Resident #124 requested medication throughout the shift. On 03/21/22 at 1:50 P.M. interview with Resident #124 revealed she had pain all the time that was from her osteoarthritis and had Tylenol ordered which helped. Resident #124 indicated she was anxious about not receiving her medications when there was no nurse but mostly anxious about not receiving her Synthroid, which was ordered to be given at 9:00 P.M. Resident #124 indicated she had to take the Synthroid on an empty stomach and there had been at least two other times when she had missed the medication and this made her very anxious. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	d. On 03/09/22 at 2:23 P.M. interview with STNA #574 revealed when she worked on 03/05/22 from 11:00 P. M. to 7:00 A.M., she observed Resident #130 walking around the facility throughout the night and asking for a nurse and asking if there was a nurse. STNA #574 revealed throughout the night the resident did not specifically request pain medication but appeared very anxious. STNA #574 also indicated Resident #130 communicated with other residents there was no nurse in the facility. STNA #574 revealed this in turn made many other residents in the facility very anxious. During the interview, the STNA verified Resident #130 did not receive any of prescribed pain medication on 03/05/22 from 8:00 P.M. to 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. On 03/21/22 at 2:20 P.M. interview with Resident #130 revealed he did not get his nighttime medications on 03/05/22 and at first it made him anxious. The resident revealed he thought the STNAs were not telling the truth about there being no nurse until he went looking for a nurse and could not find one. Resident #130 verified he could not get his pain medication or his blood sugar checked when there was no nurse working. Resident #130 acknowledged he was up throughout the night because he could not sleep and kept asking if the nurse was here yet. e. On 03/08/22 at 11:15 A.M. interview with Resident #117 revealed there was no nurse working in the facility during periods of time from 03/05/22 to 03/07/22. The resident voiced concerns related to not receiving her Synthroid medication. Resident #117 revealed the STNA staff had reported to her there was no nurse working to pass medications. Resident #117 revealed she was upset because if she does not get her medication, it can cause her problems with her thyroid. f. On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M. Resident #120 was complaining she did not receive her bedtime medications or pain medications. On 03/21/22 at 1:35 P.M. interview with Resident #120 revealed she takes Tylenol at bedtime every night and when she did not receive her medication on 03/05/22 it was rough to sleep, she was anxious and up and down all night. g. On 03/08/22 at 11:35 A.M. interview with Resident #149 revealed she did not receive her medications on Saturday (03/05/22) night and she wanted to report the facility. Resident #149 revealed due to the lack of medications, she did not sleep much and kept asking if there was a nurse. On 03/08/22 at 4:05 P.M. interview with the Administrator revealed she received a call from facility staff on 03/05/22 at 7:15 P.M. indicating there was no licensed nurse available onsite to relieve the 7:00 A.M. to 7:00 P.M. nurses. The Administrator revealed the scheduled (7:00 P.M. to 7:00 A.M.) staff nurse called off and the scheduled agency nurse arrived on 03/05/22 but left by 7:30 P.M. leaving no licensed nurse to relieve the off-going shift nurses. The Administrator revealed she and Scheduler #539 made multiple calls without success to facility staff nurses and agencies to get a licensed nurse to work on 03/05/22 for the night shift (through 03/06/22 at 7:00 A.M.). (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 facility policy titled Abuse, Neglect and Misappropriation, dated June 2021 revealed it was the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. It was the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment, and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property. The facility policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Accurate and timely reporting of incidents, both alleged and substantiated, would be sent to officials in accordance with the state law. If the alleged violation was verified, appropriate corrective action would be taken by the facility. The policy included, accurate and timely identification of any event which would place our residents was t risk is a primary concern of the facility. This deficiency substantiates Complaint Number OH00130768.

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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** 36307 Based on record review, review of nursing staff schedules, review of the facility assessment, review of the facility staffing policy and procedure, review of facility medication error reports, review of a facility self-reported incident (SRI), staff interviews and interview with Medical Director #578 the facility failed to maintain sufficient levels of licensed nursing staff to meet the total care needs of all facility residents. This resulted in Immediate Jeopardy beginning on 03/05/22 at approximately 8:30 P.M. when no licensed nurse (licensed practical nurse (LPN) or registered nurse (RN)) was on duty to provide for the routine care, monitoring, medication administration, assessments, response to urgent resident needs and/or treatments for all 52 residents residing in the facility. The facility remained without a licensed nurse from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and then was again without a licensed nurse on 03/07/22 from 1:00 A. M. to 7:00 A.M. The lack of licensed nurse in the facility to provide nursing care resulted in actual or the potential for actual harm for residents related to the lack of administration of medications, wound care, supervision, enteral nutrition administration and/or treatment/management of chronic and/or acute disease processes/diagnoses for the residents for which only a licensed nurse was qualified to provide. This had the potential to affect all 52 residents. On 03/09/22 at 11:10 A.M. the Administrator, Regional Clinical Support Nurse #579, and the Interim Director of Nursing (IDON) were notified Immediate Jeopardy began on 03/05/22 at 8:30 P.M. when the facility failed to ensure a licensed nurse was on duty and present in the facility to provide for the routine care, monitoring, medication administration, assessments, response to urgent resident needs and treatments for all 52 residents residing in the facility. There was no licensed nurse on duty from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and again on 03/07/22 at 1:00 A.M. until 7:00 A.M. leaving residents without access to a licensed nurse to meet their total care needs. The Immediate Jeopardy was removed on 03/09/22 when the facility implemented the following corrective actions: On 03/08/22 the facility identified all residents had the potential to be affected related to the lack of licensed nurse on duty and in the facility. Beginning 03/08/22 the facility indicated they would attempt to schedule an additional licensed nurse for each 12-hour shift. On 03/08/22 at 12:27 P.M. Medical Director #578 was notified by Regional Clinical Support Nurse #579 regarding the staffing concern from 03/05/22 for 7:00 P.M. to 7:00 A.M. and from 03/07/22 from 1:00 A.M. to 7:00 A.M. including resident missed medications, treatments, enteral feedings and blood glucose checks. On 03/08/22 the Administrator was educated by Regional Clinical Support Nurse #579 regarding communication via an immediate phone call to the Regional Support Team regarding any open nurse shift positions due to call-offs that are unable to be filled in a timely manner, nurse no shows, etc to meet the care needs of the residents including medication administration. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/08/22 the Administrator, Human Resource #580 and Scheduler/STNA #539 were educated by Regional Clinical Support Nurse #579 regarding conducting staffing meetings two times daily to review any call-offs and ensure adequate coverage is obtained as needed to meet the care needs of the residents including medication administration. On 03/08/22 at 2:02 P.M. all 18 facility nurses were educated via blast text through OnShift regarding the importance of safe staffing to foster safe resident care, proper procedure for nurse call-offs, and to immediately notify the Interim DON if an oncoming nurse does not report to work as scheduled and there is no coverage. Nurses were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 5:15 P.M. all 18 State tested Nursing Assistant (STNA) staff were educated via blast text through OnShift regarding if there is not a nurse in the building to immediately notify the Administrator, and then the Interim DON if there isn't an immediate response from the Administrator. STNAs were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 6:55 P.M. the Interim DON's phone number was posted at all nursing stations. On 03/08/22 the facility implemented a plan to hold a staffing meeting with the Administrator, HR Director #580 and Scheduler/STNA #539 in attendance to review scheduled nursing staff for the day to ensure there was always a licensed nursing staff member on duty to meet the care needs of the residents including medication administration. The daily posted staffing would be reviewed during the meeting to ensure an adequate number of nurses were scheduled for the day. The staffing meeting would occur two times daily Monday through Friday for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. Beginning 03/08/22 the facility implemented a plan for the Interim DON/designee to verify via a telephone call to facility on the off shift (7:00 P.M. to 7:00 A.M. (nights and weekends) all scheduled nurses had arrived for their scheduled shifts to ensure there was always licensed staff in the facility to meet the care needs of the residents including medication administration. This will occur daily for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. Between 03/09/22 and 03/10/22 the facility completed medication error reports for each resident. On 03/09/22 the facility Interdisciplinary (IDT) team, including the Activity Director, Admission Director, Nurse Scheduler, Administrator, Receptionist, Maintenance Director, and Therapy Director completed Ambassador rounds for all residents to conduct psycho-social wellness checks with no negative outcomes identified at that time. On 03/09/22 at 8:42 A.M. Human Resource Director #580 made telephone contact with 35 nurse and STNA staff members who did not respond in OnShift to the text blasts from 03/08/22 at 2:02 P.M. and 5:15 P.M. and verbally educated them on those texts to complete the education. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 at 7:30 P.M. all 36 nursing (RN, LPN and STNA) staff members were educated via telephone contact and in person by Human Resources Director #580 and Scheduler/STNA #539 on staffing guidelines regarding sufficient nursing staff required on each shift to meet the needs of the residents in the facility with notification to the IDON, ADON, and nursing scheduler for assistance if unable to schedule sufficient staff. The staff were also educated regarding the facility's proper call-off procedure. On 03/09/22 one on one education was provided by Regional Clinical Support Nurse #579 to Licensed Practical Nurse (LPN) #507 who was the only nurse on duty on 03/05/22 at 7:00 P.M. and 03/07/22 at 1:00 A. M. who left the facility without having adequate coverage regarding her obligation to ensure adequate licensed nursing staff always remain in the facility to meet the care needs of the residents including administration of medications. On 03/09/22 the facility implemented a plan for the IDON and/or Regional Support team to cover open nurse shifts until a DON was in place to meet the care needs of the residents including medication administration. Results of all audits will be reviewed in QAPI for tracking and trending purposes. Although the Immediate Jeopardy was removed on 03/09/22, 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. Review of the facility staffing schedules, assignments sheets and punch detail revealed on 03/05/22 from 7:00 A.M. to 7:00 P.M. there were two nurses, LPN #507 and LPN #576 on duty for the entire 12 hour shift and one nurse LPN #506 on duty for 8 hours from 7:00 A.M. to 3:00 P.M. to provide care for the 52 residents residing in the nursing facility. Review of a nurse/STNA schedule for 03/05/22 as well as the attendance punch records for 03/05/22, revealed LPN #507 punched in at 8:30 A.M. and punched out at 8:30 P.M. The facility schedule reflected on 03/05/22 there were two nurses, facility LPN #577 and agency LPN #581, scheduled for the shift beginning at 7:00 P.M. However, interview and record review revealed facility LPN #577 never arrived for his shift. Agency LPN #581 arrived at 7:00 P.M. but left at 7:26 P.M. because she did not want to be the only nurse in the facility. The facility schedule reflected on 03/06/22 there were two nurses, facility LPN #507 and facility LPN #505 scheduled for the entire 12 hour shift from 7:00 A.M. to 7:00 P.M. Facility LPN #577 and agency LPN #582 were scheduled for the shift beginning at 7:00 P.M. Interview and record review revealed LPN #577 never arrived to start the 7:00 P.M. shift. Agency LPN #582 arrived at 7:00 P.M. but was unable to punch in or gain access to the facility electronic medical record (EMR) system with her agency badge and password. LPN #582 got frustrated because she could not do anything, called her agency, and left the facility at approximately 7:30 P.M. (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 attendance punch records indicated LPN #505 remained in the facility until 03/07/22 at 12:00 A.M. and LPN #507 remained in the facility on 03/07/22 until 1:00 A.M. However, no nurse(s) arrived to replace them. And LPN #507 left the facility after working 18 hours. Review of a facility self-reported incident (SRI), tracking number 218870 created on 03/10/22 a 3:52 P.M. revealed the facility reported an allegation of neglect/mistreatment to the State agency. The SRI revealed during the evening of 03/05/22 from 8:30 P.M. to 7:00 A.M. (03/06/22) and 03/07/22 from 1:00 A.M. to 7:00 A.M. the facility did not have a nurse in the building. The facility identified 52 residents affected by the incident. A narrative summary of the incident revealed a staff nurse called off prompting the agency nurse to leave the facility. The SRI noted as a result of the incident, on 03/08/22 the facility medical director and physicians were notified of the staffing concerns from 03/05/22 at 8:30 P.M. to 03/06/22 at 7:00 A.M. and from 03/07/22 from 1:00 A.M. to 7:00 A.M. including missed medications, wound treatments, enteral (tube feedings) and blood glucose checks. In addition, resident responsible parties were also notified of the missed medications and blood glucose checks. Record review revealed Medication/Treatment Incident Reports were completed on 03/10/22 for all 52 residents in the facility as a result of there being no nurse in the facility on 03/05/22 from 8:30 P.M. to 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. The reports indicated all 52 residents in the facility during that time failed to receive their prescribed medications. The reports further indicated each resident's physician as well as the Medical Director were notified of the incident on 03/08/22 and responsible parties were notified on 03/09/22. On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 03/06/22 at 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 7:00 A.M. STNA #520 revealed when she arrived to work at 11:00 P.M. on 03/05/22 quite a few of the residents were asking for pain medication. STNA #520 revealed the same thing happened on Sunday, 03/06/22. STNA #520 revealed there was no licensed nurse working in the facility and she and two other aides, STNA #566 and STNA #574 were working to keep all the residents' safe, clean and dry and to prevent any falls. STNA #520 indicated she contacted both the Administrator and Scheduler #539 multiple times on 03/05/22 from 11:00 P.M. until 12:00 A.M. The scheduler responded and indicated they knew about the staffing situation, and they were making phone calls. At the end of her shift on 03/06/22 at 7:00 A.M. STNA #520 revealed she left written messages regarding the staffing situation in the mailboxes of the Administrator and Scheduler. STNA #520 revealed the Administrator and Scheduler called her for a conference call on Monday, 03/07/22 to discuss the staffing situation and asked her to be patient and understanding regarding the staffing and they were working on it and it would not be an overnight fix. On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M., residents were complaining they did not receive their medications, some residents were complaining of pain and some residents were panicking because there was no nurse in the facility. STNA #566 also stated Sunday night (03/06/22) was the same and the residents only got their first round of night meds (prior to 1:00 A.M. on 03/07/22). STNA #566 stated she did not know what to do. She stated the medication cart keys were locked in the medication carts and in the morning on 03/07/22 the 7:00 A.M. nurses, who arrived on duty could not open the carts to get the keys and had to get someone to open the medication carts. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 at 1:16 P.M. interview with STNA #518 revealed she worked the 3:00 P.M. to 11:00 P.M. shift on 03/05/22 and 03/06/22. STNA #518 revealed there was no nurse in the facility on 03/05/22 after 8:30 P.M. and she was aware there was no nurse in the facility on 03/07/22 after 1:00 A.M. She stated she personally spoke with the scheduler on 03/05/22 at approximately 7:30 P.M. and was told they were working on getting a nurse and to do the best they could. STNA #518 revealed the situation was the same on 03/06/22 when no nurses arrived for the 7:00 P.M. shift but LPN #505 and LPN #507 stayed over until 12:00 A.M. and 1:00 A.M. , respectively. LPN #507 came and found her at 11:00 P.M. and indicated her replacement had shown up at approximately 7:00 P.M. but left almost immediately after discovering she would be the only nurse. On 03/09/22 at 1:36 P.M. interview with STNA #575 revealed during shift change at 7:00 P.M. on 03/06/22, an agency nurse (LPN #581) showed up but she had no log-in information for the facility electronic medical record system. STNA #575 indicated the nurse called the agency and then left because there was nothing she could do. The facility nurse, LPN #507 was sick and dizzy and called the Administrator on 03/05/22 at 8:30 P.M. STNA #575 revealed LPN #507 did not receive a return call (from the Administrator) and eventually locked up the narcotic keys and left. STNA #575 revealed we took care of the residents and put them to bed. She stated some were requesting their medications, but we were STNAs and could not do anything but take care of them. On 03/09/22 at 2:05 P.M. interview with LPN #576 revealed she was an agency nurse who was scheduled to work on 03/05/22 from 7:00 A.M. to 7:30 P.M. at the facility. She stated she had worked at the facility in the past and this was the second or third time she had experienced staffing problems. She indicated she was assigned two halls when she arrived at the facility at 7:00 A.M., the 300 Hall (secured dementia unit) and the 400 Hall with two STNAs to assist her. LPN #576 indicated on 03/05/22 the relief nurse LPN #577 called off at 5:14 P.M. and the agency relief nurse LPN #581 arrived at 7:00 P.M. but indicated that she was not staying because she did not want to be the only nurse in the facility. LPN #576 revealed she called the Administrator at 7:15 P.M. regarding LPN #581's staffing concerns and again at 7:26 P.M. when LPN #581 decided she was not staying because it was unsafe, and she left. LPN #576 indicated she counted the narcotics in the medication carts with LPN #507 and left the facility at 8:00 P.M. LPN #507 was still in the facility when she left. LPN #576 indicated on 03/05/22 when she left the facility, there was only one nurse, LPN #507 along with three STNAs (#520, #566 and #574) remaining in the facility. On 03/09/22 at 3:40 P.M. interview with Scheduler/STNA #539 revealed she had worked at the facility since July 2021. She stated she schedules staffing for the facility a month out and posts the entire month at least two weeks before, usually on the 18th of the month. She posts the schedule so if staff want to pick up extra shifts, they know what shifts are available. She also sends out mass texts via the On Shift System for facility staff and enters information into staffing agency portals or emails them directly to let them know of the availability of shifts and facility staffing needs. Scheduler/STNA #539 revealed she typically staffs three nurses for the 7:00 A.M. to 7:00 P.M. shift and two nurses for the 7:00 P.M. to 7:00 A.M. shift and tries to get a medication pass nurse for 7:00 P.M. to 11:00 P.M. and then drops to two nurses at 11:00 P.M. Schedule/STNA #539 revealed when she received the call off notification from LPN #577, she immediately started making attempts to replace him with another licensed nurse. She stated she contacted the Administrator and was working with her using On Shift, texting people, offering bonuses but got a lot of no. She stated she also posted to all of the agencies and still got no response. Scheduler/STNA #539 indicated she continued to try to get staffing for the facility and went to bed with the phone still making phone calls and worrying about the STNAs left to work in the facility with no licensed nurse as well as the residents. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/10/22 at 12:58 A.M. interview with LPN #507 revealed she was scheduled to work at the facility on 03/05/22 from 7:00 A.M. to 7:30 P.M. with another staff nurse (LPN #506) scheduled from 7:00 A.M. to 3:00 P.M. and an agency nurse (LPN #576) scheduled for the 7:00 A.M. to 7:30 P.M. shift. LPN #507 indicated LPN #506 left at 3:00 P.M. and she assumed care for the residents on the 100 hall and 200 hall by herself, which was difficult for one nurse. Agency LPN #576 was assigned to care for residents on the 300 Hall and the secured dementia unit. At 7:00 P.M., both LPN #507 and Agency LPN #576 were waiting for their relief staff to arrive. LPN #507 indicated she was sick and barely making it to the end of the shift. She had a headache, vomiting, diarrhea and was dizzy. LPN #507 revealed she sent messages to the scheduler (regarding staffing) with no response. She also called the Administrator at approximately 7:30 P.M. and told her she was sick and couldn't stay. The Administrator's response was, can you hang in for a little longer-about an hour? LPN #507 revealed Agency LPN #576 left at 7:30 P.M. and she (LPN #507) stayed until 8:30 P.M. as the only nurse in the facility and was trying to hang on. LPN #507 revealed at that time no one had told her an oncoming nurse had called off. LPN #507 indicated she stayed for another hour (until approximately 8:00 P.M.-8:30 P.M.), and no one came. LPN #507 stated she sent four messages to the scheduler with no response. LPN #507 revealed she locked the keys in the medication room and placed the medication room key in the office and told the Administrator where they were in a hidden location. During the interview, LPN #507 revealed she returned to the facility on [DATE] at 7:00 A.M. and worked until 03/07/22 at 1:00 A.M. (although she was scheduled to leave on 03/06/22 at 7:30 P.M.). LPN #507 revealed it was like [NAME]-[NAME] all over again. Facility LPN #577 who was scheduled to come in on 03/06/22 at 7:00 P.M. did not show up and she was told he had quit. An agency nurse, LPN #582 did arrive to the facility at 11:00 P.M. but did not stay because she had no access to anything, was unable to scan her badge to administer medications and stated she was not staying because she felt it was unsafe. 2. Record review revealed Resident #105 was admitted to the facility on [DATE] with diagnoses including abdominal hernia with obstruction, infection following a surgical procedure, atrial fibrillation, congestive heart failure, cardiac pacemaker, hypertension, hypothyroidism and osteoarthritis. Review of the physician's admission orders, dated 03/04/22 revealed to apply NPWT (wound vac) to abdominal wound every Monday, Wednesday, Friday and if unable to keep sealed, convert to wet-to-dry dressing three times a week and as needed. No care plan had been developed relative to Resident #105's altered skin integrity was initiated. Review of a nursing progress note, dated 03/04/22 at 6:18 P.M. revealed a wound vac was not available at the time and an abdominal dressing was in place from hospital. No drainage noted. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 at 2:23 P.M. interview with STNA #574 revealed she arrived to work at 10:55 P.M. on 03/05/22 for the 11:00 P.M. to 7:00 A.M. shift and was informed there was no nurse working in the facility. STNA #574 revealed at approximately 3:00 A.M. Resident #105 was in no apparent distress and it appeared her abdominal dressing was intact. At approximately 4:30 A.M., as STNA #574 was making rounds, she noted Resident #105 had blood on her gown and her abdominal dressing was on the floor. She conferred with the other STNAs to determine if 911 should be called or if they should attempt to contact the resident's physician. STNA #574 revealed she contacted Resident #105's physician, Medical Director #578 at approximately 5:00 A.M. and informed him the resident had removed her dressing and there was blood on her gown. Medical Director #578 advised STNA #574 to put multiple abdominal pad dressings on the wound and use the resident's abdominal binder to secure the pads. STNA #574 revealed Medical Director #578 told her the resident would be fine until a nurse arrived in a couple of hours. STNA #574 stated she again asked Medical Director #578 if he was sure, and he responded yes and disconnected the telephone call. STNA #578 revealed she placed multiple abdominal dressing pads over Resident #105's wound and used the resident's abdominal binder to secure the dressings in place as directed by the physician. On 03/08/22 at 2:21 P.M. interview with Medical Director #578 revealed he had received a telephone call from an STNA (STNA #574) at the facility at approximately 5:00 A.M. the morning of 03/06/22 indicating Resident #105 had removed her abdominal dressing and was bleeding. Medical Director #578 revealed he directed STNA #574 to replace the dressing with abdominal pads and secure the pads with the resident's abdominal binder. He stated he reassured STNA #574 it would be okay until a nurse arrived to assess the wound. 3. Record review revealed Resident #140 was admitted to the facility's secured dementia unit on 06/26/18 with diagnoses including dementia without behavioral disturbance, type 2 diabetes mellitus, hypertension, acquired absence of right fingers, depression and anxiety. A plan of care relative to Resident #140's elopement risk and exit-seeking behavior was initiated upon admission and updated on 04/07/20. Interventions included to encourage Resident #140 to apply Wanderguard, check placement every shift and at bedtime, encourage resident to stay in common areas, assess for hunger, thirst, ambulation or toileting needs when found attempting to exit, complete elopement risk assessment quarterly and as need and provide diversionary activities. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 01/02/22 revealed Resident #140 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 99. The resident exhibited inattention and disorganized thinking and required limited assistance from one staff person for some activities of daily living and was independent with locomotion on and off the unit using a wheelchair. Review of the quarterly Elopement Risk Evaluation, dated 01/07/22 revealed Resident #140 had a history of elopement or attempted leaving the facility without informing staff, verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door. The evaluation revealed the resident's wandering behavior was likely to affect the safety or well-being of self/others and likely to affect the privacy of others. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/08/22 at 12:02 P.M. Resident #140 was observed maneuvering in his wheelchair towards the exit doors asking have you seen my wife? Resident #140 was redirected away from the exit doors when the Wanderguard alarmed. There was one STNA assigned to the secured dementia unit at that time and a nurse assigned to both the secured dementia unit as well as the 400 hall. The secured dementia unit had a census of 13 on 03/08/22. On 03/09/22 at 2:05 P.M. interview with LPN #576 revealed she was an agency nurse who was scheduled to work on 03/05/22 from 7:00 A.M. to 03/06/22 at 7:30 P.M. at the facility. She indicated she was assigned two halls when she arrived at the facility at 7:00 A.M., the 300 Hall (secured dementia unit) and the 400 Hall with two STNAs to assist her. She stated STNA #511 was scheduled to leave early at 11:00 A.M. which left only one STNA available to assist with resident care. LPN #576 revealed one resident (Resident #140) on the dementia unit was an elopement risk and continually made attempts to leave the dementia unit. LPN #576 indicated it was very difficult to divide her attention between giving Resident #104 (a resident with complex medical issues and tracheostomy) the attention his condition warranted and at the same time ensuring Resident #140 on the dementia unit did not elope, especially with the lack of help from the remaining STNA assigned to assist her. LPN #576 indicated Resident #140 at one time pushed on the secured dementia unit exit doors long enough for them to open after a short period of time and he was able to get onto the hallway outside of the secured unit. LPN #576 revealed during her shift, she contacted the nurse practitioner to update her on Resident #104's condition and was given an order to send Resident #104 to the hospital. LPN #576 revealed Resident #140 continued his elopement attempts throughout the entire shift. 4. Review of the physician's orders for March 2022 revealed Resident #122 received an oral diet with nectar thick liquids and also had physician's order for enteral tube feeding/nutrition Isosource 1.5 250 milliliters (ml) via gastrostomy (peg) tube at 9:00 A.M. and 9:00 P.M. The resident also had an order for 250 ml water flushes every six hours and scheduled for 12:00 A.M., 06:00 A.M. 12:00 P.M. and 6:00 P.M. Review of the March 2022 administration record revealed Resident #122 did not receive her enteral feeding as ordered on 03/05/22 at 9:00 P.M. or water flushes as ordered on 03/06/22 at 12:00 A.M. or 6:00 A.M. or on 03/07/22 at 6:00 A.M. 5. Review of the physician's orders for March 2022 revealed Resident #130 had an order for enteral feeding/nutrition via gastrostomy tube Isosource 1.5 300 ml via peg tube every four hours for supplement. An order to check for enteral feed residuals every four hours (schedule included 5:00 A.M. and 9:00 P.M.) and an order for 150 ml water flush via peg tube every four hours (schedule included at 1:00 A.M. 5:00 A.M. and 9:00 P.M.). The resident also had physician orders including to provide gastrostomy tube care completed on the night shift. Review of the March 2022 administration record revealed the resident did not receive the enteral feeding, water flushes or monitoring on 03/05/22 from 8:00 P.M. to 03/06/22 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. 6. Review of the physician's orders for March 2022 revealed Resident #133 had an order for enteral feeding/nutrition Isosource 1.5 Cal Liquid 300 ml via jejunostomy (j) tube for supplement along with 120 ml free water flush via j tube every four hours at 1:00 A.M., 5:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M. The resident also had an order for tracheostomy care and j tube care to be completed on night shift. (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 March 2022 administration records MAR revealed Resident #133 did not receive any enteral feeding, water flushes, trach care, j tube care or monitoring as ordered from 03/05/22 at 8:00 P.M. to 03/06/22 at 7:00 A.M. or 03/07/22 from 1:00 A.M. to 7:00 A.M. This included the administration of Isosource 1.5 Cal Liquid 300 ml and 120 ml free water flush via j tube at 9:00 P.M. on 03/05/22 and 1:00 A.M. and 5:00 A.M. on 03/06/22. 7. Review of physician's orders for March 2022 revealed Resident #102 was to receive enteral feeding/nutrition Isosource 1.5 at 50 ml/hr continuously via peg tube and 230 ml water flush every six hours. The resident also had an order for trach care and gastrostomy tube care to be completed on night shift. Review of MAR for March 2022 indicated Resident #102 did not receive her scheduled enteral tube feeding, water flushes, trach care, gastrostomy tube care or monitoring as ordered from 03/05/22 at 8:00 P.M. to 03/06/22 at 7:00 A.M. or 03/07/22 from 1:00 A.M. to 7:00 A.M. This included ensuring the Isosource 1.5 was running continuously, 230 ml water flushes every six hours at 12:00 A.M. and 06:00 A.M. on 03/06/22 and on 12:00 A.M. and 6:00 A.M. on 03/07/22. Review of the March 2022 MAR also revealed Resident #102 did not receive scheduled percussion vest treatment, prescribed for two times a day to run with aerosol treatments on 03/05/22 at 9:00 P.M. 8. The following staff and resident interviews also identified concerns related to the facility staffing from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and again on 03/07/22 from 1:00 A.M. to 7:00 A.M. a. On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 03/06/22 at 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 03/07/22 at 7:00 A.M. STNA #520 revealed when she arrived at work on 03/05/22 at 11:00 P.M. Resident #122 was crying in pain and needed pain medication. STNA #520 indicated Resident #122 was one of many residents complaining of pain and the STNA felt bad because there was no nurse working and she could not administer medications to the residents. STNA #520 revealed she tried to offer other interventions for pain that were ineffective, and Resident #122 was in pain throughout the whole night on 03/06/22 and 03/07/22. On 03/21/22 at 1:55 P.M. the surveyor attempted to interview Resident #122. The resident was unable to communicate in sentences/conversation but nodded her head yes and no. Resident #122 indicated she was in pain throughout the night when she did not get her pain medication on the above dates. She was unable to verbalize anything specific to the pain but nodded yes to generalized pain. Resident #122 also nodded yes to being anxious about having no nurse in the facility and acknowledged it had not occurred again since those dates. b. On 03/08/22 at 11:48 A.M. interview with Resident #108 revealed she did not receive any medications or her pain medication on Saturday (03/05/22) night because there was no nurse. The resident reported she was having pain which she described as being intolerable. The resident revealed she repeatedly asked STNA #566 that night if the nurse was there to give her pain medication. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M., Resident #108 immediately voiced complaints of pain and stated she did not receive her bedtime medications or pain medications (Tylenol Extra Strength). STNA #566 indicated Resident #108 was in pain throughout the whole night (03/05/22 to 03/06/22) but there was no nurse working in the facility to administer pain medications to the resident. On 03/21/22 at 2:05 P.M. during a follow up interview with Resident #108 the resident again voiced concerns she discovered there were no nurses in the facility when she went to the nurses' station to check on her medications. Resident #108 revealed she became very frustrated and anxious because she did not get her anxiety medication or her pain medicatio [TRUNCATED]

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on record review, facility policy and procedure review and interview the facility failed to ensure Resident #148, who had a diagnosis of dementia received appropriate treatment and services, including the administration of medication to attain or maintain her highest practicable mental and psychosocial well-being. Resident #148 experienced increased anxiety and restlessness due to not receiving her prescribed Namenda, a medication used for the treatment of moderate to severe dementia in people with Alzheimer's disease. This affected one resident (#148) of one resident reviewed for dementia services. Findings include: Record review revealed Resident #148 was admitted to the facility on [DATE] for a respite stay. The resident resided in the facility from [DATE] until 03/12/22. Resident #148 had diagnoses including dementia with behavioral disturbance, depression, diabetes mellitus and glaucoma. Record review revealed the resident received Hospice services. Review of the physician's admission medication orders, dated 03/07/22 revealed Resident #148 had an order for Namenda XR Extended Release 28 milligrams (mg) capsule by mouth once a day for dementia. Review of a medical progress note, dated 03/08/22 at 12:06 P.M. revealed it was a late entry note. The note revealed the resident had been admitted on [DATE] for respite care. The resident was ambulatory in the hallway on the dementia unit, pleasantly confused, forgetful but physically appeared highly functional. Per nursing staff, last night the resident was having a hard time settling in and was walking down the hall for most of the night and slept maybe only a couple of hours. The note revealed continue Namenda XR 28 mg daily. An order administration note, dated 03/09/22 at 10:16 A.M. revealed Namenda XR capsule extended release 24 hour 28 mg . once a day for dementia medication not available. There was no corresponding note as to why the medication was not available or any actions taken to obtain the medication for administration at that time. A progress note, dated 03/10/22 at 3:53 P.M. revealed the resident had been exit seeking this day. Resident has been pushing on door in the unit today. A note, dated 03/11/22 at 5:45 P.M. revealed the had been exit seeking and talking about going home multiples times on this date. The note revealed the resident was easily re-directed. Review of the March 2022 medication administration record (MAR) revealed the Namenda XR 28 mg was not documented as being given on 03/08/22, 03/09/22 or 03/11/22 as ordered. The administration record included documentation the medication was however administered on 03/10/22 and 03/12/22. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/22/22 at 12:39 P.M. interview with the Interim Director of Nursing (IDON) revealed upon Resident #148's admission for the respite stay on 03/07/22, her medications were brought from home. The nurses who documented the Namenda medication was not available revealed they could not locate the bottle of medication. There was no evidence of any follow up to determine why the medication could not be located or to obtain the medication so it could be administered as ordered for the resident. The IDON verified the administration record inaccurately documented the medication was administered on 03/10/22 and 03/12/22 when it was not. On 03/22/22 at 3:13 P.M. interview with Resident #148's daughter revealed she found the resident's bottle of Namenda at home and realized she had never taken it to the facility. The daughter indicated she felt her mother was more anxious than usual and related this to having not received the Namenda during her stay in the facility (between 03/08/22 and 03/12/22). Resident #148's daughter revealed no one from the facility contacted her regarding the medication not being available as ordered. Review of facility policy titled Medication Administration, dated January 2020 revealed immediately upon administration of medication the nurse documents this on the medication administration record (MAR). Omission or delay of any medication required a brief explanation. Documentation must be completed of medications not administered as ordered with the reason why, notification completed and negative outcome to resident, if any. On 03/23/22 at 9:11 A.M. during a follow up interview with the IDON, the IDON confirmed there was no documentation indicating any facility nurse contacted the family or pharmacy regarding the Namenda medication which was ordered for the resident's diagnosis of dementia. This deficiency substantiates Complaint Number OH00131025.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on record review, review of nursing staff schedules, review of the facility policy and procedures for Medication Administration, Pain Management and Diabetic Management, review of facility medication error reports, review of a facility self-reported incident (SRI) and staff interviews the facility failed to ensure medications were administered as ordered to all residents to prevent the actual occurrence of or potential for significant medication errors. This resulted in Immediate Jeopardy beginning on 03/05/22 at approximately 8:30 P.M. when no licensed nurse (licensed practical nurse (LPN) or registered nurse (RN)) was on duty to provide for the routine and as needed medication administration for all 52 residents residing in the facility. The facility remained without a licensed nurse from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and then was again without a licensed nurse on 03/07/22 from 1:00 A.M. to 7:00 A.M. The lack of licensed nurse in the facility to administer medications resulted in actual or the potential for actual harm for residents, including Resident #108, #122, #124, #130, #115, #117, #144, #116, #101, #111, #114, #120, #149, #125, #126, #129, #133, #134 and #139 related to the lack of administration of pain medication resulting in increased/intolerable pain, lack of blood glucose monitoring and/or insulin administration resulting in elevated blood glucose levels, and/or lack of thyroid, antibiotic, anti-anxiety, anti-coagulation and anti-seizure medications to treat and manage chronic and/or acute disease processes/diagnoses for the residents. This had the potential to affect all 52 residents who were identified by the facility to have medications ordered to be administered during the time periods in which there was no licensed nurse on duty. All 52 residents had medications ordered for administration during the times when there were no nurses working in the facility. On 03/09/22 at 11:10 A.M. the Administrator, Regional Clinical Support Nurse #579, and the Interim Director of Nursing (IDON) were notified Immediate Jeopardy began on 03/05/22 at 8:30 P.M. when the facility failed to ensure a licensed nurse was on duty and present in the facility to provide for the routine care and medication administration of all 52 residents residing in the facility. There was no licensed nurse on duty from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and again on 03/07/22 at 1:00 A.M. until 7:00 A.M. leaving residents with no access to medications to address complaints of pain, to adequately manage blood sugars for diabetic residents and/or to administer routine medications necessary for disease process management. The Immediate Jeopardy was removed on 03/09/22 when the facility implemented the following corrective actions: On 03/08/22 the facility identified all residents had the potential to be affected related to the lack of licensed nurse on duty and in the facility. Beginning 03/08/22 the facility indicated they would attempt to schedule an additional licensed nurse for each 12-hour shift. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/08/22 at 12:27 P.M. Medical Director #578 was notified by Regional Clinical Support Nurse #579 regarding the staffing concern from 03/05/22 for 7:00 P.M. to 7:00 A.M. and from 03/07/22 from 1:00 A.M. to 7:00 A.M. including resident missed medications and blood glucose checks. On 03/08/22 the Administrator was educated by Regional Clinical Support Nurse #579 regarding communication via an immediate phone call to the Regional Support Team regarding any open nurse shift positions due to call-offs that are unable to be filled in a timely manner, nurse no shows, etc to meet the care needs of the residents including medication administration. On 03/08/22 the Administrator, Human Resource #580 and Scheduler/STNA #539 were educated by Regional Clinical Support Nurse #579 regarding conducting staffing meetings two times daily to review any call-offs and ensure adequate coverage is obtained as needed to meet the care needs of the residents including medication administration. On 03/08/22 at 2:02 P.M. all 18 facility nurses were educated via blast text through OnShift regarding the importance of safe staffing to foster safe resident care, proper procedure for nurse call-offs, and to immediately notify the Interim DON if an oncoming nurse does not report to work as scheduled and there is no coverage. Nurses were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 5:15 P.M. all 18 State tested Nursing Assistant (STNA) staff were educated via blast text through OnShift regarding if there is not a nurse in the building to immediately notify the Administrator, and then the Interim DON if there isn't an immediate response from the Administrator. STNAs were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 6:55 P.M. the Interim DON's phone number was posted at all nursing stations. On 03/08/22 the facility implemented a plan to hold a staffing meeting with the Administrator, HR Director #580 and Scheduler/STNA #539 in attendance to review scheduled nursing staff for the day to ensure there was always a licensed nursing staff member on duty to meet the care needs of the residents including medication administration. The daily posted staffing would be reviewed during the meeting to ensure an adequate number of nurses were scheduled for the day. The staffing meeting would occur two times daily Monday through Friday for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. Beginning 03/08/22 the facility implemented a plan for the Interim DON/designee to verify via a telephone call to facility on the off shift (7:00 P.M. to 7:00 A.M. (nights and weekends) all scheduled nurses had arrived for their scheduled shifts to ensure there was always licensed staff in the facility to meet the care needs of the residents including medication administration. This will occur daily for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. Between 03/09/22 and 03/10/22 the facility completed medication error reports for each resident. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 the facility Interdisciplinary (IDT) team, including the Activity Director, Admission Director, Nurse Scheduler, Administrator, Receptionist, Maintenance Director, and Therapy Director completed Ambassador rounds for all residents to conduct psycho-social wellness checks with no negative outcomes identified at that time. On 03/09/22 at 8:42 A.M. Human Resource Director #580 made telephone contact with 35 nurse and STNA staff members who did not respond in OnShift to the text blasts from 03/08/22 at 2:02 P.M. and 5:15 P.M. and verbally educated them on those texts to complete the education. On 03/09/22 at 7:30 P.M. all 36 nursing (RN, LPN and STNA) staff members were educated via telephone contact and in person by Human Resources Director #580 and Scheduler/STNA #539 on staffing guidelines regarding sufficient nursing staff required on each shift to meet the needs of the residents in the facility with notification to the IDON, ADON, and nursing scheduler for assistance if unable to schedule sufficient staff. The staff were also educated regarding the facility's proper call-off procedure. On 03/09/22 one on one education was provided by Regional Clinical Support Nurse #579 to Licensed Practical Nurse (LPN) #507 who was the only nurse on duty on 03/05/22 at 7:00 P.M. and 03/07/22 at 1:00 A. M. who left the facility without having adequate coverage regarding her obligation to ensure adequate licensed nursing staff always remain in the facility to meet the care needs of the residents including administration of medications. On 03/09/22 the facility implemented a plan for the IDON and/or Regional Support team to cover open nurse shifts until a DON was in place to meet the care needs of the residents including medication administration. Results of all audits will be reviewed in QAPI for tracking and trending purposes. Although the Immediate Jeopardy was removed on 03/09/22, 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. Resident #122 was admitted to the facility on [DATE] with diagnoses including quadriplegia, right-sided hemiplegia/hemiparesis, anxiety disorder, gastrostomy and insomnia. A care plan initiated on 09/16/21 revealed Resident #122 had chronic pain related to physical debility and verbalization of intermittent pain with a goal of adequate relief of pain or ability to cope with pain incompletely relieved. Interventions included to administer analgesics as ordered, anticipate the resident's need for pain relief and respond immediately to any complaint of pain, monitor/record/report cause of pain, pain characteristics and signs/symptoms of non-verbal pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent Healthcare and Rehabilitation.	1290 Fairchild Avenue Kent, OH 44240

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the physician's medication orders for March 2022 revealed Resident #122 had medication orders including Eliquis five mg one tablet at bedtime for prevention of blood clots, Metoprolol Tartrate 25 mg one tablet via enteral (peg) tube at bedtime for hypertension with parameters to hold for systolic blood pressure less than 110 or heart rate less than 60, Oxycodone-Acetaminophen 5-325 mg one tablet every four hours as needed for pain, Gabapentin 300 mg one tablet via peg tube for nerve pain. Resident #122 was prescribed Oxycodone-Acetaminophen 5-325 mg one tablet via gastrostomy (peg) tube every four hours as needed for pain. Resident #122's was medicated with Oxycodone on 03/05/22 at 6:13 P. M. She received her next dose of Oxycodone-Acetaminophen 5-325 mg on 03/06/22 at 8:00 A.M., verbalizing a pain level of 10 out of 10 on a scale of 1 to 10. The resident received a dose of Oxycodone on 03/06/22 at 11:00 P.M. but no doses on 03/07/22 between 1:00 A.M. and 7:00 A.M. Review of the administration record revealed no medications at all including the ordered Eliquis for prevention of blood clots, Metoprolol for blood pressure or prn pain medication was administered to the resident on 03/05/22 from 8:30 A.M. to 03/06/22 at 7:00 A.M. or from 03/07/22 from 1:00 A.M. to 7:00 A.M. On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 03/06/22 at 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 03/07/22 at 7:00 A.M. STNA #520 revealed when she arrived at work on 03/05/22 at 11:00 P.M. Resident #122 was crying in pain and needed pain medication. STNA #520 indicated Resident #122 was one of many residents complaining of pain and the STNA felt bad because there was no nurse working and she could not administer medications to the residents. STNA #520 revealed she tried to offer other interventions for pain that were ineffective, and Resident #122 was in pain throughout the whole night on 03/06/22 and 03/07/22. On 03/21/22 at 1:55 P.M. the surveyor attempted to interview Resident #122. The resident was unable to communicate in sentences/conversation but nodded her head yes and no. Resident #122 indicated she was in pain throughout the night when she did not get her pain medication on the above dates. She was unable to verbalize anything specific to the pain but nodded yes to generalized pain. Resident #122 also nodded yes to being anxious about having no nurse in the facility and acknowledged it had not occurred again since those dates. 2. Resident #108 was admitted to the facility on [DATE] with diagnoses including dementia, history of COVID-19, hypertension, type 2 diabetes mellitus, chronic obstructive pulmonary disease, acute respiratory failure, schizoaffective disorder, alcohol dependence in remission and generalized anxiety disorder. Record review revealed a plan of care, initiated on 11/27/18 related to acute/chronic pain due to chronic physical disability, depression and disease process with the goal of Resident #108 experiencing comfort. Interventions included to administer medication (analgesic) as ordered, monitor the effectiveness of pain interventions, monitor/record/report to nurse any signs and symptoms of non-verbal pain such as vocalizations including grunting, moaning or yelling out and to monitor/record/report to nurse resident complaints of pain or requests for pain treatment. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the physician's medication orders revealed a current order for Tylenol Extra Strength, two tablets every six hours as needed (prn) for pain. Review of the medication administration record for March 2022 revealed as needed doses of the medication were administered on 03/01/22, 03/03/22 and on 03/04/22 at 5:47 A.M. There was no evidence the medication was administered on 03/05/22 or 03/06/22. On 03/08/22 at 11:48 A.M. interview with Resident #108 revealed she did not receive any medications or her pain medication on Saturday (03/05/22) night because there was no nurse. The resident reported she was having pain which she described as being intolerable. The resident revealed she repeatedly asked STNA #566 that night if the nurse was there to give her pain medication. On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M., Resident #108 immediately voiced complaints of pain and stated she did not receive her bedtime medications or pain medications (Tylenol Extra Strength). STNA #566 indicated Resident #108 was in pain throughout the whole night (03/05/22 to 03/06/22) but there was no nurse working in the facility to administer pain medications to the resident. On 03/21/22 at 2:05 P.M. during a follow up interview with Resident #108 the resident again voiced concerns she discovered there were no nurses in the facility when she went to the nurses' station to check on her medications. Resident #108 revealed she became very frustrated and anxious because she did not get her anxiety medication or her pain medication. In addition, she stated she also did not get her Melatonin and was unable to sleep the entire night. She stated that she had a rough night. She indicated she takes Tylenol every night which is effective in managing her pain, she did not get any of her medications and was anxious about what would happen if there was an emergency in the facility. 3. Resident #124 was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation, peripheral vascular disease, pulmonary embolism, deep vein thrombosis, hypertension, osteoarthritis and breast cancer. A plan of care, initiated on 02/12/21 revealed Resident #124 had pain related to peripheral vascular disease with a goal of no side effects related to the use of analgesics. Interventions included to administer analgesics as per orders, monitor and report any complaints of pain or requests for pain treatment. Resident #124 was able to call for assistance when in pain, ask for medication, tell how much pain was experienced and tell what increased or alleviated pain. Review of the current physician's medication orders revealed Resident #124 had an order for Acetaminophen 650 mg every 8 hours as needed for pain and Eliquis five mg one tablet by mouth at bedtime for atrial fibrillation. Resident #124 also had physician orders including to monitor for side effects of anticoagulants and to monitor for pain. Record review revealed the resident did not receive the Eliquis (for treatment of atrial fibrillation) or any pain medications on 03/05/22 from 8:30 A.M. to 03/06/22 at 7:00 A.M. or from 03/07/22 from 1:00 A.M. to 7:00 A.M. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the March 2022 medication administration record (MAR) revealed Resident #124's pain level was documented at a level five out of 10 with pain being the most severe pain on the morning of 03/06/22 after not receiving pain medication on 03/05/22 from 8:00 P.M. to 03/06/22 at 7:00 A.M. Resident #124's previous pain levels were recorded as being 0/10. On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 7:00 A.M. STNA #520 revealed when she arrived to work at 11:00 P.M. on 03/05/22, Resident #124 was asking if there was a nurse. STNA #520 indicated Resident #124 was one of many residents requesting medications and the STNA felt bad because there was no nurse working in the facility and she could not administer medications. STNA #520 indicated Resident #124 requested medication throughout the shift. On 03/21/22 at 1:50 P.M. interview with Resident #124 revealed she had pain all the time that was from her osteoarthritis and had Tylenol ordered which helped. Resident #124 indicated she was anxious about not receiving her medications when there was no nurse but mostly anxious about not receiving her Synthroid, which was ordered to be given at 9:00 P.M. Resident #124 indicated she had to take the Synthroid on an empty stomach and there had been at least two other times when she had missed the medication and this made her very anxious. 4. Resident #130 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertensive heart failure, congestive heart failure, and phantom limb syndrome with pain and chronic pain. Record review revealed the resident had no plan of care initiated relative to pain. A pain assessment, dated 02/24/22 revealed Resident #130 had back pain related to a 2018 surgery as well as phantom pain due to amputation of left lower leg. The resident identified his pain as an 8 out of 10 on the pain scale with 10 being the worst pain. Review of the current physician's medication orders for March 2022 revealed the resident was ordered Humalog (insulin) Solution 100 Unit/ML per sliding scale based on blood glucose levels, Oxycodone HCl five mg one tablet every six hours as needed for pain, Lyrica 50 mg one capsule by mouth at bedtime for phantom limb pain, Baclofen 10 mg one tablet by mouth at bedtime for muscle spasms. Resident #130 also had a physician's order to monitor for pain to be completed on the night shift. Resident #130 received a dose of Oxycodone on 03/05/22 at 11:48 A.M. Review of the March 2022 administration records revealed no evidence of pain monitoring as ordered on 03/05/22 from 8:00 P.M. to 03/06/22 at 7:00 A.M. or on 03/07/22 during the night shift. On 03/05/22 Resident #130 did not receive scheduled 9:00 P.M. medications which included Lyrica 50 mg and Baclofen 10 mg for pain and muscle spasms. On 03/06/22 Resident #130 did not receive scheduled 6:00 A.M. medications including Baclofen 10 mg or Humalog insulin (if needed) as there was no evidence the resident's blood glucose level was checked. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the resident's blood glucose level revealed on 03/05/22 at 5:02 P.M. the resident's blood glucose level was 70 mg/dL. Resident #130's blood glucose level was not checked again until 03/06/22 at 12:11 P.M. at which time the blood sugar was elevated at 274 mg/dL and the resident required Humalog 9 units subcutaneously. On 03/09/22 at 2:23 P.M. interview with STNA #574 revealed when she worked on 03/05/22 from 11:00 P.M. to 7:00 A.M., she observed Resident #130 walking around the facility throughout the night and asking for a nurse and asking if there was a nurse. STNA #574 revealed throughout the night the resident did not specifically request pain medication but appeared very anxious. STNA #574 also indicated Resident #130 communicated with other residents there was no nurse in the facility. STNA #574 revealed this in turn made many other residents in the facility very anxious. During the interview, the STNA verified Resident #130 did not receive any of prescribed pain medication on 03/05/22 from 8:00 P.M. to 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. On 03/21/22 at 2:20 P.M. interview with Resident #130 revealed he did not get his nighttime medications on 03/05/22 and at first it made him anxious. The resident revealed he thought the STNAs were not telling the truth about there being no nurse until he went looking for a nurse and could not find one. Resident #130 verified he could not get his pain medication or his blood sugar checked when there was no nurse working. Resident #130 acknowledged he was up throughout the night because he could not sleep and kept asking if the nurse was here yet. 5. Review of Resident #115's medical record revealed current physician orders for March 2022 for Insulin Glargine 100 Units/ml 17 units subcutaneously at bedtime (9:00 P.M.) for diabetes mellitus, Lidocaine five percent patch remove at 9:00 P.M., Gabapentin 300 mg one capsule by mouth for nerve pain at 9:00 P.M. and Oxycodone HCl 5 mg one tablet by mouth every eight hours (scheduled for 10:00 P.M. and 6:00 A.M.) for pain. Resident #115 also had a physician's order to have a pain assessment completed on night shift. Review of the March 2022 administration record revealed Resident #115 did not receive any of her medications, including Insulin Glargine 100 Units/ml 17 units, Gabapentin or Oxycodone HCl 5 mg tablet at bedtime on 03/05/22. In addition, no pain monitoring was completed for the resident. On 03/06/22 Resident #115 did not receive the scheduled 6:00 A.M. dose of Oxycodone five mg. On 03/06/22 Resident #115's blood glucose level was 189 mg/dL at 10:02 A.M., 217 mg/dL at 12:19 P.M., and 169 mg/dL at 6:21 P.M. Review of Resident #115's blood glucose level on 03/07/22 at 10:12 A.M. revealed it was elevated at 343 mg/dL after not receiving her prescribed insulin and she required insulin coverage of Humalog insulin 10 units subcutaneously for the elevated blood glucose level. On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M. Resident #115 was complaining she did not receive her bedtime medications for pain. STNA #566 explained to the resident the medications could not be administered as there was no nurse working in the facility to administer any medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/21/22 at 1:40 P.M. interview with Resident #115 revealed she had concerns she did not receive any medications as ordered by the physician on 03/05/22 and 03/07/22. Although the medications were not administered, the resident denied having any excessive pain or blood sugar concerns on these dates. 6. Review of Resident #117's physician's medication orders for March 2022 revealed the resident had orders including Levemir Solution Insulin 100 Units/ml inject 22 units subcutaneously at bedtime (9:00 P.M.) for diabetes, Levothyroxine Sodium 100 mcg one tablet by mouth at 6:00 A.M. for thyroid disease and blood glucose checks with Humalog Solution Insulin per sliding scale at 6:00 A.M. and 9:00 P.M. Resident #117 also had a physician's order to monitor for signs and symptoms of hypo/hyperglycemia. Review of the March 2022 administration records revealed Resident #117 did not receive any of her medications or hypo/hyperglycemia monitoring as ordered on 03/05/22 from 8:00 P.M. to 03/06/22 at 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. as ordered. On 03/05/22 Resident #117 did not receive her blood glucose check at 9:00 P.M. or 9:00 P.M. medications which included routine insulin, Levemir Solution 22 units. On 03/06/22 Resident #117 did not receive her scheduled 6:00 A.M. medications including Levothyroxine 100 mcg or blood sugar check to determine whether any Humalog insulin per sliding scale was necessary. Review of Resident #117's blood glucose level on 03/06/22 at 11:02 A.M. revealed the blood glucose level was elevated at 219 mg/dL (milligrams per deciliter) which required Humalog Insulin 6 units subcutaneously per sliding scale. On 03/08/22 at 11:15 A.M. interview with Resident #117 revealed there was no nurse working in the facility during periods of time from 03/05/22 to 03/07/22. The resident voiced concerns related to not receiving her Synthroid medication. Resident #117 revealed the STNA staff had reported to her there was no nurse working to pass medications. Resident #117 revealed she was upset because if she does not get her medication, it can cause her problems with her thyroid. 7. Review of Resident #144's current physician's medication orders for March 2022 revealed the resident had an order for Acetaminophen 500 mg two tablets by mouth at bedtime for pain, Cyclobenzaprine HCl 5 mg one tablet by mouth at bedtime for pain and Humulin R Solution Insulin subcutaneously per sliding scale at 6:00 A.M. and 9:00 P.M. Review of the March 2022 administration records revealed Resident #144 did not receive any of her ordered medications on 03/05/22 from 8:00 P.M. to 03/06/22 at 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. The resident had an order to assess for pain and signs/symptoms of hypo/hyperglycemia that were not completed as ordered during these time periods. On 03/05/22 Resident #144 did not receive her scheduled 9:00 P.M. medications including Acetaminophen 500 mg, Cyclobenzaprine HCl 5 mg or blood glucose monitoring to determine if the resident required Humulin Insulin per sliding scale. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/06/22 Resident #144 did not receive her scheduled 6:00 A.M. blood glucose check or Humulin Insulin per sliding scale if it would have been needed. Review of Resident #144's blood glucose level on 03/06/22 at 1:40 P.M. revealed the level was elevated at 225 mg/dL (milligrams per deciliter) which required Humalog Insulin four units subcutaneously per sliding scale at that time. On 03/08/22 at 11:22 A.M. interview with Resident #144 revealed she did not receive her bedtime medication on Saturday. 8. Review of Resident #116's current physician's medication orders for March 2022 revealed the resident had an order for Buspirone HCl 15 mg one-half tablet by mouth at bedtime for anxiety, Baclofen 10 mg one tablet by mouth at bedtime for cerebral infarction and Tramadol HCl 50 mg one tablet by mouth at bedtime for pain. Review of the March 2022 Medication Administration Record (MAR) revealed Resident #116 did not receive any of her ordered medications at bedtime on 03/05/22. In addition, there was no assessment of the resident's pain as ordered during these time periods. Medications not administered included on 03/05/22 at 9:00 P.M. Buspirone 7.5 mg, Baclofen 10 mg and Tramadol HCl 50 mg. On 03/08/22 at 11:24 A.M. interview with Resident #116 revealed she had not received any medications including pain medication on 03/05/22 and no one did anything about her pain all night. On 03/21/22 at 11:35 A.M. during a follow up interview with Resident #116, the resident indicated when she did not get her medications she had a lot of pain all over and was unable to sleep. 9. Review of the current physician's orders for Resident #101 for March 2022 revealed an order for Eliquis (anticoagulant) 5 milligrams (mg) tablet by mouth twice a day for pulmonary embolus scheduled to be administered at 9:00 A.M. and 9:00 P.M. Review of the March 2022 Medication Administration Record (MAR) revealed Resident #101 did not receive the scheduled Eliquis on 03/05/22 at 9:00 P.M. 10. Review of Resident #111's current medication physician's orders for March 2022 revealed an order for daily glucose monitoring at 6:00 A.M., 11:00 A.M., 4:00 P.M. and 9:00 P.M. with sliding scale insulin orders with Humalog. Review of the March 2022 administration record revealed Resident #111 did not receive any of medications or blood glucose monitoring on 03/05/22 from 8:00 P.M. to 7:00 A.M. or on 03/07/22 from 1:00 A.M. to 7:00 A.M. as ordered. On 03/05/22 Resident #111 did not receive his scheduled 9:00 P.M. blood glucose check to determine if Humalog Insulin was to be administered per sliding scale. On 03/06/22 Resident #111 did not receive his scheduled 6:00 A.M. blood glucose check to determine if Humalog Insulin was to be administered per sliding scale. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The next blood glucose level obtained on 03/06/22 at 1:40 P.M. revealed the resident's blood glucose was elevated at 225 mg/dL (milligrams per deciliter) which required Humalog Insulin four units subcutaneously per sliding scale. 11. Review of Resident #114's current physician orders for March 2022 revealed Resident #114 had an order for Levothyroxine Sodium 125 micrograms (mcg) by mouth ordered for 9:00 P.M. for low thyroid hormone level, Melatonin 3 mg one tablet by mouth at 9:00 P.M. for restlessness, Verapamil HCl Extended Release 240 mg one tablet by mouth at 9:00 P.M. for hypertension, Ativan 0.5 mg one tablet by mouth at 9:00 P.M. for anxiety and Mucinex Extended Release 12 Hour 600 mg one tablet by mouth two times a day for congestion Ibuprofen 200 mg two tablets by mouth at bedtime for pain. Review of the March 2022 administration records for Resident #114 revealed the resident did not receive all of her scheduled bedtime medications on 03/05/22 which included 9:00 P.M. medications, Ibuprofen 200 mg, Levothyroxine 125 mcg, Melatonin 3 mg, Verapamil HCl ER 240 mg, Ativan 0.5 mg and Mucinex ER 600 mg. On 03/21/22 at 1:30 P.M. an attempt was made to interview Resident #114. However, the resident had difficulty hearing/understanding the questions posed. 12. Review of Resident #120's current physician's orders for March 2022 revealed the resident had mediation orders including orders for Divalproex Sodium ER 24-hour 250 mg three tablets by mouth at bedtime, Latanoprost Solution 0.005 percent one drop both eyes at bedtime for glaucoma, Artificial Tears Solution 0.4 percent one drop both eyes at bedtime for dry eyes, Brimonidine Tartrate Solution 0.2 percent one drop both eyes at bedtime for glaucoma, Brinzolamide Suspension 1 percent one drop both eyes at bedtime for glaucoma, Timolol Maleate Solution 0.5 percent one drop both eyes at bedtime for glaucoma, Risperdal 2 mg one tablet at bedtime for schizophrenia and Tylenol 325 two tablets by mouth at bedtime for pain. Resident #120 also had a physician's order for monitoring for pain and antipsychotic side effects on the night shift. Review of the March 2022 administration record revealed Resident #120 did not receive medications as ordered or monitoring for pain or antipsychotic side effects on 03/05/22 including the administration of Tylenol 650 mg, Divalproex Sodium ER 750 mg, Latanoprost Solution 0.005 percent 1 drop both eyes, Artificial Tears Solution 0.4 percent, Brimonidine Tartrate Solution 0.2 percent, Brinzolamide Suspension 1 percent, Risperdal 2 mg and Timolol Solution 0.5 percent. On 03/08/22 at 3:23 P.M. interview with STNA #566 revealed when she arrived to work on 03/05/22 at 11:00 P.M. Resident #120 was complaining she did not receive her bedtime medications or pain medications. On 03/21/22 at 1:35 P.M. interview with Resident #120 revealed she takes Tylenol at bedtime every night and when she did not receive her medication on 03/05/22 it was rough to sleep, she was anxious and up and down all night. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	13. Review of Resident #149's physician medication orders for March 2022 revealed the resident had orders for medications including Gabapentin 600 mg one capsule by mouth at bedtime for neuropathy, Topamax 50 mg one tablet by mouth at bedtime for headaches and Xanax 0.25 mg one tablet by mouth at bedtime for anxiety. Resident #149 also had an order to monitor pain each shift. Review of the March 2022 administration records revealed no medications or pain assessment were completed as ordered on 03/05/22 from 8:00 P.M. to 03/06/22 at 7:00 A.M. including the administration at 9:00 P.M. which included Gabapentin 600 mg, Topamax 50 mg and Xanax 0.25 mg. Resident #149 experienced anxiety and sleeplessness throughout the night. On 03/08/22 at 11:35 A.M. interview with Resident #149 revealed she did not receive her medications on Saturday (03/05/22) ni [TRUNCATED]

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety 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** 36307 Based on record review, review of nursing staff schedules, review of the Executive Director Job Description, review of a facility self-reported incident (SRI) and staff interviews the facility failed to maintain effective administrative services to prevent and/or timely address a lack of licensed nursing staff in the facility to meet the total care needs of all residents. This resulted in Immediate Jeopardy beginning on 03/05/22 at approximately 8:30 P.M. when no licensed nurse (licensed practical nurse (LPN) or registered nurse (RN)) was on duty to provide for the routine care, monitoring, medication administration, assessments, response to urgent resident needs and/or treatments for all 52 residents residing in the facility. The facility remained without a licensed nurse from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and then was again without a licensed nurse on 03/07/22 from 1:00 A.M. to 7:00 A.M. The lack of effective administration to address these staffing issues resulted in resident neglect, significant medication errors and actual or the potential for actual harm for residents related to the lack of administration of medications, wound care, supervision, enteral nutrition administration and/or treatment/management of chronic and/or acute disease processes/diagnoses for the residents for which only a licensed nurse was qualified to provide. An essential job function and responsibility of the Executive Director/Administrator is to ensure an adequate number of appropriately trained professionals and auxiliary personnel are on duty at all times to meet the needs of the residents. This had the potential to affect all 52 residents. On 03/09/22 at 11:10 A.M. the Administrator, Regional Clinical Support Nurse #579, and the Interim Director of Nursing (IDON) were notified Immediate Jeopardy began on 03/05/22 at 8:30 P.M. when the facility failed to ensure a licensed nurse was on duty and present in the facility to provide for the routine care, monitoring, medication administration, assessments, response to urgent resident needs and treatments for all 52 residents residing in the facility. There was no licensed nurse on duty from 03/05/22 at 8:30 P.M. until 03/06/22 at 7:00 A.M. and again on 03/07/22 at 1:00 A.M. until 7:00 A.M. leaving residents without access to a licensed nurse to meet their total care needs. The Immediate Jeopardy was removed on 03/09/22 when the facility implemented the following corrective actions: On 03/08/22 the facility identified all residents had the potential to be affected related to the lack of licensed nurse on duty and in the facility. Beginning 03/08/22 the facility indicated they would attempt to schedule an additional licensed nurse for each 12-hour shift. On 03/08/22 at 12:27 P.M. Medical Director #578 was notified by Regional Clinical Support Nurse #579 regarding the staffing concern from 03/05/22 for 7:00 P.M. to 7:00 A.M. and from 03/07/22 from 1:00 A.M. to 7:00 A.M. including resident missed medications, treatments, enteral feedings and blood glucose checks. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/08/22 the Administrator was educated by Regional Clinical Support Nurse #579 regarding communication via an immediate phone call to the Regional Support Team regarding any open nurse shift positions due to call-offs that are unable to be filled in a timely manner, nurse no shows, etc to meet the care needs of the residents including medication administration. On 03/08/22 the Administrator, Human Resource #580 and Scheduler/STNA #539 were educated by Regional Clinical Support Nurse #579 regarding conducting staffing meetings two times daily to review any call-offs and ensure adequate coverage is obtained as needed to meet the care needs of the residents including medication administration. On 03/08/22 at 2:02 P.M. all 18 facility nurses were educated via blast text through OnShift regarding the importance of safe staffing to foster safe resident care, proper procedure for nurse call-offs, and to immediately notify the Interim DON if an oncoming nurse does not report to work as scheduled and there is no coverage. Nurses were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 5:15 P.M. all 18 State tested Nursing Assistant (STNA) staff were educated via blast text through OnShift regarding if there is not a nurse in the building to immediately notify the Administrator, and then the Interim DON if there isn't an immediate response from the Administrator. STNAs were asked to please reply to the message to ensure they received and understood the education. On 03/08/22 at 6:55 P.M. the Interim DON's phone number was posted at all nursing stations. On 03/08/22 the facility implemented a plan to hold a staffing meeting with the Administrator, HR Director #580 and Scheduler/STNA #539 in attendance to review scheduled nursing staff for the day to ensure there was always a licensed nursing staff member on duty to meet the care needs of the residents including medication administration. The daily posted staffing would be reviewed during the meeting to ensure an adequate number of nurses were scheduled for the day. The staffing meeting would occur two times daily Monday through Friday for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. Beginning 03/08/22 the facility implemented a plan for the Interim DON/designee to verify via a telephone call to facility on the off shift (7:00 P.M. to 7:00 A.M. (nights and weekends) all scheduled nurses had arrived for their scheduled shifts to ensure there was always licensed staff in the facility to meet the care needs of the residents including medication administration. This will occur daily for four weeks and then randomly thereafter. Ad hoc education will be given for any non-compliance. On 03/09/22 the facility Interdisciplinary (IDT) team, including the Activity Director, Admission Director, Nurse Scheduler, Administrator, Receptionist, Maintenance Director, and Therapy Director completed Ambassador rounds for all residents to conduct psycho-social wellness checks with no negative outcomes identified at that time. On 03/09/22 at 8:42 A.M. Human Resource Director #580 made telephone contact with 35 nurse and STNA staff members who did not respond in OnShift to the text blasts from 03/08/22 at 2:02 P.M. and 5:15 P.M. and verbally educated them on those texts to complete the education. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 at 7:30 P.M. all 36 nursing (RN, LPN and STNA) staff members were educated via telephone contact and in person by Human Resources Director #580 and Scheduler/STNA #539 on staffing guidelines regarding sufficient nursing staff required on each shift to meet the needs of the residents in the facility with notification to the IDON, ADON, and nursing scheduler for assistance if unable to schedule sufficient staff. The staff were also educated regarding the facility's proper call-off procedure. On 03/09/22 the facility implemented a plan for the IDON and/or Regional Support team to cover open nurse shifts until a DON was in place to meet the care needs of the residents including medication administration. Results of all audits will be reviewed in QAPI for tracking and trending purposes. Although the Immediate Jeopardy was removed on 03/09/22, 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: The current facility Administrator had a hire date of 02/08/2022. Review of the Executive Director (Administrator) Job Description revealed the purpose of the job description was to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to ensure that the highest degree of quality care can be provided to our residents at all times. Personnel functions on the job description included ensuring an adequate number of appropriately trained professionals and auxiliary personnel were on duty at all times to meet the needs of the residents. Review of a facility self-reported incident (SRI), tracking number 218870 created on 03/10/22 a 3:52 P.M. revealed the facility reported an allegation of neglect/mistreatment to the State agency. The SRI revealed during the evening of 03/05/22 from 8:30 P.M. to 7:00 A.M. (03/06/22) and 03/07/22 from 1:00 A.M. to 7:00 A. M. the facility did not have a nurse in the building. The facility identified 52 residents affected by the incident. A narrative summary of the incident revealed a staff nurse called off prompting the agency nurse to leave the facility. The SRI noted as a result of the incident, on 03/08/22 the facility medical director and physicians were notified of the staffing concerns from 03/05/22 at 8:30 P.M. to 03/06/22 at 7:00 A.M. and from 03/07/22 from 1:00 A.M. to 7:00 A.M. including missed medications, wound treatments, enteral (tube feedings) and blood glucose checks. In addition, resident responsible parties were also notified of the missed medications and blood glucose checks. The facility substantiated the allegation of neglect. (See Findings at F600). Review of the facility staffing schedules, assignments sheets and punch detail revealed on 03/05/22 from 7:00 A.M. to 7:00 P.M. there were two nurses, LPN #507 and LPN #576 on duty for the entire 12 hour shift and one nurse LPN #506 on duty for 8 hours from 7:00 A.M. to 3:00 P.M. to provide care for the 52 residents residing in the nursing facility. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of a nurse/STNA schedule for 03/05/22 as well as the attendance punch records for 03/05/22, revealed LPN #507 punched in at 8:30 A.M. and punched out at 8:30 P.M. The facility schedule reflected on 03/05/22 there were two nurses, facility LPN #577 and agency LPN #581, scheduled for the shift beginning at 7:00 P.M. However, interview and record review revealed facility LPN #577 never arrived for his shift. Agency LPN #581 arrived at 7:00 P.M. but left at 7:26 P.M. because she did not want to be the only nurse in the facility. The facility schedule reflected on 03/06/22 there were two nurses, facility LPN #507 and facility LPN #505 scheduled for the entire 12 hour shift from 7:00 A.M. to 7:00 P.M. Facility LPN #577 and agency LPN #582 were scheduled for the shift beginning at 7:00 P.M. Interview and record review revealed LPN #577 never arrived to start the 7:00 P.M. shift. Agency LPN #582 arrived at 7:00 P.M. but was unable to punch in or gain access to the facility electronic medical record (EMR) system with her agency badge and password. LPN #582 got frustrated because she could not do anything, called her agency, and left the facility at approximately 7:30 P.M. Review of the facility attendance punch records indicated LPN #505 remained in the facility until 03/07/22 at 12:00 A.M. and LPN #507 remained in the facility on 03/07/22 until 1:00 A.M. However, no nurse(s) arrived to replace them. And LPN #507 left the facility after working 18 hours. (See Findings at F725). On 03/08/22 at 3:02 P.M. interview with STNA #520 revealed she worked at the facility on 03/05/22 from 11:00 P.M. to 03/06/22 at 7:00 A.M. and on 03/06/22 from 11:00 P.M. to 7:00 A.M. STNA #520 revealed when she arrived to work at 11:00 P.M. on 03/05/22 quite a few of the residents were asking for pain medication. STNA #520 revealed the same thing happened on Sunday, 03/06/22. STNA #520 revealed there was no licensed nurse working in the facility and she and two other aides, STNA #566 and STNA #574 were working to keep all the residents' safe, clean and dry and to prevent any falls. STNA #520 indicated she contacted both the Administrator and Scheduler #539 multiple times on 03/05/22 from 11:00 P.M. until 12:00 A.M. The scheduler responded and indicated they knew about the staffing situation, and they were making phone calls. At the end of her shift on 03/06/22 at 7:00 A.M. STNA #520 revealed she left written messages regarding the staffing situation in the mailboxes of the Administrator and Scheduler. STNA #520 revealed the Administrator and Scheduler called her for a conference call on Monday, 03/07/22 to discuss the staffing situation and asked her to be patient and understanding regarding the staffing and they were working on it and it would not be an overnight fix. (See Findings at F760). On 03/09/22 at 1:16 P.M. interview with STNA #518 revealed she worked the 3:00 P.M. to 11:00 P.M. shift on 03/05/22 and 03/06/22. STNA #518 revealed there was no nurse in the facility on 03/05/22 after 8:30 P.M. and she was aware there was no nurse in the facility on 03/07/22 after 1:00 A.M. She stated she personally spoke with the scheduler on 03/05/22 at approximately 7:30 P.M. and was told they were working on getting a nurse and to do the best they could. STNA #518 revealed the situation was the same on 03/06/22 when no nurses arrived for the 7:00 P.M. shift but LPN #505 and LPN #507 stayed over until 12:00 A.M. and 1:00 A.M. , respectively. LPN #507 came and found her at 11:00 P.M. and indicated her replacement had shown up at approximately 7:00 P.M. but left almost immediately after discovering she would be the only nurse. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/09/22 at 1:36 P.M. interview with STNA #575 revealed during shift change at 7:00 P.M. on 03/06/22, an agency nurse (LPN #581) showed up but she had no log-in information for the facility electronic medical record system. STNA #575 indicated the nurse called the agency and then left because there was nothing she could do. The facility nurse, LPN #507 was sick and dizzy and called the Administrator on 03/05/22 at 8:30 P.M. STNA #575 revealed LPN #507 did not receive a return call (from the Administrator) and eventually locked up the narcotic keys and left. STNA #575 revealed we took care of the residents and put them to bed. She stated some were requesting their medications, but we were STNAs and could not do anything but take care of them. On 03/09/22 at 2:05 P.M. interview with LPN #576 revealed she was an agency nurse who was scheduled to work on 03/05/22 from 7:00 A.M. to 7:30 P.M. at the facility. She stated she had worked at the facility in the past and this was the second or third time she had experienced staffing problems. She indicated she was assigned two halls when she arrived at the facility at 7:00 A.M., the 300 Hall (secured dementia unit) and the 400 Hall with two STNAs to assist her. LPN #576 indicated on 03/05/22 the relief nurse LPN #577 called off at 5:14 P.M. and the agency relief nurse LPN #581 arrived at 7:00 P.M. but indicated that she was not staying because she did not want to be the only nurse in the facility. LPN #576 revealed she called the Administrator at 7:15 P.M. regarding LPN #581's staffing concerns and again at 7:26 P.M. when LPN #581 decided she was not staying because it was unsafe, and she left. LPN #576 indicated she counted the narcotics in the medication carts with LPN #507 and left the facility at 8:00 P.M. LPN #507 was still in the facility when she left. LPN #576 indicated on 03/05/22 when she left the facility, there was only one nurse, LPN #507 along with three STNAs (#520, #566 and #574) remaining in the facility. On 03/09/22 at 3:40 P.M. interview with Scheduler/STNA #539 revealed she had worked at the facility since July 2021. She stated she schedules staffing for the facility a month out and posts the entire month at least two weeks before, usually on the 18th of the month. She posts the schedule so if staff want to pick up extra shifts, they know what shifts are available. She also sends out mass texts via the On Shift System for facility staff and enters information into staffing agency portals or emails them directly to let them know of the availability of shifts and facility staffing needs. Scheduler/STNA #539 revealed she typically staffs three nurses for the 7:00 A.M. to 7:00 P.M. shift and two nurses for the 7:00 P.M. to 7:00 A.M. shift and tries to get a medication pass nurse for 7:00 P.M. to 11:00 P.M. and then drops to two nurses at 11:00 P.M. Schedule/STNA #539 revealed when she received the call off notification from LPN #577, she immediately started making attempts to replace him with another licensed nurse. She stated she contacted the Administrator and was working with her using On Shift, texting people, offering bonuses but got a lot of no. She stated she also posted to all of the agencies and still got no response. Scheduler/STNA #539 indicated she continued to try to get staffing for the facility and went to bed with the phone still making phone calls and worrying about the STNAs left to work in the facility with no licensed nurse as well as the residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/10/22 at 12:58 A.M. interview with LPN #507 revealed she was scheduled to work at the facility on 03/05/22 from 7:00 A.M. to 7:30 P.M. with another staff nurse (LPN #506) scheduled from 7:00 A.M. to 3:00 P.M. and an agency nurse (LPN #576) scheduled for the 7:00 A.M. to 7:30 P.M. shift. LPN #507 indicated LPN #506 left at 3:00 P.M. and she assumed care for the residents on the 100 hall and 200 hall by herself, which was difficult for one nurse. Agency LPN #576 was assigned to care for residents on the 300 Hall and the secured dementia unit. At 7:00 P.M., both LPN #507 and Agency LPN #576 were waiting for their relief staff to arrive. LPN #507 indicated she was sick and barely making it to the end of the shift. She had a headache, vomiting, diarrhea and was dizzy. LPN #507 revealed she sent messages to the scheduler (regarding staffing) with no response. She also called the Administrator at approximately 7:30 P.M. and told her she was sick and couldn't stay. The Administrator's response was, can you hang in for a little longer-about an hour? LPN #507 revealed Agency LPN #576 left at 7:30 P.M. and she (LPN #507) stayed until 8:30 P.M. as the only nurse in the facility and was trying to hang on. LPN #507 revealed at that time no one had told her an oncoming nurse had called off. LPN #507 indicated she stayed for another hour (until approximately 8:00 P.M.-8:30 P.M.), and no one came. LPN #507 stated she sent four messages to the scheduler with no response. LPN #507 revealed she locked the keys in the medication room and placed the medication room key in the office and told the Administrator where they were in a hidden location. During the interview, LPN #507 revealed she returned to the facility on [DATE] at 7:00 A.M. and worked until 03/07/22 at 1:00 A.M. (although she was scheduled to leave on 03/06/22 at 7:30 P.M.). LPN #507 revealed it was like [NAME]-[NAME] all over again. Facility LPN #577 who was scheduled to come in on 03/06/22 at 7:00 P.M. did not show up and she was told he had quit. An agency nurse, LPN #582 did arrive to the facility at 11:00 P.M. but did not stay because she had no access to anything, was unable to scan her badge to administer medications and stated she was not staying because she felt it was unsafe. On 03/08/22 at 4:05 P.M. interview with the Administrator revealed she received a call from facility staff on 03/05/22 at 7:15 P.M. indicating there was no licensed nurse available onsite to relieve the 7:00 A.M. to 7:00 P.M. nurses. The Administrator revealed the scheduled (7:00 P.M. to 7:00 A.M.) staff nurse called off and the scheduled agency nurse arrived on 03/05/22 but left by 7:30 P.M. leaving no licensed nurse to relieve the off-going shift nurses. The Administrator revealed she and Scheduler #539 made multiple calls without success to facility staff nurses and agencies to get a licensed nurse to work on 03/05/22 for the night shift (through 03/06/22 at 7:00 A.M.). During the interview, the Administrator failed to provide any additional information to support evidence of any interviews or direct administrative oversight during these days/shifts when there was no licensed nurse on duty and present in the facility to care for all 52 residents residing in the facility. This deficiency substantiates Complaint Number OH00130768.