STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365969	A. Building B. Wing	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anchor Lodge Nursing Home Inc	3756 W Erie Ave Lorain, OH 44053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observations, medical record review, policy review, resident and staff interviews, the facility failed to ensure residents were served meals in a dignified manner. This affected seven (#7, #10, #11, #21, #33, #64, and #66) of 82 residents observed for dining. The facility census was 82. Findings include: 1. Review of the medical record for resident #11 revealed an initial admitted [DATE]. Diagnoses cerebrovascular disease, encounter for palliative care, unspecified protein-calorie malnutrition, vascular dementia, adult failure to thrive, and anxiety disorder. Review of the quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and required extensive assistance of one staff for eating. Observation on 10/31/22 at 11:34 A.M., of State tested Nurse Aide (STNA) #592 standing next to Resident #11 feeding her lunch. Interview on 10/31/22 at 11:37 A.M., with STNA #592 verified the observation and stated he should be sitting while feeding the resident. 2. Observation on 10/31/22 at 11:23 A.M., of residents on the second floor dining area revealed Resident #10 with no meal tray sitting at a table with Residents #17 and #46, who both had received their meals. In addition, Resident #7 was observed with no meal tray sitting at a table with Resident #42 who had received his meal. Observation on 10/31/22 11:41 A.M., revealed Residents #10 and #7 receive their meals. Interview at this time, with Resident #10, revealed meals come up on the cart based on the resident's room, if the resident chooses to eat in the dining area, the resident would have to wait for the cart that their tray was on. Interview on 10/31/22 at 11:51 A.M., with State tested Nurse Aide (STNA) #567 verified the observation and stated give or take most of the residents in the dining area usually ate in the dining area. STNA #567 stated meals on the meal carts were set up by the order of resident's room except the residents who required to be fed meals were on the last cart. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/02/22 at 12:20 P.M., with Dining Services Director (DSD) #511, stated she had asked the aides to let her know who the residents were that ate in the dining area, so she can put them all on one cart. DSD #511 stated the residents should be served table to table, but it was an easy fix. 44454 3. Review of Resident #66's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included amyotrophic lateral sclerosis, protein-calorie malnutrition, and candidal stomatitis. Resident #66 was a full code. Observation on 11/01/22, from 11:44 A.M. through 12:09 P.M., revealed Resident #66 was sitting up in a wheelchair and State tested Nurse Aide (STNA) #552 was standing while feeding Resident #66 the lunch meal. Interview on 11/01/22 at 12:10 P.M., with STNA #552 verified the staff member was standing while feeding Resident #66 who was seated in her wheelchair. STNA #552 reported she always stood while feeding Resident #66 in her room. 16453 4. Observation on 10/31/22 at 11:49 A.M., revealed Resident #70 was observed eating her meal while Resident #33 had not received her meal tray. The residents were interviewed at that time and stated their meal trays always come at different times. The residents stated there are four of them that eat in the dinning room at the same table. Observation on 11/02/22 at 11:47 A.M., revealed Resident #70 was eating her lunch and was sitting at a table with Resident #21, Resident #33 and Resident #64. Interviews occurred with all four residents at the time of the observation. The residents stated they always eat together for lunch and dinner. The residents stated Resident #70 always gets her meal tray first and is usually finished with her meal before Resident #21, Resident #33 and Resident #64 receive theirs. The residents all stated it would be very nice to get served at the same time so they can enjoy the meals together. Observation and interview on 11/02/22 at 11:53 A.M., with Care Coordinator #569 A.M., confirmed Resident #70 is the only resident who received her meal at a table with three other residents (Resident #21, Resident #33 and Resident #64). The interview confirmed Resident #70 is just about finished with her meal and the other residents have not received theirs. The interview confirmed residents should be served meals at the same time, whenever possible. Review of the policy titled Meal Service Policy dated January 2021, revealed he policy of the facility was to ensure that all residents are treated with dignity and respect at all times. The facility is committed to providing the resident with a positive dining experience at the extent possible. All residents seated at the same table will be served at the same time, prior to serving others at other tables.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on observations, medical record review, resident and staff interviews, the facility failed to provide the resident the choice of when to receive a shower. This affected one (#77) of three residents sampled for choices. The facility census was 82. Findings include: Review of Resident #77's medical record revealed an admitted [DATE], with medical diagnoses including: multiple sclerosis, major depression, anxiety and spastic quadriplegia. Review of Resident #77's annual Minimum Data Set (MDS) assessment identified Resident #77 is alert and oriented and under section F, Resident #77 was asked: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? The assessment identified her response was very Important. The Assessment confirmed Resident #77 is dependent on staff for all activities of daily living. Observation and interview on 10/31/22 at 10:07 A.M., with Resident #77, revealed the resident was asked if she had concerns regarding bathing/showers. Resident #77 stated she is scheduled for showers on Tuesdays and Fridays on the 2-10 P.M. shift. Resident #77 stated she likes the showers before dinner, so her hair dries before she goes to sleep. Resident #77 stated she often does not get a shower. She stated its been since 10/20/22, since she had a shower and her hair washed. Resident #77's hair did appear greasy and need of washing. Observation and interview on 11/02/22 at 9:39 A.M., with Resident #77, revealed the resident was asked if she receive a shower yesterday (Tuesday 11/01/22) and confirmed she had not. Resident #77's hair remained greasy in appearance. Resident #77 confirmed she needs her hair washed really bad. Resident #77 stated at this time she has not received a shower and hair washing since 10/20/22. Interview on 11/02/22 at 2:16 P.M., with Director of Nursing (DON) in the presence of Resident #77, revealed the DON identified residents are scheduled for showers by their room numbers. The DON provided shower sheets and she identified the sheets were completed by the nursing assistants. The DON confirmed none of the shower sheets list if a resident received a bed bath or a shower. Resident #77 confirmed to the DON that when agency staff are working she is not getting her showers and getting a bed bath instead. The DON was observed to tell Resident #77 she would see if the staff could get to her.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure accurate advanced directive information was present throughout the medical record. This affected two (#17 and #55) of five residents reviewed for advanced directives. The facility census was 82. Findings include: 1. Review of Resident #17's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses including: heart disease, heart failure, dementia, altered mental status, chronic kidney disease, metabolic encephalopathy, acquired absence of other left and right toe(s), type II diabetes mellitus, insomnia, and malignant neoplasm of rectum. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident was moderately cognitively impaired. Resident #17 required extensive assistance of two staff for bed mobility and transfers. Review of Resident #17's electronic medical record revealed Resident #17 was identified as having a Do Not Resuscitate Comfort Care (DNRCC) code status signifying cardiopulmonary resuscitative (CPR) measures were not to be conducted in case of cardiac or respiratory arrest. Review of Resident #17's paper medical record revealed the resident was a full code status, signifying all resuscitation procedures would be conducted in case of cardiac or respiratory arrest. Review of physician's orders located in Resident #17's paper medical record, identified an order dated [DATE] for DNRCC. Interview on [DATE] at 11:12 A.M. with Licensed Practical Nurse (LPN) #554 verified the inconsistent advanced directives. Interview on [DATE] at 9:30 A.M. with LPN #548 revealed when a nurse needed to see what a resident's code status was, they looked in either the paper or electronic medical records which should always match. 2. Review of Resident #55's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses including: lymphedema, heart failure, and dementia. Review of Resident #55's quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident was cognitively intact and required the extensive assistance of two staff for bed mobility and transfers. Review of the physician orders located in the electronic medical record for Resident #55 identified an order dated [DATE] for Do Not Resuscitate Comfort Care (DNRCC). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #55's paper medical record revealed no code status form indicating what the resident's code status was. Review of the policy titled Advanced Directive Policy & Procedure, revised [DATE], revealed each resident's advanced directives would be documented accurately in the record to allow for accurate verification at the time when the directive would be implemented.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, staff interview, and review of the policy, the facility failed to notify the physician when a resident sustained a severe weight loss. This affected one (#66) of three residents reviewed for notification. The facility census was 82. Findings include: Review of Resident #66's medical record revealed an admitted [DATE], with diagnoses including: amyotrophic lateral sclerosis, protein-calorie malnutrition, and candidal stomatitis. Review of physician's orders identified a current order dated 03/01/22, for weekly weights for Resident #66 to be completed; regular diet with pureed consistency; and house supplement (four ounces) after meals. Review of the medical nutrition assessment dated [DATE], indicated Resident #66 was underweight and malnourished. Resident #66 was on a diet of pureed texture with the recommendation of fortified foods. The assessment indicated weight trends would be monitored. Resident #66 weighed 82.0 pounds at the time of the assessment. Review of the plan of care for at risk for malnutrition dated 06/27/22, revealed Resident #66 was malnourished and at risk for continued malnutrition due to diagnoses, history of significant weight changes, underweight body mass index, abdominal discomfort with refusal of as needed medications, need for mechanically altered diet texture, and overall poor acceptance of house supplement. Interventions included monitoring diet tolerance, monitoring weight per protocol, and providing diet as ordered. There was no mention of Resident #66 refusing to be weighed. Review of the weight record revealed Resident #66 weighed 88 pounds on 07/26/22. On 10/17/22, Resident #66's weight was recorded at 78.5 pounds, a significant weight loss of 9.5 pounds, which is a 10.8 % loss in three months. Further review of Resident #66's medical record including the weight record and progress notes revealed no indication the physician was notified of Resident #66's significant weight loss. Review of the dietary progress note dated 10/31/22 indicated Resident #66 had triggered for significant weight loss following three months of the resident declining to be weighed. The resident's house supplement was increased to twice per day and the resident would continue to be monitored to attempt to maintain her weight. The physician was not notified of Resident #66's weight loss. Interview on 11/03/22 at 10:48 A.M. with Dietitian #618 verified Resident #66 sustained severe weight loss between 07/26/22 and 10/17/22. Dietitian #618 reported nursing staff was responsible for reporting weight loss to the physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/03/22 at approximately 1:40 P.M., with the Director of Nursing (DON) verified there was no documentation indicating the physician had been notified of Resident #66's significant weight loss. Review of the policy titled Weight Change Policy, dated August 2019, revealed the physician would be notified of significant weight losses and documentation of the notification would be noted in the resident's medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35768 Based on observations, resident and staff interviews, the facility failed to ensure the environment was maintained in a safe and clean manner. This affected five (#10, #45, #71, #74 and #76) of 82 resident's environment observed. The facility census was 82. Findings include: 1. Observations on 10/31/22 at 9:20 A.M., revealed the window blinds for Resident #10 were broken. Interview with Resident #10, at the time of the observation, revealed the blinds had been broken for at least two years. 2. Observations on 10/31/22 at 9:20 A.M., revealed the heater cover for Resident #74 was broken and lying on the floor. 3. Observations on 10/31/22 at 9:30 A.M., revealed three empty medication cups debris and party were observed behind the bed. The floor in Resident #76 room was observed to be sticky. Interview with Resident #76, at the time of the observation, stated the staff sweep the floor and leave, they do not mop. Interview on 11/01/22 at 11:30 A.M., with Housekeeper (HSK) #524 revealed the resident's rooms were cleaned daily and she had enough time in the day to get all her work done. HSK #524 stated she started with the residents' bathroom and then worked out of the room from there. HSK #524 stated if the resident's room had carpet she would vacuum and mopped if there were regular floors. Interview on 11/01/22 at 12:32 P.M., with the Quality Assurance Nurse #624 verified the findings and stated maintenance would be notified immediately. 39969 4. Interview on 10/31/22 at 9:58 A.M., with Resident #45 revealed the housekeeping don't always clean their rooms. Observation of Resident #45's floor, at the time of the interview, revealed the floor appear dirty and scuffed. Interview on 11/01/22 at 11:30 A.M., with Housekeeper (HSK) #524 verified the floor in Resident #45's floor appeared dirty and scuffed up. HSK #524 stated she had not been in the room yet today but prior had cleaned it the best she could including scrubbing it with force. HSK #524 stated that's just the way the floor was. 5. Observation on 10/31/22 at 10:01 A.M., of Resident #71 revealed the brown molding coming off wall and a piece of molding missing on the wall exposing the crumbly plaster across from the resident's bed. Also, the heater cover was hanging off the base board. Interview at this time, with Resident #71 stated she had asked few times about getting that fixed and no one did anything and the last time she had asked was a week ago. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/31/22 at approximately 10:05 A.M., with Maintenance Assistant (MA) #531 verified the observation and stated he will get it fixed.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review and staff interviews, the facility failed to ensure residents and/or their representatives received written transfer notices when transferred to the hospital. This affected two (#81 and #36) of two residents reviewed for hospitalization s. The facility census was 82. Findings include: 1. Review of the medical record for Resident #81 revealed an admitted was 08/23/22, diagnoses included: dysphagia following a stroke, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side, dementia, and chronic obstructive pulmonary disease. Review of the progress note dated 09/13/22 at 4:53 A.M. revealed Resident #81 was transferred to the emergency department (ED). Review of the Transfer/Discharge notice dated 09/13/22 revealed reason to transfer and bed hold policy. Noted on the line for Resident/Representative revealed the resident's representative verbalized understanding and was reviewed by Nurse Clinical Coordinator (NCC) #546. Interview on 11/02/22 at 9:38 A.M., with NCC #546 revealed she had completed the transfer/discharge form and notified the resident's representative. NCC #546 stated then the form goes to Social Services (SS) #569 and put in a binder. Interview on 11/02/22 at 10:51 A.M., with SS #569 revealed nursing completes the transfer/discharge form and notifies the family. SS #569 stated the completed form then comes to her and she keeps them in binder. SS #569 stated then at the beginning of the month she scans them to herself and email them to the Ohio long term care Ombudsman. SS #569 stated they just review it with the family, and they can get the copy upon request. SS #569 stated nursing reviewed the transfer/discharge form with Resident #81's family. SS #569 then stated normally they get a copy usually nursing will give them a copy. Follow-up interview on 11/02/22 at 11:31 A.M., with NCC #546 stated she completed the form, notified the family, and gave it to social services. NCC #546 stated she was not sure what happens after that. NCC #546 stated she did not give a copy to Resident #81's family or to the resident. Follow up interview on 11/02/22 at 11:33 A.M., with SS #569, stated their process was to send out to the family or give to the resident if they are their own responsible party. SS #569 stated she sent Resident #81's representative the form and then stated she had given it to them when they came to get the resident's things. SS #569 stated she didn't have anything to show that the resident's representative was given a written copy. 44454 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #36's medical record revealed an admitted [DATE]. The resident was transferred to the hospital on 09/12/22. Diagnoses included cerebral palsy, epilepsy, hypertension, anxiety, paraplegia, muscle weakness, and altered mental status. Review of Resident #36's progress notes revealed on 09/12/22, Resident #36 was sent to the hospital due to altered mental status. Review of Resident #36's transfer notice revealed the resident's emergency contact was verbally informed of Resident #36's transfer. The transfer notice was not signed by Resident #36 or their emergency contact. Interview on 11/02/22 at 3:30 P.M., with Care Coordinator #569 verified there was no evidence Resident #36 received written notice regarding the transfer.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review and staff interview, the facility failed to ensure residents and/or their representatives received the bed hold notices in writing when transferred to the hospital. This affected two (#81 and #36) of two residents reviewed for hospitalization s. The facility census was 82. Findings include: 1. Review of the medical record for Resident #81 revealed an admitted was 08/23/22. diagnoses included dysphagia following a stroke, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side, dementia, and chronic obstructive pulmonary disease. Review of the progress note dated 09/13/22 at 4:53 A.M. revealed Resident #81 was transferred to the emergency department (ED). Review of the Transfer/Discharge notice dated 09/13/22 revealed reason to transfer and bed hold policy. Noted on the line for Resident/Representative revealed the resident's representative verbalized understanding and was reviewed by Nurse Clinical Coordinator (NCC) #546. Interview on 11/02/22 at 9:38 A.M., with NCC #546 revealed she had completed the transfer/discharge form with the bed hold policy and notified the resident's representative. NCC #546 stated then the form goes to Social Services (SS) #569 and put in a binder. Interview on 11/02/22 at 10:51 A.M., with SS #569 revealed nursing completes the transfer/discharge form with the bed hold policy and notifies the family. SS #569 stated the completed forms then comes to her and she keeps them in binder. SS #569 stated they just review it with the family, and they can get the copy upon request. SS #569 stated nursing reviewed the transfer/discharge form including the bed hold policy with Resident #81's family. SS #569 then stated normally they get a copy usually nursing will give them a copy. Follow-up interview on 11/02/22 at 11:31 A.M., with NCC #546 stated she completed the forms, notified the family, and gave it to social services. NCC #546 stated she was not sure what happens after that. NCC #546 stated she did not give a copy to Resident #81's family or to the resident. Follow up interview on 11/02/22 at 11:33 A.M., with SS #569, stated their process was to send out to the family or give to the resident if they are their own responsible party. SS #569 stated she sent Resident #81's representative the forms and then stated she had given it to them when they came to get the resident's things. SS #569 stated she didn't have anything to show that the resident's representative was given a written copy. 44454 2. Review of Resident #36's medical record revealed an admitted [DATE]. The resident was transferred to the hospital on 09/12/22. Diagnoses included cerebral palsy, epilepsy, hypertension, anxiety, paraplegia, muscle weakness, and altered mental status. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's progress notes revealed on 09/12/22, Resident #36 was sent to the hospital due to altered mental status. Review of Resident #36's bed hold notice revealed the resident's emergency contact was verbally informed of Resident #36's transfer. The bed hold notice was not signed by Resident #36 or their emergency contact. Interview on 11/02/22 at 3:30 P.M. with Care Coordinator #569 verified there was no evidence Resident #36 received written notice of the facility's bed hold policy.

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Anchor Lodge Nursing Home Inc	3756 W Erie Ave Lorain, OH 44053

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on observations, medical record review, policy review, resident and staff interviews, the facility failed to ensure a dependent resident was provided assistance with grooming. This affected one (#61) of four reviewed for activities of daily living (ADL). The facility census was 82. Findings include: Review of Resident #61's medical record revealed an admitted [DATE], with diagnoses including: left above the knee amputation, congestive heart failure, high blood pressure and chronic obstructive pulmonary disease. Review of Resident #61's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 had moderately impaired cognition and was totally dependant on staff for personal hygiene (shaving). Resident #61 did have a plan of care for ADLs, however nothing specific to his wishes/needs regarding shaving. Observation and interview on 10/31/22 at 1:40 P.M., with Resident #61 revealed the resident was observed with multiple days of facial hair. Resident #61 was asked if he liked having the facial hair and he identified he does not. Resident #61 confirmed he likes to be clean shaven daily. Resident #61 confirmed this was important to him. Observation and interview on 11/02/22 at 7:43 A.M., with Resident #61 revealed the resident remained unshaven at this time. Resident #61 again confirmed he wished to be shaved every day, which he identified is certainly not happening. Observation and interviews on 11/02/22 09:35 A.M., of Resident #61 with Licensed Practical Nurse (LPN) #603, revealed the resident remained unshaven. Resident #61 was asked about shaving and confirmed to LPN #603 that he likes to be clean shaven, every day. LPN #603 confirmed he has multiple days of facial hair growth and he would shave Resident #61. Observation and interview on 11/02/22 at 11:22 A.M.,of Resident #61 revealed the resident had a big smile on his face as he was clean shaven. Resident #61 wiped his hands across his checks and chin and stated dont I look so much better. Resident #61 stated thanks for your help I feel so much younger. Review of the policy tilted Activities of Daily Living dated October 2019 revealed licensed and certified staff to provide assistance to the residents for care that they are no longer able to provide on their own. We will encourage as much self care as the resident is able to perform and assist with the completion of tasks unable to complete. The policy listed grooming and identified all resident will be provided assistance in the following area as requested, needed and as indicated on the care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on medical record review and staff interview, the facility failed to monitor and treat residents who had limited bowel movements. This affected two (#10 and #79) of five reviewed for bowel and bladder. The facility census was 82. Findings Include: 1. Review of medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included Parkinson's Disease, unspecified dementia, bipolar disorder, and anxiety disorder. Review of the plan of care dated 01/10/22 revealed the resident had the potential for alteration in bowel elimination. Interventions included to assist with toileting as needed, record all stools, and report irregularities to the charge nurse. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/04/22, revealed the resident had intact cognition. The resident required extensive assistance for toileting. The resident was identified to be continent of bowel. Review of physician orders identified orders for bisacodyl suppository (12/28/21) 10 milligrams (mg) as needed for constipation if milk of magnesium is not effective. Notify the physician if no bowel movements occur in four days. Milk of magnesium 30 milliliters (ml) (12/28/21) as needed for constipation, notify physician if not bowel movement after four days. Review of the nurses notes and medication administration record (MAR) for October 2022 revealed staff did not administer medications to alleviate constipation. Review of bowel movements for October 2022 revealed Resident #10 had no bowel movement on 10/04/22 through 10/06/22, 10/16/22 through 10/20/22, and 10/22/22 through 11/01/22. Interview on 11/02/22 at 2:18 P.M., with Resident #10 stated he had four to five days without having a bowel movement. Resident #10 stated he never asked for medications to encourage bowel movements. 2. Review of medical record for Resident #79 revealed an admitted [DATE]. Diagnoses included: Alzheimer's Disease, unspecified dementia, and delusional disorder. Review of the plan of care dated 01/19/21 revealed the resident had the potential for alteration in bowel elimination, constipation. Interventions included to assist with toileting as needed, record all stools, and report irregularities to the charge nurse, and encourage fluid intake as appropriate. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/07/22, revealed the resident had intact cognition. The resident required supervision for toileting. The resident was identified to be occasionally incontinent of bowel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders identified orders for bisacodyl suppository (01/18/21) 10 mg as needed for constipation if milk of magnesium is not effective. Notify the physician if no bowel movements occur in four days. Milk of magnesium 30 milliliters (ml) (01/18/21) as needed for constipation, notify physician if not bowel movement after four days. Review of the nurses notes and medication administration record (MAR) for October 2022 revealed staff did not administer medications to alleviate constipation. Review of bowel movements for October 2022 revealed Resident #79 had no bowel movement on 10/03/22 through 10/09/22, and 10/27/22 through 10/29/22. Interview on 11/02/22 at 3:00 P.M., with Resident #79 stated her stomach hurts all the time, the medications don't work. Resident #79 was not fluent in English and was difficult to understand at times. Interview on 11/02/22 at 3:30 P.M., with the Quality Assurance Nurse #624 verified lack of documentation indicating lack of bowel movements for Resident #10 and #79.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, resident and staff interview, and review of facility policies, the facility failed to ensure weights were obtained per physician order, and ongoing monitoring was provided for residents identified at nutritional risk and sustaining weight loss. This resulted in Actual Harm when Resident #66 experienced a severe weight loss of 10.8 % from 07/26/22 to 10/17/22. There was no evidence weekly weights were obtained per physician order or that subsequent monitoring or interventions were considered or implemented during this time. Additionally, the facility failed to ensure Resident #51's weekly weights were obtained per physician orders, which placed the resident at risk for more than minimal harm that did not result in actual harm to the resident. This affected two (#66 and #51) of three residents reviewed for nutrition. The facility census was 82. Findings include: 1. Review of Resident #66's medical record revealed an admitted [DATE], with diagnoses including amyotrophic lateral sclerosis, protein-calorie malnutrition, and candidal stomatitis. Review of physician's orders identified a current order dated 03/01/22, for weekly weights for Resident #66 to be completed; regular diet with pureed consistency; and house supplement (four ounces) after meals. Review of the medical nutrition assessment dated [DATE], indicated Resident #66 was underweight and malnourished. Resident #66 was on a diet of pureed texture with the recommendation of fortified foods. The assessment indicated weight trends would be monitored. Resident #66 weighed 82.0 pounds at the time of the assessment. Review of the plan of care for at risk for malnutrition dated 06/27/22, revealed Resident #66 was malnourished and at risk for continued malnutrition due to diagnoses, history of significant weight changes, underweight body mass index, abdominal discomfort with refusal of as needed medications, need for mechanically altered diet texture, and overall poor acceptance of house supplement. Interventions included monitoring diet tolerance, monitoring weight per protocol, and providing diet as ordered. There was no mention of Resident #66 refusing to be weighed. Review of Resident #66's quarterly Minimum Data Set (MDS) assessment, dated 08/09/22, revealed the resident was alert and oriented with no cognitive deficits and required staff assistance for eating. The resident's weight was 88 pounds with no weight loss. Review of Resident #66's Minimum Data Set (MDS) assessments dated 03/08/22, 05/23/22, and 08/09/22, revealed the resident did not reject/refuse care. Review of the weight records for Resident #66 revealed there were no weekly weights documented per physician order for 03/08/22, 06/16/22, 07/07/22, 07/14/22, 08/03/22, 08/10/22, 08/17/22, 08/24/22, 08/31/22, 09/07/22, 09/14/22, 09/21/22, 09/28/22, 10/05/22, 10/12/22, and 10/24/22. On 07/26/22, her weight was 88 pounds. There were no weekly or monthly weights obtained or documented between 07/26/22 and 10/17/22. On 10/17/22, Resident #66's weight was recorded at 78.5 pounds. This represented a severe weight loss of 10.8% in three months' time. There was no weekly weight obtained on 10/24/22. On 11/01/22, Resident #66's weight was 84.0 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the meal intakes for 07/01/22 through 10/31/22 revealed the resident's meal intakes were documented as 50-75% and always required/had the assistance of one staff for eating. Further review of Resident #66's medical record including the weight record and progress notes revealed no indication the resident had refused to be weighed on 03/08/22, 06/16/22, 07/07/22, 07/14/22, 08/03/22, 08/10/22, 08/17/22, 08/24/22, 08/31/22, 09/07/22, 09/14/22, 09/21/22, 09/28/22, 10/05/22, 10/12/22, and 10/24/22. There was no evidence the dietitian was notified, the resident was assessed, or interventions were considered/implemented between 07/26/22 and 10/30/22. There was no assessment of Resident #66's severe weight loss on 10/17/22 until 14 days later (10/31/22). Review of the dietary progress note dated 10/31/22 indicated Resident #66 had triggered for significant weight loss following three months of the resident declining to be weighed. The resident's house supplement was increased to twice per day and the resident would continue to be monitored to attempt to maintain her weight. Additional review of the plan of care revealed it was updated on 10/31/22 and it indicated Resident #66 was at risk for harm/injury to self-related to refusing care and refusing to be weighed. Interventions included consulting the dietitian as needed. Interview on 10/31/22 at 1:26 P.M., with Resident #66 revealed she has never refused to be weighed and stated that she wasn't always hungry enough to drink the supplement and would save them sometimes for later. Interview on 11/01/22 at 12:10 P.M., with State tested Nurse Aide (STNA) #552 revealed STNA #552 was regularly assigned to care for Resident #66. STNA #552 reported Resident #66 required staff assistance with eating and the aide assigned to care for Resident #66 was responsible for assisting Resident #66 with eating. Interview on 11/02/22 at 2:16 P.M., with STNA #552 revealed the staff member was responsible for obtaining the resident's weight. STNA #552 stated she believed Resident #66 was a monthly weight. STNA #552 also reported Resident #66 had only refused to be weighed on one occasion due to being extremely tired and not feeling well that day. Interview on 11/03/22 at 7:39 A.M., with Licensed Practical Nurse (LPN) #548 revealed the staff member was regularly assigned to care for Resident #66. LPN #548 reported STNAs were responsible for obtaining weights and if a resident refused to be weighed the STNA was responsible for reporting this to the nurse assigned to the resident. LPN #548 stated she was not aware of Resident #66 ever refusing to be weighed. LPN #548 reported upon noticing Resident #66's significant weight loss, she contacted the physician to have the resident's supplement increased from one time per day to twice per day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/03/22 at 10:48 A.M., with Dietitian #618 verified Resident #66 sustained severe weight loss between 07/26/22 and 10/17/22. Dietitian #618 verified weekly weights were not obtained/documented for 03/08/22, 06/16/22, 07/07/22, 07/14/22, 08/03/22, 08/10/22, 08/17/22, 08/24/22, 08/31/22, 09/07/22, 09/14/22, 09/21/22, 09/28/22, 10/05/22, 10/12/22, and 10/24/22, as ordered by the physician and said nursing staff were responsible for obtaining weights. Dietitian #618 indicated nursing staff reported the resident had refused those weights. Dietitian #618 verified if a resident refused to be weighed it should have been documented. Dietitian #618 reported if weekly weights had been obtained per physician order and he had noticed a downward trend, he likely would have ordered laboratory test and the additional supplement at that time. During the interview, Dietitian #618 reported he had approximately 415 residents across numerous facilities he was responsible for. Interview on 11/03/22 at approximately 1:40 P.M., with the Director of Nursing (DON) verified there was no additional documentation indicating the resident had refused to be weighed on 03/08/22, 06/16/22, 07/07/22, 07/14/22, 08/03/22, 08/10/22, 08/17/22, 08/24/22, 08/31/22, 09/07/22, 09/14/22, 09/21/22, 09/28/22, 10/05/22, 10/12/22, and 10/24/22. 2. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), dysphagia, dementia, and history of ovarian cancer. Review of the physician orders for October 2022 revealed active orders for weekly weights with a start date of 07/28/22. Review of the resident's weights under weights and vitals revealed on 07/29/22, the resident weighed 127 pounds. There was no evidence of weekly or monthly weights were obtained in August 2022 and September 2022. The next weight listed was on 10/06/22 and the resident weighed 125 pounds. On 10/17/22, the resident weighed 119 pounds and on 10/26/22 the resident weighed 111 pounds which was the last weight entered. Review of the care plan dated 08/01/22 revealed Resident #51 was at risk for malnutrition related to diagnoses, need for mechanically altered diet texture related to diagnoses of dysphagia, at risk for weight fluctuation related to history of varying degrees of edema to both lower extremities, and Coumadin. Interventions included to monitor the resident's weight per protocol. Review of the nutrition progress note dated 09/12/22 at 9:04 A.M., revealed no recent weight times one and half months. Last known weight was 127 pounds on 07/29/22. Goal was for weight maintenance. There was no mention of addressing the lack of weights and not following the physician orders for weekly weights for Resident #51. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition, required supervision with set up help for eating, no weight was listed, weight changes were not assessed, and received a mechanically altered diet. Interview on 11/03/22 at 9:58 A.M. STNA #555 stated she had worked at the facility for three years and often cared for Resident #51. STNA #555 stated a list of residents for weights, whether it was for monthly or weekly, was put out for the aides to obtain the weights. STNA #555 stated after they obtain the weights the completed list was then given to the nurse to enter. STNA #555 stated Resident #51 had never refused to be weighed and that she did not know why the weights were not obtained during August 2022 and September 2022. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/03/22 at 10:13 A.M. with LPN #548 verified Resident #51 had a physician order for weekly weights and that there were no weights for August 2022 and September 2022. LPN #548 stated the aides get the weights and write them down but don't always give them to the nurses. LPN #548 stated that may have been the issues, plus having a lot of agency staff. Interview on 11/03/22 at 10:49 A.M. with Registered Dietitian (RD) #618 verified Resident #51 was on weekly weights. RD #618 stated he didn't know why the weights were not being obtained per order and that was a question for nursing. RD #618 stated he had noticed Resident #51 had a weight loss trend but during October, nothing significant until the weight taken on 10/26/22. RD #618 stated he had asked for a reweigh last Thursday, 10/27/22. RD #618 stated he didn't know when the reweigh was done and that would be a question for nursing. RD #618 stated it was written on a piece of paper and just needed to be entered in the electronic medical record. RD #618 stated he had no expectation of when a reweigh needed to be obtained and that he had 415 residents that he has to take care of. Review of the policy titled Weight Change Policy, dated August 2019, revealed the facility would ensure weights were obtained as ordered and monitored appropriately. The policy further stated weekly weights would be obtained until weight is stable or until recommended otherwise. Review of the policy titled Nutrition Interventions Policy, revised July 2019, revealed the facility would ensure nutritional interventions would be implemented as recommended to ensure the best possible nutritional status of residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46196 Based on observations, medical record review, review of policy, and staff interview, the facility failed to ensure measures were in place to change and date oxygen tubing and saline bottles for use with oxygen concentrators. This affected one (#337) of one resident reviewed for respiratory care. The facility census was 82. Findings include: Review of Resident #337's medical record revealed an admitted [DATE], with admitting diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and primary pulmonary hypertension. Review of the care plan for a potential for altered respiratory status dated 10/18/22, revealed interventions of: assessment of respiratory status; assessment of breath sounds; position to facilitate breathing and comfort; administration of oxygen as ordered; provide assistance with using respiratory devices as ordered; teach cough and deep breathing; position to facilitate breathing and comfort; and administration of oxygen continuously. Review of the October 2022 physician orders on the electronic Treatment Administration Record (eTAR) and under the orders category in the Electronic Health Record included an order to change oxygen tuning every week. Observation on 10/31/22 at 10:26 A.M., of Resident #337, revealed the resident was observed laying supine in the bed. At the resident's bedside was an oxygen concentrator which had a bottle of saline for use with oxygen administration connected with tubing to the posterior side of the concentrator, and which was connected to tubing which terminated in a Nasal Cannula (NC) which was worn by the resident. The oxygen tubing and the bottle of saline were absent of dates indicating when the items were first utilized in the delivery of oxygen to the resident. Interview on 10/31/22 at 10:32 A.M., with Regional Nurse #626 confirmed the oxygen tubing and the bottle of saline for use with oxygen administration were absent of any type of writing to indicate when the items were first utilized in the delivery of oxygen to the resident. Observation on 11/01/22 at 3:21 P.M., revealed Resident #337 was observed laying supine in the bed, with the NC tubing positioned appropriately on the resident, and there was a bottle of saline attached to the concentrator. There was a piece of paper tape folded onto the NC tubing near the point of attachment on the concentrator, on which was written the date of 11/01/22. Observation on 11/03/22 at 8:48 A.M., revealed Resident #337 was observed laying supine in the bed, with respirations of a regular rate and depth. The oxygen tubing was observed with no change to the date from the previous observation. The bottle of saline attached to the oxygen concentrator was observed and did not have any writing to indicate the date on which the saline was opened or first utilized. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Oxygen Therapy, dated July 2013, the described purpose of the policy was to safely administer instructions per physician orders. The policy does not address cleaning of oxygen equipment or dating tubing or water concentrators.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 16453 Based on medical record review, resident and staff interviews, the facility failed to ensure medical transportation was set up for a resident to attend a physician appointments. This affected one (#77) of two residents reviewed for transportation. The facility census was 82. Findings include: Review of Resident #77's medical record identified admission to the facility occurred on 02/28/15, with medical diagnoses including: multiple sclerosis, major depression, anxiety and spastic quadriplegia. Review of Resident #77's annual Minimum Data Set (MDS) assessment identified Resident #77 is alert and oriented. The record identified Resident #77 had a suprapubic urinary catheter. Interview on 10/31/22 at 10:15 A.M., with Resident #77 confirmed she had an appointment with an outside urology physician today; however no transportation was set up, so the appointment was missed. Further interview confirmed Resident #77 additionally had an appointment on 09/30/22 with a Urologist that was missed for lack of transportation. Resident #77 identified the appointment was for bladder spasms and urine leaking issues from her catheter. Interview on 11/03/22 at 9:38 A.M., with the Administrator confirmed Resident #77 did miss her Urology physician appointments on 09/30/22 and 10/31/22 for lack of transportation. The interview confirmed Resident #77 required a stretcher transportation and the facility has had issues with the transportation company.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on medical record review, laboratory review and staff interview, the facility failed to ensure a pharmacy recommendation for laboratory test to monitor medications was completed. This affected one (#18) of five residents reviewed for unnecessary medications. The facility census was 82. Findings include: Review of Resident #18's medical record revealed an admitted [DATE]. Resident #18 had diagnoses including: bipolar disorder, morbid obesity, anxiety, major depression, stroke, chronic pan and diabetes. Resident #18's medication regime included the anti-psychotic medication Seroquel 25 milligram (mg) at bedtime and 12.5 mg twice a day. Review of Resident #18's pharmacy review and physician recommendation form dated 03/11/22, revealed the facility pharmacist recommended: It is recommended for a patient taking anti-psychotic medication to receive a LFT (liver function test) every 6 months. The recommendation identified this is over due for Resident #18. The physician responded with Agree on 03/23/22. Review of laboratory testing for Resident #18, dated 03/24/22 and 08/30/22, identified an ALT (alanine transaminase) was completed. Review of the facility laboratory testing identified LFT (liver function testing) included 8 components: Total Protein, Albumin, A/G ratio, Alkaline Phos, AST, ALT, Total Bilirubin and Direct bilirubin. Interview on 11/04/22 at 9:48 A.M., with the Director of Nursing confirmed one component of the recommended LFT was completed on 03/24/22 and 08/30/22, following the pharmacy recommendation; however the other seven components were noted not completed as requested by the pharmacist and approved by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365969	A. Building B. Wing	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anchor Lodge Nursing Home Inc	3756 W Erie Ave Lorain, OH 44053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on medical record review, observations, Humalog Kwickpen procedure review and staff interview the facility failed to ensure a resident was free from significant medication error as evident by not priming the insulin pen-injector before administration. This affected one (#70) of eight residents observed for medication administration. The facility census was 82. Findings include: Review of medical record for Resident #70 revealed an admitted [DATE]. Diagnoses included major depressive disorder and type 1 diabetes mellitus without complications. Review of physician order dated 10/06/22 revealed Resident #70 receives Humalog solution per sliding scale. Observation on 11/02/22 at 8:00 A.M., of Licensed Practical Nurse (LPN) #603, revealed the nurse grabbed the pen-injector, turned the dial to two units and administered the insulin. Interview immediately after the observation, with LPN #603 revealed the nurse had limited knowledge related to priming the pen-injector before administering insulin. LPN #603 verified the pen was not primed prior to administration. Review of Humalog KwickPen procedures via www.med.umich.edu revealed to prime the pen, staff were to select a dose of two units, take off the outer and inner needle cap, point the pen upward before tapping insulin to move air bubbles to the top, then press the button all the way in to make sure insulin comes out of the needle.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39969 Based on observation, record review, and staff interviews, the facility failed to ensure proper serving for the mechanical soft meat was served. This affected two residents (#22 and #56) but had the potential to affect all 19 residents (#1, #7, #11, #16, #22, #29, #35, #42, #43, #51, #56, #57, #59, #65, #67, #71, #73, #74, and #358) that received the mechanical soft diet. The facility census was 82. Findings include: Observation on 11/02/22 at 11:14 A.M. and 11:16 A.M., revealed Dietary Cook (DC) #513 prepare two mechanical soft meal trays using the gray handled, number eight scoop (four ounces) for the mechanical soft country fried steak. The first meal cart was completed and left out the kitchen at 11:19 A.M. Review of the menu spreadsheet revealed for the mechanical soft meat scoop size was a number six scoop (five and one third ounces). Review of the facility identified list of residents who received mechanical soft diets revealed 19 residents (#1, #7, #11, #16, #22, #29, #35, #42, #43, #51, #56, #57, #59, #65, #67, #71, #73, #74, and #358). Interview on 11/02/22 at 11:21 A.M., with DC #513, verified the mechanical soft meat scoop size per the spreadsheet was the number six scoop and verified she used the number eight scoop and was the wrong scoop size. Interview on 11/02/22 at 12:32 P.M., with Dining Services Director (DSD) #511 stated the residents on the first cart that received the mechanical soft diet included Residents #22 and #56.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on record review, observation, and staff interview, the facility failed to ensure meals provided to a resident accommodated the resident's allergies and preferences. This affected one (#66) of three residents reviewed for nutrition. The facility census was 82. Findings include: Review of Resident #66's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included amyotrophic lateral sclerosis, protein-calorie malnutrition, and candidal stomatitis. Resident #66 was a full code. Review of Resident #66's quarterly Minimum Data Set (MDS) assessment, dated 08/09/22, revealed the resident was alert and oriented with no cognitive deficits. The assessment indicated Resident #66 required staff assistance for eating. Review of Resident #66's diet history and food preference list dated 03/02/22 indicated food allergies/intolerance's and dislikes included strawberries. Review of the resident's meal ticket indicated NO STRAWBERRY. Observation on 11/01/22 at 11:33 A.M., revealed Resident #66 received strawberry yogurt on her lunch meal tray. Interview with Resident #66, at the time of the observation, revealed the resident was allergic to strawberries and often received food items that weren't in accordance with her allergies and/or preferences. Interview with State tested Nurse Aide (STNA) #552, at the time of the observation, verified Resident #66 received strawberry yogurt and was not supposed to due to an allergy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on record review, observations and staff interview, the facility failed to administer medications in a sanitary manner. This affected two (#34 and #59) of eight residents observed for medication administration. The facility census was 82. Findings include: Review of medical record for Resident #34 revealed an admitted [DATE]. Diagnoses included adult failure to thrive, encounter for palliative care, and chronic kidney disease. Review of medical record for Resident #59 revealed an admitted [DATE]. Diagnoses included unspecified sequelae of cerebral infarction and chronic kidney disease. Observations on 11/02/22 from 8:21 A.M. to 8:32 A.M., revealed Licensed Practical Nurse (LPN) #603 administering medications for Resident #34 and #59. LPN# 603 was observed to put a glove on the right hand which was used to open medication bottles and pop medications into the gloved hand for each resident. Interview on 11/02/22 at 8:36 A.M., with LPN #603 verified that he used the gloved hand to open bottles and then pop medications into the same gloved hand for both residents.