STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366094	A. Building B. Wing	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Gahanna	167 North Stygler Road Gahanna, OH 43230

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44068 Based on staff interview, resident interview, observations, medical record review, and facility policy review, the facility failed to ensure Resident #30 had a way to orient to time and date and failed to ensure Resident #237 was permitted to leave the facility as he wished. This affected two (#30 and #237) of five residents reviewed for dignity. The facility census was 84. Findings include: 1.Review of the medical record for Resident #237 revealed an admitted [DATE]. Diagnoses included acute embolism and thrombosis of unspecified deep veins of the right lower extremity, atherosclerotic heart disease, syncope and collapse, idiopathic gout, hypertension (HTN), arthritis, sickle-cell trait, peripheral vascular disease (PVD), chronic kidney disease (CKD), alcohol dependence, tobacco use, hyperlipidemia, obstructive sleep apnea (OSA), hematemesis, and nausea. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/22/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment). The resident required supervision and set up for all Activities of daily Living (ADL's). Review of physician orders for September 2022 identified an order dated 09/09/22 revealed the resident was permitted to leave the facility with family or friends with his medications. Interview and observation on 09/26/22 at 1:43 P.M. with Resident #237 revealed he was visibly upset, speaking loudly, shaking his head from side to side, and he stated he was told by Social Services #156, he could not leave the facility because his insurance did not cover him getting into cars and leaving. Interview on 10/03/22 at 4:10 P.M. with Social Services #156 confirmed Resident #237 was told he was not allowed to go out of the facility, for about a week until she received clarification from Corporate Office that confirmed residents who were cognitively intact could leave the facility as they wished during the day but could not stay out overnight. Review of the facility policy titled, Resident Rights revised 12/2016 revealed resident rights included the right to visit others outside the facility. 43064 (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 - Few	2. Observation on 09/27/22 at 9:48 A.M. revealed Resident #30's call light was on, she reported she needed staff to get her up for dialysis. When Resident #30 was informed it was Tuesday, she stated she was embarrassed, and she did not know what day it was and never did. Resident #30 stated she did not have a calendar or clock and she relied on staff to tell her the time and the day. Observation at that time revealed no clock or calendar in Resident #30's room. Observation and interview on 09/28/22 at 12:25 P.M. of Resident #30's room revealed no clock or calendar present. Interview with Activities Director #128 confirmed there was no clock or calendar in Resident #30's room. She stated usually, residents received an activity calendar, however, the printer had been down at the beginning of the month, she had been on vacation, and then she had gotten sick so, Resident #30 did not receive a calendar. She additionally stated if the resident did not have a pinboard, like Resident #30, the calendar often got swept away. Interview on 09/28/22 at 9:29 A.M. with Housekeeping Supervisor #160 and Maintenance Director #148 revealed every resident should have a pinboard and clock. They reported during 2020 they had turned a lot of double rooms into single rooms, so the cork boards had not been in the correct spot. Interview on 10/03/22 at 10:50 A.M. with Resident #30 revealed the facility had gotten her a clock but it was broken. Observation and interview on 10/03/22 at 2:27 P.M. revealed the clock in Resident #30's room indicated the time was 6:30. This was confirmed by RN #165 at that time and the clock was changed to the correct time. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including encephalopathy, anemia, type two diabetes mellitus, rheumatoid arthritis, cognitive communication deficit, anxiety disorder, depression, and chronic kidney disease. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #30 had intact cognition.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, resident interview, observations, medical record review, and facility policy review, the facility failed to ensure Resident #66's call light was within reach. This affected one (Resident #66) of three residents reviewed for call light access. The facility census was 84. Findings include: Review of the medical record for Resident #66 revealed an initial admitted [DATE] and a re-entry date of 07/08/22. Diagnoses included Alzheimer's Disease, lumbar vertebra fracture, low back pain, muscle weakness, difficulty walking, dysphagia, unsteadiness on her feet, encephalopathy. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 07/15/22, revealed the resident had moderately impaired cognition with no Brief Interview of Mental Status (BIMS) score due to the resident being rarely or never understood. There were no documented behaviors. The resident required extensive to total assistance of one staff for all Activities of daily Living (ADL's) except eating which she required set up help and supervision. Review of the change in condition Minimum Data Set (MDS) assessment, dated 08/27/22, revealed the resident had severely impaired cognition with a Brief Interview of Mental Status (BIMS) score of zero out of 15. There were no documented behaviors. The resident required extensive to total assistance of one staff for all Activities of daily Living (ADL's) except eating which she required set up and supervision. Review of Resident #66's plan of care dated 06/24/22 revealed no care plan for having her call light within reach. Interview and observation on 09/26/22 at 2:46 P.M. revealed Resident #66's call light was on floor and not within the residents reach. The resident confirmed she was unsure where he call-light was located and was able to push the button when the call light was within reach. Observation on 10/03/22 at 11:46 A.M. revealed Resident #66's call light on the floor between the bed and wall. The observation was confirmed immediately with State tested Nurse Aide (STNA) #132 who confirmed call lights were to be placed within resident's reach. Review of the facility policy titled, Answering the Call Light revised 10/2010 revealed when the resident was in bed or confined to a chair the resident's call light was to be within easy reach of the resident.

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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** 07316 Based on observations, medical record review, resident interview, and staff interview, the facility failed to ensure residents had the right to make choices about aspects of their life that are significant and to choose bathing schedules. This affected two of 25 sampled residents (#14 and #29). The facility census was 88. Findings include: 1. Review of the medical record for Resident #14 revealed an admitted [DATE] and diagnoses including diabetes and end stage renal disease. The resident went out of the facility for hemodialysis three times weekly (Monday, Wednesday, Friday, per physician's order). An annual Minimum Data Set assessment completed on 01/14/23 stated the resident had a brief interview for mental status score of 15, indicating intact cognition. The resident required extensive assistance from one staff for bathing. Interview with Resident #14 on 02/01/23 at 2:10 P.M. revealed she often missed showers because they were scheduled on her dialysis days. She stated she leaves around 6:00 A.M. and returns around 1:30-1:45 P.M. She stated she was just too tired after dialysis to get a shower. The resident took off her shoes and socks and a strong odor was noted about her feet. Review of shower records revealed Resident #14 had refused showers on 01/13/23, 01/20/23, and 02/03/23, (all Fridays). Review of dialysis communication records revealed Resident #14 had received dialysis on 01/13/23, 01/20/23, and 02/03/23. Interview with Nursing Assistant #165 on 02/06/23 at 1:05 P.M. revealed Resident #14 was scheduled for showers on Tuesday and Friday. She further confirmed that Resident #14 was too tired to get a shower on Fridays after dialysis. She confirmed the shower schedule had not been adjusted to avoid showers on dialysis days. 2. Review of the medical record for Resident #29 revealed an admitted [DATE]. A Minimum Data Set assessment completed 12/15/22 stated a brief interview for mental status score of 14, indicating intact cognition. The resident required extensive assistance from one staff for bathing. Observations on 02/02/23 at 10:10 A.M. revealed Resident #29's call light to be on. The resident told the surveyor, at that time, he had his call light on because he wanted a shower. Registered Nurse #119 was observed to enter Resident #29's room at 10:15 A.M. She turned off the call light and exited the room. She stated to the surveyor that she knew the resident wanted a shower. On 02/02/23 at 12:40 P.M. Resident #29 stated he had not yet received a shower as requested. Interview with Resident #29 on 02/06/23 at 8:35 A.M. revealed his sister came to the facility on [DATE] and assisted him with his shower. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 02/06/23 at 11:30 A.M. revealed Resident #29's sister had given him a shower on 02/02/23 around 4:00 P.M. He stated the resident's sister had came to his office and told him that the resident might want extra showers, in addition to his two scheduled showers. The Administrator confirmed staff had not assisted the resident with his shower. He stated he felt the facility had until the end of the shift (7:00 P.M.) to honor the resident's request for a shower, even though the resident had requested the shower at 10:10 A.M.

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, observations, medical record review, and facility policy review, the facility failed to allow Resident #247 visitors. This affected one of five residents reviewed for dignity (Resident #247). The facility census was 84. Findings include: Review of the medical record for Resident #247 revealed an admitted [DATE]. Diagnoses included enterocolitis due to clostridium difficile (C-diff) (bacterial infection of the intestines). Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/30/22, revealed the assessment was incomplete and the resident's cognition had not been assessed. Further review of the MDS revealed the resident was not on isolation/quarantine. The resident required extensive assistance of one to two staff for all Activities of Daily Living (ADL's) except eating which he required set up and supervision. Review of the plan of care dated 09/27/22 revealed the no care plan related to isolation or infectious disease. Review of physician orders for September 2022 identified an order for strict contact precautions. Further review of the orders revealed the resident was on a tapered dose of vancomycin for c-diff until 11/04/22. Review of the Electronic Treatment Administration Record (ETAR) for September 2022 revealed the residents order for strict contact precautions was signed off as completed every day since ordered. Observation on 10/03/22 at 2:17 P.M. while speaking to Registered Nurse (RN) #125, the Office Staff #111 interrupted to ask if Resident #247, could have visitors since he was on isolation. RN #125 confirmed the resident could not have visitors since he was on isolation. Interview on 10/03/22 at 2:33 P.M. with RN #125 confirmed residents with isolation precautions were allowed to have visitors as long as the visitors wore the required Personal Protective Equipment (PPE). Interview on 10/03/22 2:40 P.M. with Office Staff #111 revealed residents on isolation were not allowed to have visitors. She stated she confirmed if residents on isolation precautions could have visitors with RN #125 while the surveyor was present. She revealed one of Resident #247's relatives called and asked if the resident could have visitors since he was on isolation and the receptionist informed the relative that Resident #247 could not have visitors after verifying with RN #125. Review of the facility policy titled, Resident Rights revised 12/2016 revealed resident rights included the right to visit and be visited by others from outside the facility.

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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** 42728 Based on record reviews and staff interviews, the facility failed to ensure the physician was notified when a resident was out of ordered enteral feeding solution. This affected one resident (Resident #52) reviewed for tube feeding during the annual survey. The facility census was 84. Findings include: Record review for Resident #52 revealed this resident was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder, unspecified dementia with behavioral disturbance, hypotension, adult failure to thrive, hypovolemia, insomnia, and depression. Review of the quarterly MDS assessment, dated 08/17/22, revealed this resident had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 08. This resident was assessed to require extensive assistance from one staff member for bed mobility, to be dependent upon two staff members for transfers, and to be dependent upon one staff member for eating, toileting, and bathing. This resident was assessed to have a feeding tube. Review of the care plan, revised 09/20/22, revealed this resident was at risk of malnutrition/dehydration. Interventions included tube feeding as ordered. Review of the physicians order, dated 08/16/22, revealed an order to administer Two Cal HN at 95 milliliters and hour for 12 hours from 7:00 P.M. to 7:00 A.M. Review of the Medication Administration Record (MAR) revealed documentation Two Cal HN was not administered as ordered on 09/27/22, 09/29/22, 09/30/22, 10/01/22, or 10/02/22. Review of the progress note, dated 09/28/22 and timed 7:03 A.M. revealed Two Cal HN not available, waiting on dietitian to review order. There was no documentation of the notification of the physician. Review of the progress note, dated 09/29/22 and timed 11:12 P.M., revealed Two Cal HN not available, waiting on dietitian to clarify order. There was no documentation of the notification of the physician. Review of the progress note, dated 10/01/22 and timed 5:00 A.M., revealed Two Cal HN not available, waiting on dietitian to clarify order. There was no documentation of the notification of the physician. Review of the progress note, dated 10/02/22 and timed 5:54 A.M., revealed Two Cal HN not available, waiting on dietitian to clarify order. There was no documentation of the notification of 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	Review of the progress note, dated 10/02/22 and timed 11:33 P.M., revealed Two Cal HN not available, still waiting on dietitian to clarify order. There was no documentation of the notification of the physician. Observation and interview with Licensed Practical Nurse (LPN) #120 on 10/03/22 at 10:45 A.M. verified there was not any documentation or other evidence the physician was notified Resident #52 was out of tube feeding solution from 09/27/22 through 10/02/22.

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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** 38522 Based on record review and interview, the facility failed to notify the Long-Term Care Ombudsman (LTCO) of resident transfers/discharges as required. This affected one resident (Resident #18) of three residents reviewed for admission, discharge and transfer rights. The facility census was 84 residents. Findings include: Review of Resident #18's medical record revealed an admitted [DATE] and diagnoses including acute and chronic respiratory failure, chronic obstructive pulmonary disease, type two diabetes, dysphagia, tracheostomy status and anemia. Review of Resident #18's census data revealed a discharge date of [DATE]. Review of nurses' notes revealed on 07/28/22 at 9:27 A.M. Resident #18 continued to have emesis through his tracheostomy. Orders given to send Resident #18 to the emergency room for further monitoring. Family notified of new order. No evidence was provided regarding LTCO notification of Resident #18's discharge on 07/28/22. Phone interview on 09/28/22 at 10:41 A.M. with Social Service Designee (SSD) #156 revealed she did not provide transfer/discharge notifications to the LTCO as required. Phone interview on 09/28/22 at 4:31 P.M. with LTCO intake staff #166 indicated they had not received any information regarding resident transfers or discharges from the facility since February 2022.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview, record review and policy review, the facility failed to ensure all of Resident #240's medications were available upon his discharge home. This affected one resident (Resident #240) of three residents reviewed for admission, discharge and transfer rights. The facility census was 84 residents. Findings include: Review of Resident #240's medical record revealed an admitted [DATE] and diagnoses including quadriplegia, type two diabetes, morbid obesity, colostomy and anemia. Review of Resident #240's admission minimum data set (MDS) assessment dated [DATE] revealed Resident #240 was cognitively intact, did not display behaviors and had an indwelling catheter and ostomy. Resident #240 did received antibiotics during the review period. Review of census data revealed Resident #240 was discharged from the facility on 09/26/22. Review of Resident #240's physician's orders revealed an order dated 09/09/22, for ertapenem sodium solution reconstituted one gram, use one gram intravenously (IV) in the afternoon for extended spectrum beta-lactamases (ESBL) proteus until 10/02/22, give one gram in 50 milliliters. Review of Resident #240's September 2022 Medication Administration Record (MAR) revealed the ertapenem was not administered on 09/26/22 and a 3 was marked in the MAR on that date. The legend on the MAR indicated absent from home/leave of absence. Review of Resident #240's nurses' notes did not state Resident #240 had been discharged . Review of an electronic-MAR (e-MAR) note dated 09/26/22 at 8:00 P.M. had the word discharged . Review of Resident #240's discharge review dated 09/26/22 revealed a section on medications indicating medications being sent home or scripts for and then a list of medications: Critic-aid ointment, magnesium hydroxide suspension, Tylenol tablet, zinc sulfate capsule, selenium capsule, ascorbic acid tablet, polyethylene glycol, tetrahydrozoline hydrochloride solution, januvia tablet, refresh P.M. ointment, Systane complete solution, fluorometholone suspension, acetic acid solution, cyanocobalamin solution and nystatin powder. In the section, list other medications, there was a notation of see attached med list and a box was checked that the above medications were sent home with instructions. Resident #240 was discharging home with [County] home health who was to visit him on 09/27/22. The review did not further discuss Resident #240's intravenous antibiotic medication. Phone interview on 09/28/22 at 10:00 A.M. with Resident #240 revealed he was discharged from the facility on 09/26/22. Resident #240 stated he was supposed to have the IV antibiotics upon discharge and at the time of the interview, he had missed two days of the IV antibiotics. Resident #240 stated the [County] home health could not start their services due to the hold up with the IV antibiotics. Resident #240 verified he was given his other medication, but not the IV antibiotics at the time of discharge. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 09/28/22 at 10:30 A.M. with Social Service Designee (SSD) #156 revealed Resident #240 was discharged on [DATE] and was given his by mouth/oral medication at that time. SSD #156 stated the IV antibiotics would come from an outside pharmacy and Resident #240 was to receive home health care in [County name] county. SSD #156 indicated the IV antibiotic information was sent to the provider on 9/26/22 (evening) and re-sent on 09/27/22. SSD #156 denied any confirmation being received from the facsimiles she had sent. When asked if she called the providers to ensure the information was received, SSD #156 verified she did not call and stated the provider would call if they did not receive the information. Review of facsimile information regarding Resident #240's discharge and IV antibiotics revealed documentation was sent to [County] home health care on 09/26/22 and the outside pharmacy on 09/26/22 and 09/27/22; no time stamps were available to indicate when the facsimile was sent. Physician's orders but no prescriptions were included in the facsimile documentation. Phone interview on 09/28/22 at 11:26 A.M. with Home Health Nurse Practitioner (HHNP) #163 revealed as of the time of the interview, Resident #240 had not been admitted to home health services. HHNP #163 stated her office had been calling the facility without success as they still did not have the documentation needed to process the referral for home health services. HHNP #163 stated it was good practice to get a phone call about a referral and to verify receipt of the facsimile documents sent over. HHNP #163 stated her clinical staff had reached out to the facility on [DATE] and 09/27/22, but still did not have a prescription for the IV antibiotics just the order. HHNP #163 stated until this resolved they could not start home health services for Resident #240. Phone interview on 09/28/22 at 11:47 A.M. with Outside Pharmacy Patient Registration Coordinator (OPPRC) #164 revealed the outside pharmacy had been contacting the facility and still had not received a prescription for Resident #240's IV antibiotics. OPPRC #164 confirmed the facility did not contact them on 09/26/22 when Resident #240 discharged and sent demographic information over to them on 09/27/22 around 5:00 P.M. also after Resident #240 had discharged from the facility. Review of the facility's policy, Discharge Review Plan, dated December 2016 revealed the discharge review shall include a description of the residents' special treatments or procedures (treatments and procedures that are not part of basis services provided) and medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration and recognition of significant side effects that would be most likely to occur in the resident). Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review and staff interview, the facility failed to complete comprehensive assessments within 14 calendar days after admission. This affected two of three residents (#9 and #73) reviewed for assessment completion. The facility census was 88. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE]. Review of the admission Minimum Data Set (MDS) assessment revealed it was still in progress on 02/07/23. (14 days after admission would be 02/02/23). Interview with the Director of Nursing on 02/08/23 at 8:30 A.M. confirmed the comprehensive assessment for Resident #9 was not completed within 14 days after admission. 2. Review of the medical record for Resident #73 revealed an admitted [DATE]. Review of the admission MDS assessment revealed it was completed on 02/06/23. (14 days after admission would be 02/01/23). Interview with the Director of Nursing on 02/08/23 at 8:30 A.M. confirmed the comprehensive assessment for Resident #73 was not completed within 14 days after admission.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review and staff interview, the facility failed to ensure quarterly assessments were completed timely. This affected one of three residents (#67) reviewed for assessments. The facility census was 88. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE]. An admission Minimum Data Set assessment was completed on 10/24/22. A quarterly assessment indicated it was in progress on 02/07/23 (was due to be completed 01/24/23). Interview with the Director of Nursing on 02/08/23 at 8:30 A.M. confirmed the quarterly assessment was not completed timely for Resident #67.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, interview, and policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed in a timely manner as required. This affected six residents (Resident #2, Resident #3, Resident #18, Resident #232, Resident #233, and Resident #243) of six residents reviewed for resident assessment. The facility census was 84 residents. Findings include: 1. Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses including anemia, unspecified protein-calorie malnutrition, muscle weakness and malignant neoplasm of prostate. Review of census data revealed Resident #2 discharged from the facility on 05/05/22. Review of a late entry nurses' note dated 05/05/22 at 5:51 P.M. revealed Resident #2 was admitted to the hospital following doctor's appointment. Review of Resident #2's MDS assessments revealed a discharge return not anticipated assessment dated [DATE] that was marked as in progress and was not completed. A red box was at the top that indicated the MDS was to have been completed by 05/19/22. Interview on 09/29/22 at 1:45 P.M. with MDS/Licensed Practical Nurse (LPN) #120 verified Resident #2's discharge MDS was still in progress and should have been completed. 2. Review of Resident #3's medical record revealed an admitted [DATE] with diagnoses including rhabdomyolysis, dysphagia, anxiety disorder, chronic obstructive pulmonary disease, depression and chronic kidney disease stage three. Review of census data revealed Resident #3 discharged from the facility on 05/13/22. Review of MDS assessments revealed a discharge return not anticipated MDS assessment dated [DATE]. The assessment was marked as in progress and was not completed. A red box at the top of the opened assessment indicated the MDS was to have been completed by 05/27/22. Interview on 09/29/22 at 1:45 P.M. with MDS/LPN #120 verified Resident #3's discharge MDS was still in progress and should have been completed. 3. Review of Resident #18's medical record revealed an admitted [DATE] and diagnoses including acute and chronic respiratory failure, chronic obstructive pulmonary disease, type two diabetes, dysphagia, tracheostomy status and anemia. Review of Resident #18's census data revealed a discharge date of [DATE]. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurses' notes revealed on 07/28/22 at 9:27 A.M. Resident #18 continued to have emesis through his tracheostomy. Orders were given to send Resident #18 to the emergency room for further monitoring. Review of Resident #18's MDS data revealed an admission and a 5-day assessment were completed on 07/14/22. No discharge MDS was available for review. Interview on 09/29/22 at 1:45 P.M. with MDS/LPN #120 verified Resident #18 did not have a discharge MDS assessment. Review of the facility policy, MDS Completion and Submission Timeframes, revised September 2010 revealed discharge MDS assessments were to be completed after the discharge date plus 14 calendar days. 44068 4. Review of the medical record for Resident #243 revealed an admitted [DATE]. Diagnoses included post-procedural partial intestinal obstruction, severe protein-calorie malnutrition, post-gastric surgery syndromes, myxedema coma, hypothyroidism, autoimmune thyroiditis, multiple myeloma in remission, anemia, sleep apnea, glaucoma, and vitamin deficiency. Review of the comprehensive MDS assessment, dated 10/01/22, revealed the assessment was in progress (19 days after the resident's admission). Further review of the assessment revealed the resident had impaired cognition with a Brief Interview of Mental Status (BIMS) score of 12 out of 15 (moderate impairment). The resident's functional status had not been assessed. Review of the email dated 10/12/22 at 10:10 A.M. from the Regional RN #20 to the Surveyor confirmed Resident #243 did not have a timely completed MDS. 5. Review of the medical record for Resident #232 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included displaced intertrochanteric fracture of the right femur, atrial fibrillation (a-fib), Diabetes Mellitus II (DM2), emphysema, dysphagia, and severe protein-calorie malnutrition. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/22/22, revealed the assessment remained in progress (23 days since the resident's re-entry to the facility). Review of the email dated 10/12/22 at 10:10 A.M. from the Regional RN #20 to the Surveyor confirmed Resident #232 did not have a timely completed MDS. 6. Review of the medical record for Resident #233 revealed an admitted [DATE]. Diagnoses included status post motor-vehicle accident-causing injury, asthma, epileptic seizures, fracture of the left forearm, displaced [NAME] fracture of the left and right tibia, and fractures of the left and right ribs. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 10/03/22, revealed the assessment was in progress and did not have any categories completed outside of K (swallowing and nutritional status). (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Electronic Message (email) dated 10/11/22 at 5:07 P.M. from the Unit Manager Licensed Practical Nurse (LPN) #120 confirmed the Resident #233's MDS assessment had not been completed. Review of the email dated 10/12/22 at 10:10 A.M. from the Regional RN #20 to the Surveyor confirmed Resident #233 did not have a timely completed MDS. Review of the facility's policy titled, MDS Completion and Submission Timeframes revised 07/2017 revealed the facility was responsible for ensuring that resident assessments were submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review the facility failed to ensure Resident #17's Pre-admission Screening and Resident Review (PASARR) was completed accurately. This affected one resident (#17) of two residents reviewed for PASARR's. Findings include: Review of the medical record for Resident #17 revealed they were admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, lymphedema, hyperlipidemia, cognitive communication deficit, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had intact cognition and required the extensive assistance of one person for personal hygiene. Review of the PASARR dated 02/18/22 revealed Resident #17 had a mood disorder, delusional disorder, panic or severe anxiety disorder, post-traumatic stress disorder (PTSD), and paranoid disorder. Review of the psychiatric note dated 07/08/22 revealed Resident #17 had a history of bipolar disorder and anxiety, there was no documentation related to delusional disorder, PTSD, or paranoid disorder. Review of the 01/01/22 hospital record revealed no past medical history for Resident #17 related to delusional disorder, PTSD, or paranoid disorder. Interview on 09/28/22 at 11:07 A.M. and 1:50 P.M. with Social Services #156 confirmed the PASARR indicated Resident #17 had delusional disorder, PTSD, and paranoid disorder but there was nothing in the medical record to indicate Resident #17 had these diagnoses.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, resident interview, observations, medical record review, facility policy review, the facility failed to ensure care plans were comprehensive. This affected six Residents (Residents #14, #51, #55, #66, #68, and #233) of 29 residents reviewed for care plans. The facility census was 84. Findings include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included cerebral infarction, non-dominant, left side (L)hemiplegia and hemiparesis following a cerebral infarction (CVA), hypertension (HTN), heart disease, and dysphagia. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 08/17/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment) and no documented behaviors. The resident required limited to extensive assistance of one to two or more staff for all Activities of daily Living (ADL's). Review of physician orders for October 2022 revealed an order dated 08/17/22 for cimetidine 400 mg two times daily for hypersexuality. Review of the plan of care dated 08/15/22 and revised 10/04/22 revealed the resident had no care plan related to behaviors. Review of the email dated 10/05/22 at 5:14 P.M. from the Regional Nurse #165 to the Surveyor verified Resident #51 had no prior careplan that addressed behaviors and had a care plan added on 10/05/22 revealing the resident had a behavior problem related to inappropriate sexual behavior. The interventions included administration of medication per physician orders, intervention and redirection as needed, monitoring and assessments of the behaviors, documentation, and notification of the physician of increased behaviors as needed. 2. Review of the medical record for Resident #66 revealed an initial admitted [DATE] and a re-entry date of 07/08/22. Diagnoses included Alzheimer's Disease, lumbar vertebra fracture, low back pain, muscle weakness, difficulty walking, dysphagia, unsteadiness on her feet, encephalopathy, and severe protein-calorie malnutrition. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 07/15/22, revealed the resident had moderately impaired cognition with no Brief Interview of Mental Status (BIMS) score due to the resident being rarely or never understood. There were no documented behaviors. The resident required extensive to total assistance of one staff for all Activities of Daily Living (ADL's) except eating which she required set up and supervision. Review of the plan of care dated 06/24/22 revealed there was no care plans regarding hospice, hearing impairment, or code status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic message (email) dated 10/06/22 at 6:18 P.M. from the Administrator to the Surveyor confirmed Resident #66 had no care plans regarding hospice, hearing impairment, or codes status. 3. Review of the medical record for Resident #233 revealed an admitted [DATE]. Diagnoses included status post motor-vehicle accident-causing injury, asthma, epileptic seizures, fracture of the left forearm, displaced [NAME] fracture of the left and right tibia, and fractures of the left and right ribs. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 10/03/22, revealed the assessment was in progress and did not have any categories completed outside of K (swallowing and nutritional status). Review of the plan of care dated 09/25/22 revealed the resident did not have any care plans related to pain or wound care. Review of the email dated 10/11/22 at 2:22 P.M. from the Administrator to the Surveyor confirmed Resident #233 did not have a pain or wound care plan. Review of the facility policy titled, Assisting the Nurse in Examining and Assessing the Resident undated, revealed the primary purpose of assessing the resident is to gather detailed information that will help to develop a plan of care that is appropriate for the resident. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered revised 12/2016 revealed the comprehensive, person-centered care plan was to be developed within seven (7) days of the completion of the required comprehensive assessment (MDS) and were to include identified problem areas. 42728 4. Record review for Resident #68 revealed this resident was admitted to the facility on [DATE] and had diagnoses including acute respiratory failure with hypoxia, ileus, hypertension, type two diabetes mellitus, dysphagia, schizophrenia, muscle weakness, difficulty walking, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/22, revealed this resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting, extensive assistance from two staff members for transfers, and supervision with setup help only for eating. Review of the active care plans for this resident revealed there was not a care plan detailing the resident's activity preferences or needs. Interview with Licensed Practical Nurse (LPN) #120 on 10/04/22 at 4:30 P.M. verified there was not a care plan in place addressing the activity needs or preferences of Resident #68. 43064 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record revealed Resident #14 admitted on [DATE] with diagnoses including type two diabetes mellitus, hypertension, end stage renal disease with dependence on renal dialysis, cerebral infarction, cognitive communication deficit, gastro-esophageal reflux disease, hypothyroidism, pain in left knee, and insomnia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had intact cognition and received dialysis. Review of the physician's order for Resident #14 dated 04/25/22 revealed an order for buspirone tablet five milligrams, one tablet by mouth three times a day for anxiety. Review of the plan of care dated 04/06/22 revealed Resident #14 was at risk for side effects; however, no potential cause was listed. The goal of this focus was to have no drug related side effects, and the plan of care was absent for interventions. Review of Resident #14's physician's orders dated 05/05/22 revealed orders for Oxycodone five milligrams two tablets by mouth every four hours as needed for severe pain rated eight to ten and one tablet by mouth every four hours as needed for moderate pain rated four to seven. Review of the plan of care dated 04/06/22 revealed Resident #14 was at risk for alteration in comfort, however, the care plan did not identify the cause. The interventions included calming music or television, medications as ordered, monitoring for adverse effects of pain medications, monitoring for effectiveness of interventions, monitoring for levels of increased pain and notifying the physician, and using a pain scale as reported by the resident. Review of the physician's order for Resident #14 dated 06/13/22 revealed an order for hemodialysis with Fresnius medical care every Monday, Wednesday, and Friday. Review of the plan of care dated 03/21/22 revealed Resident #14 received dialysis on Monday, Wednesday, and Friday related to End Stage Renal Disease (ESRD). Interventions included assisting with transfers when going to dialysis and fluid restrictions as ordered. Interview on 10/03/22 at 12:21 P.M. with Unit Manager Licensed Practical Nurse (LPN) #120 confirmed Resident #14's care plan for dialysis, pain, and anxiety medications were not complete and comprehensive. 6. Review of the medical record for Resident #55 revealed an admitted [DATE] revealed an admitted chronic diastolic heart failure, type two diabetes mellitus, chronic kidney disease stage two, depression, unspecified dementia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had severely impaired cognition. Review of the physician order dated 05/13/22 revealed an order for Tylenol tablet 325 milligrams (mg) one tablet by mouth every 6 hours as needed for mild pain of one to five. Review of the physician order dated 06/08/22 revealed an order for Tramadol tablet 50 mg every eight hours as needed for severe pain of six to ten. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for September 2022 revealed Tylenol and Tramadol was administered for pain. Review of the plan of care dated 05/13/22 revealed Resident #55 was at risk for an alteration in comfort, however, there was nothing listed as a cause. The only intervention was to reposition the resident for comfort. Review of the plan of care dated 05/13/22 revealed Resident #55 received a psychoactive medication. Interventions included giving medications as ordered, monitoring for effectiveness, observing and reporting any changes in mental status, and a resident specific behavior intervention. Review of the physician order dated 06/20/22 to 09/26/22 revealed Resident #55 had an order for Ativan tablet 0.5 milligrams (mg) one tablet by mouth every eight hours as needed for agitation. Interview on 10/03/22 at 12:21 P.M. with Unit Manager LPN #120 confirmed Resident #55's care plan for pain and anxiety was not complete and comprehensive.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, record reviews, and review of facility policies, the facility failed to ensure showers and nail care were completed for residents who were dependent upon staff for assistance. This affected six residents (Residents #13, #28, #52, #59, #68, and #235) out of the nine residents who were reviewed for Activities of Daily Living (ADL's) during the annual survey. The facility census was 84. Findings include: 1. Record review for Resident #68 revealed this resident was admitted to the facility on [DATE] and had diagnoses including acute respiratory failure with hypoxia, ileus, hypertension, type two diabetes mellitus, dysphagia, schizophrenia, muscle weakness, difficulty walking, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/22, revealed this resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 04. This resident was assessed to be dependent upon one staff member for bathing. Review of the care plan, dated 07/18/22, revealed this resident had an ADL self care performance deficit. Interventions included to provide extensive assistance to total assistance with showering two to three times a week and as necessary. Review of the facility provided shower schedule, not dated, revealed this resident was scheduled to receive a shower or bath every Wednesday and Sunday on night shift. Review of the facility Skin Monitoring: Comprehensive Shower Review sheets for 08/2022 and 09/2022, provided by the facility, revealed there were only sheets completed for Resident #68 on 09/07/22 and 09/21/22. Review of the State tested Nursing Assistant (STNA) documentation of bathing provided in the residents medical record for 08/2022 and 09/2022 revealed documentation bathing was completed for the resident on 08/03/22, 08/22/22, 09/09/22, 09/16/22, and 09/17/22. Review of the progress notes, dated 08/01/22 through 09/30/22, revealed no documentation of refusals of care or services including bathing. Observation of Resident #68 on 09/26/22 at 12:47 P.M. revealed the resident was observed lying in bed in a hospital gown. The residents hair was observed to appear greasy and uncombed. Interview with Resident #68 on 09/26/22 at 12:47 P.M. revealed the resident could not remember the last bath or shower received and stated she would like to have one because she felt dirty. Observation of Resident #68 on 09/27/22 at 12:32 P.M. revealed the resident was lying in bed in a hospital gown. The residents hair continued to appear greasy and uncombed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #68 on 09/28/22 at 9:45 A.M. revealed the resident was lying in bed in a hospital gown. The residents hair continued to appear greasy and uncombed. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with Registered Nurse (RN) #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with RN #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the residents medical record. 2. Record review for Resident #59 revealed this resident was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, mitral valve prolapse, mild cognitive impairment, muscle weakness, unspecified dementia with behavioral disturbance, and hypertension. Review of the admission MDS assessment, dated 08/15/22, revealed this resident had moderately impaired cognition evidenced by a BIMS assessment score of 04. This resident was to be dependent upon one staff member for bathing. Review of the care plan, revised 09/27/22, revealed this resident had an ADL self-care deficit. Interventions included to provide extensive assistance by one staff member with bathing. Review of the facility provided shower schedule, not dated, revealed this resident was scheduled to receive a shower or bath every Wednesday and Sunday on day shift. Review of the facility Skin Monitoring: Comprehensive Shower Review sheets for 08/2022 and 09/2022, provided by the facility, revealed the only sheet completed for Resident #59 on 09/20/22. Review of the State tested Nursing Assistant (STNA) documentation of bathing provided in the residents medical record for 08/2022 and 09/2022 revealed there was no documented showers or baths completed for this resident. Review of the progress notes, dated 08/08/22 through 09/30/22, revealed no documentation of refusals of care or services including bathing. Observation on 09/26/22 at 3:45 P.M. revealed Resident #59 was sitting in the hallway in his wheelchair and was observed to have on a gray shirt and jacket. The resident had dried food debris on his face and was not clean shaven. The residents hair appeared greasy and was uncombed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/27/22 at 9:21 A.M. revealed Resident #59 was sitting in his wheelchair in the lobby sleeping. The resident still had the same gray shirt and jacket on from the day before, had dried food debris on his face, and was not clean shaven. The residents hair continued to appear greasy and be uncombed. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with RN #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with RN #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the residents medical record. 3. Record review for Resident #52 revealed this resident was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder, unspecified dementia with behavioral disturbance, adult failure to thrive, and depression. Review of the quarterly MDS assessment, dated 08/17/22, revealed this resident had mildly impaired cognition evidenced by a BIMS assessment score of 08. This resident was assessed to be dependent upon one staff member for bathing. Review of the care plan, revised 08/19/21, revealed this resident had an alteration in ADL performance. Interventions included to encourage resident participation while performing ADL's. Review of the facility provided shower schedule, not dated, revealed this resident was scheduled to receive a shower or bath every Monday and Thursday on day shift. Review of the facility Skin Monitoring: Comprehensive Shower Review sheets for 08/2022 and 09/2022, provided by the facility, revealed there had not been any sheets completed for this resident. Review of the State tested Nursing Assistant (STNA) documentation of bathing provided in the residents medical record for 08/2022 and 09/2022 revealed there was no documented showers or baths completed for this resident. Review of the progress notes, dated 08/08/22 through 09/30/22, revealed no documentation of refusals of care or services including bathing. Observation of Resident #52 on 09/26/22 at 12:15 P.M. revealed the resident was lying in bed in a hospital gown and to not be clean shaven. The residents hair appeared to be greasy and was uncombed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/27/22 at 9:16 A.M. revealed Resident #52 continued to lie in bed in a hospital gown and was not clean shaven. The residents hair continued to appear greasy and was uncombed. Observation on 10/03/22 at 11:00 A.M. revealed Resident #52 continued to lie in bed in a hospital gown and was not clean shaven. The residents hair continued to appear greasy and was uncombed. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with RN #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with RN #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the residents medical record. 43064 4. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, Type two diabetes mellitus, persistent mood disorder, chronic pain syndrome, depression, dysphagia, hyperlipidemia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition. The resident was totally dependent on one person for physical assistance for bathing. Review of the plan of care dated 06/23/22 revealed Resident #13 had an activity of daily living self-care performance deficit related to debility and limited mobility. Interventions included preventative skin care as needed, weekly skin inspection, allowing time for rest breaks, and staff assistance as needed. Review of the facility provided shower schedule, not dated, revealed Resident #13 was to receive a shower or bath every Monday and Thursday on night shift. Review of the facility Skin Monitoring: Comprehensive Shower review sheets for August 2022 and September 2022 provided by the facility revealed there were no sheets for Resident #13. Review of the electronic medical record bathing documentation for August 2022 and September 2022 revealed Resident #13 had received a bath on 08/22/22, bathing was listed as not applicable on night shift on 08/21/22, 08/22/22, 08/27/22, and on 09/16/22. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/26/22 at 12:45 P.M. with Resident #13 revealed he could not recall the last time he received a bed bath. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with Registered Nurse (RN) #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with Registered Nurse (RN) #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the resident's medical record. 5. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including hyperlipidemia, hypertension, blindness in right eye and low vision in left eye, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 had a severe cognitive impairment. She required supervision with one-person physical assistance for eating. Review of the plan of care dated 05/23/22 revealed Resident #28 had an alteration in activity of daily living (ADL) performance related to generalized weakness, decreased strength, endurance, and activity tolerance, unsteady gait, and poor safety awareness. Resident #28 required physical staff assistance with bed mobility, transfers, toileting, hygiene, and bathing. Interventions included encouraging resident participation, supervision with meals, encouraging resident to attend activities, staff to anticipate and assist as needed, and reporting declines in resident activities of daily living to physician. Review of the facility provided shower schedule, not dated, revealed Resident #28 was to receive a shower or bath every Wednesday and Sunday on night shift. Review of the Skin Monitoring: Comprehensive Shower review sheets for August 2022 and September 2022 provided by the facility revealed one shower sheet for Resident #28 dated 09/22/22 it stated 'she wants to take it later'. Review of the electronic medical record bathing documentation for August 2022 and September 2022 revealed it was documented on 08/26/22 that bathing was not applicable and on 09/22/22 a shower was completed. Observation on 09/26/22 at 12:43 P.M. of Resident #28 revealed her fingernails were observed to be long, curled at the end, and dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 09/28/22 at 12:47 P.M. with State tested Nursing Aide (STNA) #108 revealed Resident #28's nails remained long and dirty, she was eating food with her hands. The observation was confirmed by STNA #108 at that time. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with Registered Nurse (RN) #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with Registered Nurse (RN) #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the resident's medical record. 44068 6. Review of the medical record for Resident #235 revealed an initial admitted [DATE] and a re-entry date of 09/13/22. Diagnoses included type 2 Diabetes without complications, asthma, gastro-esophageal reflux disease (GERD), atherosclerotic heart disease of native coronary artery without angina pectoris, old myocardial infarction, hypothyroidism, primary pulmonary hypertension, personal history of immunosuppression therapy, rheumatoid arthritis, thoracic aortic aneurysm, unsteadiness on feet, difficulty walking, muscle weakness, cognitive communication deficit, dysphagia, cerebral infarction, and COVID-19. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/27/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 13 out of 15 (no impairment). The resident required up to extensive assistance of one staff for all Activities of Daily Living (ADL's) except eating which she required set up help and supervision. She was able to physically help in part of bathing and required one staff's physical assistance with bathing. Review of the facility provided shower schedule dated 04/26/22 revealed Resident #235 was to be showered on Tuesday and Fridays during dayshift. Interview and observation on 09/26/22 at 1:20 P.M. with Resident #235 revealed the resident had greasy hair and her skin appeared shiny. She was observed in bed with yellow fluid on her gown and soiled tissues on her chest where she had attempted to clean the yellow fluid off of herself. The resident confirmed the yellow fluid was emesis. She also revealed staff did not care for her but would not provide specifics. Interviews on 10/04/22 at 10:56 A.M. Registered Nurse (RN) #145, 10/04/22 at 11:01 A.M. with RN #125, and 10/04/22 at 11:08 A.M. with State tested Nursing Assistant (STNA) #108 confirmed showers were often left uncompleted as a result of short staffing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #235's care plan dated 10/05/22 revealed no care plan regarding bathing. Review of the task titled, Bathing for a look back period of 30 days from 10/06/22 revealed only two documented bathes on 09/16/22 and 09/23/22. Review of the requested shower documentation, from the resident admitted to her discharge date , provided by the Administrator on 10/11/22 at 2:22 P.M. confirmed documentation for only two showers during the resident's admission on 09/16/22 and 09/23/22.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on interviews and record reviews, the facility failed to ensure activities were provided on weekends for cognitively impaired residents. This affected four residents (Residents #28, #36, #52, and #68) out of the four residents reviewed for activities during the annual survey. The facility census was 84. Findings include: 1. Record review for Resident #68 revealed this resident was admitted to the facility on [DATE] and had diagnoses including acute respiratory failure with hypoxia, ileus, hypertension, type two diabetes mellitus, dysphagia, schizophrenia, muscle weakness, difficulty walking, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/22, revealed this resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting, extensive assistance from two staff members for transfers, and supervision with setup help only for eating. Review of the facility Activity Calendar for 07/2022, 08/2022, and 09/2022 revealed every Saturday and Sunday the only activities scheduled were weekend activity packets, social time with neighbor, and sitcom television. Review of the facility Activity Participation Record for Resident #68 for 07/2022, 08/2022, and 09/2022 revealed the resident was not documented to have participated in or refused activities every Saturday or Sunday. Interview with Activity Director #128 on 09/28/22 at 10:42 A.M. revealed the she was the only activity staff member and worked Monday through Friday at the facility and did not work on Saturdays or Sundays. Activity Director #128 verified there were no employees to conduct activities with residents on the weekend and residents who were cognitively impaired were unable to complete the activities scheduled on the weekends without staff assistance. 2. Record review for Resident #52 revealed the resident was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder, unspecified dementia with behavioral disturbance, adult failure to thrive, and depression. Review of the quarterly MDS assessment, dated 08/17/22, revealed this resident had mildly impaired cognition evidenced by a BIMS assessment score of 08. This resident was assessed to require extensive assistance from one staff member for bed mobility, to be dependent upon two staff members for transfers, and to be dependent upon one staff member for eating, toileting, and bathing. Review of the care plan, dated 09/15/20, revealed this resident had an alteration in activity participation. Interventions included to post personal activity schedule in residents room and encourage resident to observe or designate activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Activity Calendar for 07/2022, 08/2022, and 09/2022 revealed every Saturday and Sunday the only activities scheduled were weekend activity packets, social time with neighbor, and sitcom television. Review of the facility Activity Participation Record for Resident #52 for 07/2022, 08/2022, and 09/2022 revealed the resident was not documented to have participated in or refused activities every Saturday or Sunday. Interview with Activity Director #128 on 09/28/22 at 10:42 A.M. revealed the she was the only activity staff member and worked Monday through Friday at the facility and did not work on Saturdays or Sundays. Activity Director #128 verified there were no employees to conduct activities with residents on the weekend and residents who were cognitively impaired were unable to complete the activities scheduled on the weekends without staff assistance. 3. Record review for Resident #36 revealed this resident was admitted to the facility on [DATE] and had diagnoses including muscle weakness, difficulty walking, mild cognitive impairment, dysphagia, cognitive communication deficit, hearing loss, vision loss, and hypertension. Review of the quarterly MDS assessment, dated 07/29/22, revealed this resident had mildly impaired cognition evidenced by a BIMS assessment score of 10. This resident was assessed to require extensive assistance from one staff member for bed mobility, extensive assistance from two staff members for transfers, and to be dependent upon one staff member for toileting and eating. Review of the care plan, dated 08/24/22, revealed this resident had an alteration in activity participation. Interventions included activities would provide resident with one on one visits and programs as needed, activities would encourage resident to participate in group activities, and resident preferred religious activities, holiday activities, and current events. Review of the facility Activity Calendar for 07/2022, 08/2022, and 09/2022 revealed every Saturday and Sunday the only activities scheduled were weekend activity packets, social time with neighbor, and sitcom television. Review of the facility Activity Participation Record for Resident #36 for 07/2022, 08/2022, and 09/2022 revealed the resident was not documented to have participated in or refused activities every Saturday or Sunday. Interview with Activity Director #128 on 09/28/22 at 10:42 A.M. revealed the she was the only activity staff member and worked Monday through Friday at the facility and did not work on Saturdays or Sundays. Activity Director #128 verified there were no employees to conduct activities with residents on the weekend and residents who were cognitively impaired were unable to complete the activities scheduled on the weekends without staff assistance. 43064 4. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including hyperlipidemia, hypertension, blindness in right eye and low vision in left eye, and major depressive disorder. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 had a severe cognitive impairment. She required extensive assistance of one person for bed mobility and locomotion and extensive assistance of two persons for transfers. Review of the plan of care dated 07/26/21 revealed Resident #28 had an alteration in activity participation related to impaired cognition. Resident #28 enjoyed watching television and listening to music. Interventions included giving the resident the opportunity to express opinion of activities attended and posting the personal activity schedule in the resident's room. Review of the facility Activity Calendar for July 2022, August 2022, and September 2022 revealed every Saturday and Sunday the only activities scheduled were weekend activity packets, social time with neighbor, and sitcom television. Review of the facility Activity Participation Record for Resident #28 for July 2022, August 2022, and September 2022 revealed the resident was not documented to have participated in activities every Saturday or Sunday. Interview on 10/03/22 at 10:35 A.M. with Activity Director #128 revealed Resident #28 did not participate on activities on weekends. Activity Director #128 stated this was because she did not work on the weekends and there was nobody to facilitate activities on those occasions.

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F 0684 Level of Harm - 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** 42728 Based on observations, interviews, record reviews, and review of facility policies, the facility failed to ensure skin assessments were completed, failed to monitor and remove sutures timely and as ordered, failed to initiate wound care and failed to arrange transportation for a follow up appointment. This affected seven residents (Residents #13, #52, #233, and #246) of 29 residents reviewed during the annual survey. The facility census was 84. Actual harm occurred to Resident #52 when the facility failed to assess the resident's skin and Resident #52 developed two new vascular wounds to his feet resulting in the resident experiencing pain and additional medical treatment. Findings include: 1. Record review for Resident #52 revealed this resident was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder, unspecified dementia with behavioral disturbance, polyneuropathy, adult failure to thrive, insomnia, and depression. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/17/22, revealed this resident had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 08. This resident was assessed to require extensive assistance from one staff member for bed mobility, to be dependent upon two staff members for transfers, and to be dependent upon one staff member for eating, toileting, and bathing. Review of the care plan, most recently revised on 08/11/21, revealed this resident was at risk for impaired skin integrity. Interventions included skin assessments as ordered. Review of the care plan, most recently revised on 06/09/22, revealed this resident had actual impairment to skin integrity related to gangrenous ulcer to left great toe. Interventions included provide wound treatment as ordered, skin assessments per facility policy, and complete skin documentation per facility policy. Review of the physicians order, dated 06/27/22, revealed apply Triad cream to end of the left great toe to protect/continue to debride site of eschar/slough, apply every three days. Review of the physicians order, dated 09/12/22, revealed skin assessment to be completed every Wednesday. Please fill out weekly skin assessment in evaluation tab. Review of facility Skin Assessment Weekly evaluations, located in the evaluation tab of the resident's electronic health record, revealed there had not been a Skin Assessment evaluation completed since 08/10/22. Review of the active physician's order, dated 10/03/22, revealed to apply skin prep to bilateral toes every shift for vascular wound. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the active physician's order, dated 10/03/22, revealed to cleanse area to left lateral foot with normal saline, apply calcium alginate to wound bed, and apply clean foam dressing every three days for vascular wound. Review of the facility Skin Grid Non-Pressure evaluation, dated 10/03/22, revealed there was a new wound to the posterior right great toe which measured 3.0 centimeters (cm) wide by 1.5 cm long by 0 cm deep and was documented to be reddish dark maroon in color. Review of the facility Skin Grid Non-Pressure evaluation, dated 10/03/22, revealed there was a new vascular wound to the lateral side of the residents left foot which measured 1.5 cm long by 2.5 cm wide by 0.3 cm deep which had a moderate amount of drainage, exposed bone, and macerated edges. Review of the progress notes, dated 08/10/22 through 10/02/22, revealed there was no documentation of new wounds to the resident's feet. Observation on 10/03/22 at 11:00 A.M. of Resident #52 revealed the resident had a dark area of skin located on the bottom of the right great toe. The resident had a bandage to the left great toe which was observed to be dry and intact and there was a wound to the lateral side of the resident's left foot which was covered with brown drainage. There was a moderate amount of brown drainage observed to be on the pillow located under the left foot of Resident #52 and on the prevalon boot which had been applied to the resident's left foot. The resident was observed to grimace and moan when State tested Nursing Assistant (STNA) #201 maneuvered the resident's feet. Interview with STNA #201 on 10/03/22 at 11:00 A.M. verified Resident #52 was observed to exhibit signs of pain when the resident's feet were moved or handled. Interview with Licensed Practical Nurse (LPN) #100 on 10/03/22 at 11:05 A.M. revealed the employee denied knowledge of any wounds present on Resident #52's feet. LPN #100 stated there was not always time to complete weekly skin assessments for all residents. Observation and interview with Regional Director of Clinical Services #165 on 10/03/22 at 11:20 A.M. verified there were wounds present to the lateral side of the left foot and bottom of the right great toe of Resident #52. Interview with Regional Director of Clinical Services #165 on 10/03/22 at 11:35 A.M. verified there was no evidence weekly skin assessments were completed and documented in the resident's electronic medical record as ordered since 08/10/22. 43064 2. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, persistent mood disorder, chronic pain syndrome, depression, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition. The resident required the extensive assistance of one person for bed mobility, was totally dependent on staff for transfers and bathing, and required the extensive assistance of two persons for personal hygiene. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care dated 09/19/22 revealed Resident #13 had an impaired skin integrity related to a Stage 3 pressure injury on his right medial thigh and a laceration on his chin. Interventions included administering medications per physician orders, air mattress to bed, monitoring laceration and removing stitches as ordered, notifying physician of deterioration of wound, observing for signs of infection, and providing wound care per physician's orders. Review of Resident #13's September and October 2022 physician's orders revealed no orders for skin treatment. Review of the progress note dated 09/17/22 at 7:37 A.M. revealed Resident #13 returned from the hospital after he received four stitches to his lower chin. Review of Resident #13's evaluations for September 2022 revealed no evidence of weekly skin assessments. Review of the skin grid non-pressure dated 09/19/22 revealed the assessment was considered in progress. Resident #13 had a skin tear on his chin obtained on 09/17/22. The area was described as being a skin tear that was sutured closed. Review of the hospital paperwork dated 09/17/22 revealed Resident #13's discharge instructions indicated his stitches would need taken out in four to five days. Interview on 09/26/22 at 12:45 P.M. with Resident #13 revealed he had skin concerns along his thighs and on his abdomen. Resident #13 called these areas boils, he stated he had them since he was admitted and revealed no treatment was in place for them. Observation on 10/04/22 at 12:10 P.M. of Resident #13 with State tested Nursing Aide (STNA) #132 revealed the area to the left and right groin, lower left and right buttocks, and right side of the abdomen were observed to have multiple areas of excoriation in which the skin was not intact. Resident #13 reported the areas were painful and had been present for a while. STNA #132 verified the observation and reported the areas had been present when Resident #13 had been moved to her hallway approximately three weeks prior. Interview on 09/27/22 at 11:49 A.M. and on 09/29/22 at 10:13 A.M. with Resident #13 revealed he had stitches to his chin, he reported they were still in place, and he did not think they were supposed to be. He was concerned about the potential of his skin healing around the stitches. Resident #13 reported due to his stitches he could not shave, and he like to be clean shaven. Observation on 09/29/22 at 10:13 A.M. of Resident #13 revealed he had a facial hair providing a thick covering of the lower half of his face. Observation of his chin revealed two to three stitches in place. Interview on 09/29/22 at 10:30 A.M. with Licensed Practical Nurse (LPN) #119 verified Resident #13's stitches were still in place and the hospital paperwork (dated 09/17/22) stated they should be removed in four to five days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/04/22 at 2:18 P.M. with Unit Manager LPN #120 revealed she was unaware of the area on Resident #13's abdomen. She reported he did have Moisture-Associated Skin Damage on and off, but it was hard to treat as he was often absent from the facility. Review of the policy Prevention of Pressure Ulcers and Injuries revised July 2017, revealed monitoring included evaluating, reporting, and documenting potential changes in the skin. The interventions and strategies should be reviewed for effectiveness on an ongoing basis. 44068 3. Review of the medical record for Resident #233 revealed an admitted [DATE]. Diagnoses included status post motor-vehicle accident-causing injury, asthma, epileptic seizures, fracture of the left forearm, displaced [NAME] fracture of the left and right tibia, and fractures of the left and right ribs. Review of the comprehensive MDS assessment, dated 10/03/22, revealed the assessment was in progress and did not have any categories completed outside of K (swallowing and nutritional status). Review of the plan of care dated 09/25/22 revealed the resident did not have any care plans related to pain or wound care. Interview and observation on 09/26/22 at 12:58 P.M. with Resident #233 revealed she was admitted on [DATE] and she had not had pin care or a dressing change to her right leg. There was no visible date on the dressing on her right leg. Review of physician orders for October 2022 identified an order dated 09/28/22 at 11:32 P.M. (three days after the resident's admission) for the dressing to her right leg to be changed nightly, stiches to the inside of her right ankle to be cleansed nightly with normal saline and an oil emulsion wrap placed over area, screw placed by her knee was to be cleaned with normal saline then dried, and cover the entire leg with acrylic wrap, every night shift for a dressing change. Review of the September 2022 Electronic Treatment Administration Record (E TAR) revealed the dressing was not signed off as completed until 09/29/22 (four days after the resident's admission) when the order started. Interview and observation on 10/04/22 at 11:45 A.M. with Resident #233 revealed her right leg dressing was dated 10/03/22. The resident stated she changed her own dressing since the nurses were not doing it. Supplies were observed at bedside. The resident stated the staff had only changed her dressing three times since she had been at the facility. She stated no sutures had been removed from her left leg per orders by the surgeon who also provided the order to leave her left leg wrapped until her follow up appointment which she missed on 10/03/22 due to the facility not setting up transportation. She also stated the social worker told her that she was unsure how the facility missed scheduling transportation for her follow up appointment since it was in her hospital discharge instructions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/04/22 at 12:07 P.M. with Human Resources (HR) #124 revealed she was scheduling appointments now that the Business Office Manager (BOM) was no longer at the facility. She confirmed the resident had a follow up appointment with her orthopedic surgeon scheduled on 10/03/22 in her discharge instructions from the hospital but she stated she had no knowledge of Resident #233 needing transportation arranged for the appointment. Interview was attempted on 10/04/22 at 12:04 P.M. and 10/06/22 at 1:05 P.M. with Registered Nurse (RN) #115 (regarding Resident #233 dressing when she worked on 10/03/22 night shift) when a voicemail was left requesting a return call at the provided number. No return contact was received. Interview on 10/04/22 at 12:10 P.M. with Office Staff #111 revealed she did not receive a form indicating the need to schedule an appointment for Resident #233. She confirmed residents often missed appointments due to lack of communication and inability to schedule transportation. She also confirmed Resident #233 had a follow up appointment with her orthopedic surgeon scheduled on 10/03/22 in her discharge instructions from the hospital that could have been scheduled well before her appointment since transportation only needed 48 hours' notice of the transportation need. Review of the email dated 10/11/22 at 2:22 P.M. from the Administrator to the Surveyor revealed Resident #233 did not have a dressing order in place for her right leg from 09/25/22 until 09/29/22 (four days) until the resident requested a dressing change since her continuity from the hospital instructed the facility to keep the dressing in placed until her follow up appointment. Review of Resident #233's After Visit Summary (from the hospital) printed on 09/25/22 at 5:21 P.M. revealed the resident had a follow up appointment scheduled on 10/03/22 where her left leg sutures would be removed. Her discharge summary revealed her left leg dressing was to remain intact until seen at her follow up appointment on 10/03/22. Further review of the summary revealed the resident's right leg had wound care instructions to change the dressing twice daily if recommended, apply bacitracin ointment over the incision twice daily, gently cleanse the wound one to two times per day with cool water, and use mild soap to clean around the wound. The facility provided no further information when the hospital continuity with the ordered right leg dressing order was highlighted and sent to the Administrator, Regional Director of Clinical Services #165, and Unit Manager LPN #120 on 10/11/22 at 3:25 P.M. Review of the facility policy titled, Transportation revised 10/2020 revealed inquiries concerning transportation was to be referred to the transportation designee who then was to assist the resident in obtaining transportation. Review of the facility policy titled, Wound Care revised 10/2010 revealed wound care was to be completed per orders and completed to promote wound healing. 4. Review of the medical record for Resident #246 revealed an admitted [DATE]. Diagnoses included multiple fracture of the pelvis, cannabis use, fracture of the lumbar vertebra, fracture of a right rib, right kidney injury, schizophrenia, cerebral infarction, ventral hernia without obstruction, acute respiratory failure without hypoxia, and pedestrian on foot collision with automobile. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the comprehensive MDS assessment, dated 10/01/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment). The resident required up to extensive assistance of one to two or more staff for all Activities of daily Living (ADL's) except eating which he required set up and supervision. Further review of the MDS confirmed the resident had a known surgical wound that he received surgical wound care for and application of non-surgical dressings. Review of the After Visit Summary for 08/24/22 through 09/24/22 revealed the resident's wound vacuum (vac) to his abdomen was removed for transport to the facility but was to be replaced. Review of the plan of care dated 09/24/22 revealed the resident had an alteration in health maintenance with no listed reasoning. Interventions included treatments per order. Review of the physician orders revealed an order for a wound vac that was placed on 09/24/22 and an order for a wet to dry dressing was initiated on 09/25/22, until the wound vac arrived. Review of the Electronic Treatment Administration Record (ETAR) for September and October 2022 revealed the order for the wound vac was signed off 09/26/22 (facility had not received the wound vac per proof of delivery), 09/28/22, and 09/30/22. Interview and observation on 09/26/22 at 3:07 P.M. with Resident #246 revealed his call light was turned on by himself to request his abdominal dressing to be changed. Observation of his abdominal dressing revealed it was undated and falling off. On 09/26/22 at 3:46 P.M. interview and observation with Registered Nurse (RN) #125 confirmed the resident did not have a date/time on the dressing, the dressing was falling off, and there was no order for a treatment to his abdomen prior to 09/25/22 because the staff was awaiting the delivery of the wound vac. Review of the Proof of Delivery revealed the resident's wound vac was delivered on 09/27/22 at 9:32 A.M. but review of the progress note dated 09/28/22 at 5:15 P.M. by Licensed Practical Nurse (LPN) #136 revealed the resident's wound vac was placed, over 24 hours after receiving the wound vac, by the RN on duty. Interview on 10/04/22 at 2:17 P.M. with Unit Manager LPN #120 confirmed Resident #246's wound vac was delivered on 09/27/22 at 9:32 A.M. (three days after his admission) but not placed until 09/28/22 (four days after his admission and 32 hours after receiving the wound vac) per the progress note. Review of the facility policy titled, Wound Care revised 10/2010 revealed the dressing was to be marked with initials, time, and date and was to be completed per physician orders.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, resident interview, observations, and medical record review, the facility failed to ensure Resident #66 was provided the appliances needed for hearing adequately. This affected one (Resident #66) of one resident reviewed for communication sensory. The facility census was 84. Findings include: Review of the medical record for Resident #66 revealed an initial admitted [DATE] and a re-entry date of 07/08/22. Diagnoses included Alzheimer's Disease, lumbar vertebra fracture, low back pain, muscle weakness, difficulty walking, dysphagia, unsteadiness on her feet, encephalopathy, and severe protein-calorie malnutrition. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 07/15/22, revealed the resident had moderately impaired cognition with no Brief Interview of Mental Status (BIMS) score due to the resident being rarely or never understood. There were no documented behaviors. The resident required extensive to total assistance of one staff for all Activities of Daily Living (ADL's) except eating which she required set up and supervision. Further review of the MDS revealed she had moderate difficulty hearing and had hearing aids. Review of the plan of care dated 06/24/22 revealed there was no care plans regarding her hearing impairment. Interview and observation on 09/26/22 at 2:46 P.M. revealed Resident #66 was resting in bed without her hearing aids in place. The resident was unable to hear the Surveyor and asked the Surveyor to write down what was being said but there were no writing utensils nor paper visible in the resident's room. The Surveyor used the laptop to type and communicate with the resident. The resident confirmed her hearing aids were not in her ears and pointed over to the nightstand where her hearing aids were stored. Interview and observation on 10/03/22 at 11:46 A.M. with Resident #66 revealed she was lying in bed without her hearing aid. She had printed signs on wall which stated hearing aid must be in left ear for patient to hear you. Hearing aid is on stand by the window (with an arrow pointing to the stand). The observations of Resident #66 without her hearing aid and the instructions on the wall were confirmed immediately with State tested Nursing Assistant (STNA) #132. Request to review the facility policy regarding hearing aids resulted in an email dated 10/12/22 at 5:17 P.M. from the Regional Director of Clinical Services #165 to the Surveyor that identified the facility did not have a policy regarding audiology/hearing aids.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview, record review and policy review, the facility failed to provide pressure ulcer wound care as ordered by the physician. This affected one resident (Resident #240) of one resident reviewed for pressure ulcers. The facility census was 84 residents. Findings include: Review of Resident #240's medical record revealed an admitted [DATE] and diagnoses including quadriplegia, type two diabetes, morbid obesity, colostomy and anemia. Review of Resident #240's admission minimum data set (MDS) assessment dated [DATE] revealed Resident #240 was cognitively intact, did not display behaviors and had an indwelling catheter and ostomy. Resident #240 was at risk for developing pressure ulcers and had had two Stage 3 pressure ulcers (defined as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss) that were present upon admission/entry or reentry. Treatments coded included pressure reducing device for chair, pressure reducing device for bed, pressure ulcer care and applications of ointments/medications other than to feet. Review of Resident #240's physician's orders revealed an order dated 09/07/22 for cleanse wound on right thigh with normal saline, pat dry and apply a mepilex dressing daily every day shift for Stage 3 [pressure ulcer]. Review of Resident #240's September 2022 Treatment Administration Record (TAR) revealed Resident #240's right thigh dressing was blank and not completed as ordered on 09/07/22, 09/08/22, 09/09/22 and 09/16/22. Review of the most recent wound evaluation dated 09/22/22 revealed Resident #240 had a Stage 3 pressure ulcer to the right buttock measuring 0.2 centimeters (cm) long by 0.2 cm wide by 0.2 cm depth. The pressure ulcer was present on admission. The evaluation indicated the pressure ulcer was improving. Review of Resident #240's nurses' notes for September 2022 revealed no refusals of pressure ulcer dressing care. Phone interview on 09/28/22 at 12:08 P.M. with Regional Director of Clinical Services (RDCS)/Registered Nurse (RN) #165 verified Resident #240's dressing should have been completed daily as ordered and indicated wound care was not documented anywhere else in the medical record so if it was not marked off on the TAR it was not done. Review of the facility policy, Wound Care, dated October 2010 revealed the type of wound care provided along with the date and time the wound care was given was to be recorded in the resident's record. Any refusals should also be documented.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and record review, the facility failed to provide Resident #17 and Resident #49 with foot care and refer them to podiatry. This affected two residents (Residents #17 and #49) of nine residents reviewed for activities of daily living. The facility census was 84. Findings include: 1. Interview on 09/26/22 at 4:00 P.M. with Resident #49 revealed he had asked to see the podiatrist since he admitted to the facility and had yet to see them. Observation on 10/03/22 at 1:20 P.M. of Resident #49's feet with Licensed Practical Nurse (LPN) #100 revealed both feet had skin that was observed flaking off. The skin of his feet was dry and cracked, which worsened closer to his toes. His toenails were observed to be thick and yellow, with some black areas around the edges. Multiple toenails were long and extended past the end of his toe by up to about a half an inch. Interview with Resident #49 at that time revealed his feet were sensitive and the dry skin was uncomfortable at times. Resident #49 revealed he had requested podiatry but had not been seen since before admission to the facility. Interview on 10/03/22 at 1:51 P.M. with Social Service Designee #156 confirmed Resident #49 had not seen the podiatrist since admission to the facility. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including chronic embolism and thrombosis, muscle weakness, cognitive communication deficit, epilepsy, and chronic pulmonary embolism. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had intact cognition. He required the extensive assistance of one person with personal hygiene. Review of the plan of care dated 07/28/22 revealed Resident #49 was at risk for alteration in comfort related to generalized pain and foot sensitivity and pain. Interventions included using a pain scale as reported by the resident, podiatry consults as ordered or needed, and family conference as needed to discuss pain management. Review of the physician's orders revealed an order dated 05/23/22 for Resident #49 and an order dated 08/19/22 for vision, dental, audiology, and podiatry to evaluate and treat. Review of the progress note dated 06/24/22 revealed Resident #49 was updated on the podiatrist's schedule. Review of the physician note dated 04/13/22 revealed Resident #49 requested to see the podiatrist to help with his toenails. Review of the progress note dated 08/09/22 revealed a meeting was held with Resident #49 and he was made aware of the date for the next podiatry visit. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care conference dated 08/19/22 revealed Resident #49 requested to see the podiatrist; he was advised he would be put on the podiatry list to be seen when they came in that month. Review of the medical record for 01/21/22 to 09/26/22 revealed it was absent for podiatry notes. 2. Interview on 09/26/22 at 3:50 P.M. with Resident #17 revealed she had not seen podiatry since admitting to the facility despite requesting to. She stated her toenails were long and sharp. Observation on 10/03/22 at 1:15 P.M. with LPN #100 revealed Resident #17 had some dry skin by her toes, she had long toenails, with her left big toenail extending more than half an inch past the end of her toe. Interview on 10/03/22 at 1:51 P.M. with Social Service Designee #156 confirmed Resident #17 had not seen the podiatrist since admission to the facility. Review of the medical record for Resident #17 revealed they admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, lymphedema, hyperlipidemia, cognitive communication deficit, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had intact cognition and required the extensive assistance of one person for personal hygiene. Review of Resident #17's physician order dated 06/21/22 revealed an order for podiatry to evaluate and treat. Review of the progress note dated 06/24/22 revealed Resident #17 was updated on the podiatrist's schedule. Review of the medical record for 01/11/22 to 09/26/22 revealed it was absent for podiatry notes.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and record review the facility failed to ensure an environment free of accident hazards when bed rails were not assessed as being appropriate for a resident, failed to implement fall interventions, and failed to ensure a wanderguard was applied for a resident after elopement. This affected three residents (Residents #13, #59, and #66). The facility census was 84. Actual harm occurred to Resident #13 when the resident's bedrails were not appropriately assessed resulting in the resident falling and sustaining a chin laceration that required sutures for closure. Findings include: 1. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, Type two diabetes mellitus, persistent mood disorder, chronic pain syndrome, depression, dysphagia, hyperlipidemia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition. The resident required the extensive assistance of one person for bed mobility and was totally dependent on staff for transfers. Review of the plan of care dated 05/02/22 revealed Resident #13 was at risk for falls and potential injury related to morbid obesity, chronic obstructive pulmonary disease, muscle weakness, unsteadiness on feet, and difficulty walking. Interventions included dycem to wheelchair, encouraging the resident to sleep in the center of the bed, evaluating the appropriateness of the side rails, low bed, maintain clear pathway, and mat on floor next to bed. Review of the progress note dated 09/17/22 at 1:33 A.M. revealed the nurse found Resident #13 on the floor alert and awake with a bleeding laceration to the chin area. The resident complained of mild pain to the chin area upon assessment. The resident was unsure if he hit his head when he fell off the bed. The broken bed side rail was identified as the cause of the fall. The nurse called emergency services and Resident #13 was transferred to the hospital. Review of the progress note dated 09/17/22 at 7:37 A.M. revealed Resident #13 returned from the hospital with four stitches to the lower chin. Review of the progress note dated 09/18/22 revealed the resident fell on ce again. Review of the 09/17/22 fall investigation revealed Resident #13 fell at 12:27 A.M. A factor observed at the time of the fall was an equipment malfunction due to the right side rail coming off of the bed. He was found on the floor and had been rolling or sliding out of the bed. The resident stated he had been asleep when he fell , previous fall interventions were in place and the intervention was to reevaluate the effectiveness of the side rail. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 09/18/22 fall investigation revealed Resident #13 fell at 5:30 A.M. He was found on the floor in his room and had rolled or slid out of the bed. The intervention was a fall mat. Review of the skin grid non-pressure dated 09/19/22 revealed the assessment was considered 'in progress.' Resident #13 had a skin tear on his chin obtained on 09/17/22. It was described as being a skin tear that was sutured closed. Interview on 09/27/22 at 11:49 A.M. and 2:54 P.M. and on 09/29/22 at 10:13 A.M. with Resident #13 revealed prior to his fall he had received a new bed frame; he did not think the bedside rail was original to the bed. Resident #13 stated it had been bolted on but was loose and could easily be moved back and forth. The resident stated on 09/17/22 he had been moving in the bed when his arm bumped the rail and fell off and due the momentum his body kept rolling. He was unsure where he hit his chin but he was sent to the hospital for it. Resident #13 stated someone told him it had been the wrong rail for the bed. Interview on 09/29/22 at 3:01 P.M. with Maintenance Director #148 and Housekeeping Supervisor #160 revealed Resident #13's bed side railing had been appropriate for his bed. The side rail had square teeth, it looked like the tooth broke on the rail itself. Both staff members said they were unsure what caused the railing to break. Observation on 09/26/22 at 12:45 P.M., 09/27/22 at 2:54 P.M., and 09/28/22 at 10:50 A.M. and 10:56 A.M. revealed no mat was observed next to Resident #13's bed or in his room. Interview on 09/28/22 at 10:50 A.M. with Resident #13 revealed he had never had a mat next to his bed. Interview on 09/28/22 at 10:56 A.M. with Licensed Practical Nurse (LPN) #119 confirmed there was no fall mat next to Resident #13's bed although it was in the care plan. Observation and interview on 10/03/22 at 10:40 A.M. revealed Resident #13 still did not have a fall mat next to his bed. Interview at that time Agency Aide #205 confirmed the observation. Interview on 10/03/22 at 4:57 P.M. and on 10/04/22 at 8:42 A.M. with Unit Manager LPN #120 revealed when Resident #13 fell he had been asleep, when he rolled, the bed rail broke. She stated she thought he had a bedrail due to his previous mattress. She reported for his 09/18/22 fall the staff had used a mattress to the bedside immediately because agency staff could not find a fall mat. A side rail evaluation for Resident #13 was requested on 10/04/22 at 8:42 A.M. and 4:20 P.M., no evaluation was provided. Review of the policy titled Falls and Fall risk, Managing dated December 2007, revealed the staff was to identify appropriate interventions to reduce the risk of falls. 42728 2. Record review for Resident #59 revealed this resident was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, mild cognitive impairment, muscle weakness, violent behavior, unspecified dementia with behavioral disturbance, and depression. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the admission MDS assessment, dated 08/15/22, revealed this resident was assessed to have moderately impaired cognition evidenced by a BIMS assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and transfers and to be dependent on one staff member for toileting. Review of the care plan, dated 08/09/22, revealed this resident was at risk for elopement. Interventions included to follow facility elopement procedures. Review of the progress note, dated 09/15/22, revealed this resident was found outside in the front stating he was leaving and no one could stop him. Social Service Director, the Assistant Director of Nursing (ADON), and the Administrator assisted in getting the resident back into the building and the ADON stated the resident would need a wander guard placed. Observation on 10/03/22 at 12:15 P.M. revealed Resident #59 did not have a wander guard in place. The observation was verified with State tested Nursing Assistant (STNA) #201 at the time of the observation. Observation and interview with Maintenance Director #148 on 10/03/22 at 12:26 P.M. revealed the elevator located next to the conference room did not contain any sort of mechanism to prevent a resident without a wander guard from getting on it and going to the first floor of the facility, where the front door was unlocked during business hours. Interview with the Regional Director of Clinical Services #165 on 10/04/22 at 4:20 P.M. verified there were no orders for a wander guard in place for Resident #59. 44068 3. Review of the medical record for Resident #66 revealed an initial admitted [DATE] and a re-entry date of 07/08/22. Diagnoses included Alzheimer's Disease, lumbar vertebra fracture, low back pain, muscle weakness, difficulty walking, dysphagia, unsteadiness on her feet, encephalopathy, and severe protein-calorie malnutrition. Review of the comprehensive MDS assessment, dated 07/15/22, revealed the resident had moderately impaired cognition with no Brief Interview of Mental Status (BIMS) score due to the resident being rarely or never understood. There were no documented behaviors. The resident required extensive to total assistance of one staff for all Activities of daily Living (ADL's) except eating which she required set up and supervision. Review of the plan of care dated 06/24/22 revealed the resident was at risk for falls and potential injury with no listed reasoning. Interventions included DPM mattress to her bed, low bed, maintain clear pathway, mat on floor next to bed, non-slip material in her chair, resident education, room close to nurses' station, and turn and reposition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the admission packet dated 06/24/22 revealed the resident was at risk for falls and potential injury related to being a new admission within 14 days, having impaired decision making, being visually impaired, needing assistance with ADL care, having an unsteady gait, suffering a fall within 31 to 180 days of the assessment, being on a narcotic and stool softener/laxative and having Alzheimer's Disease. The interventions included a low bed, clear pathway, non-slip material in chair, resident education, a room close to the nurses' station, and turn and reposition. The assessment did not acknowledge her hearing impairment. Review of the fall risk assessment dated [DATE] revealed the resident scored eight and the fall risk dated 07/13/22 revealed the resident scored seven indicating the resident was a possible fall risk. Review of the progress note dated 07/14/22 at 10:41 A.M. by Unit Manager #740 revealed the interdisciplinary team (IDT) discussion related to the resident's previous falls revealed the resident was alert and oriented to person, place, and time with periods of confusion, she was able to make her needs known to staff, was educated on the need to ask for assistance when needed and orientated to her call light. A floor mat was also placed next to the resident's bed. Observation on 09/26/22 at 2:46 P.M. and 10/03/22 at 11:46 A.M. revealed the resident was resting in bed without a mat next to her bed and her wheelchair did not have non-slip material on the cushion. Observation on 10/04/22 at 8:03 A.M. revealed the resident remained in bed without a mat next to the bed. The observation was immediately confirmed by STNA #108. Interview and observation on 10/04/22 at 8:04 A.M. and 8:35 A.M. with RN #125 confirmed there was no physicians order for a mat next to the resident's bed but confirmed the mat was in the resident's care plan, the resident was a fall risk, and the resident fell on [DATE] and 10/03/22 from her wheelchair but was unsure if non-slip cushion was in wheelchair at the time of her fall stating the resident's family kept switching her wheelchairs. Observation and interview on 10/04/22 at 8:44 A.M. with STNA #108 confirmed there was no non-slip material in the resident's chair, the resident was then propelled to the common area. Interview on 10/04/22 at 8:55 A.M. with RN #125 confirmed Resident #66 was in the same chair on 10/03/22 that she was in on 10/04/22 that did not include non-slip material on the cushion. Review of the email dated 10/05/22 at 4:56 P.M. from Regional Nurse #165 to the Surveyor revealed fall interventions in place for Resident #66 prior to her fall on 6/27/22, should have been a room closer to nurses station, non-slip material to chair, and maintenance of a clear pathway. Prior to Resident #66's fall on 09/27/22 the fall interventions which should have been in place included a DPM mattress, mat at bedside when in bed, a room closer to nurses station, non-slip material to chair, and maintenance of a clear pathway. Prior to Resident #66's fall on 10/03/22, the fall interventions which should have been in place included encourage snacks when resident becomes restless, a room closer to nurses station, non-slip material to chair, maintenance of a clear pathway, DPM mattress, and mat at bedside when in bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Falls and Fall Risk, Managing revised 12/2007 revealed in conjunction with the Attending Physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling and if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview, record review and policy review, the facility failed to provide appropriate catheter care and monitoring. This affected one resident (Resident #240) of two residents reviewed for catheter care. The facility census was 84 residents. Findings include: Review of Resident #240's medical record revealed an admitted [DATE] and diagnoses including quadriplegia, type two diabetes, morbid obesity, colostomy and anemia. Review of Resident #240's admission minimum data set (MDS) assessment dated [DATE] revealed Resident #240 was cognitively intact, did not display behaviors and had an indwelling catheter and ostomy. Review of Resident #240's physician's orders revealed no orders pertaining to changing his suprapubic catheter or providing catheter care. Review of Resident #240's September 2022 Treatment Administration Record (TAR) revealed no evidence of suprapubic catheter care or catheter changes having been completed. Review of Resident #240's nurses' notes for September 2022 revealed no evidence catheter care had been completed. Phone interview on 09/28/22 at 10:00 A.M. with Resident #240 revealed he had his suprapubic catheter for over three years. Resident #240 stated he got the catheter changed out monthly and it had been last done on 08/09/22 prior to his admission to the facility. When asked what kind of care was completed on the catheter or around the catheter site, Resident #240 stated staff provided catheter care every other day or so while he was at the facility. Resident #240 explained he had discharged home from the facility on 09/26/22. Phone interview on 09/28/22 at 12:08 P.M. with Regional Director of Clinical Services (RDCS)/Registered Nurse (RN) #165 verified Resident #240's missing orders for catheter care and as needed catheter replacement and indicated there was no evidence available to show catheter care had been completed for Resident #240. Review of the facility policy, Suprapubic Catheter Care, dated October 2010, revealed the following information should be recorded in the resident's medical record including the date and time the procedure was performed and all assessment data obtained during the procedure.

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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** 42728 Based on observations, interviews, record reviews, and review of facility policies, the facility failed to ensure adequate assistance was provided with meal intake, failed to ensure weights were obtained and monitored, and failed to ensure meal intake was documented. This affected 10 residents (Residents #14, #28, #30, #32, #36, #51, #52, #55, #68, and #243) of the 10 residents reviewed for nutrition during the annual survey. The facility census was 84. Actual harm occurred to Resident #36 when assistance with meals was not adequately provided to the resident and the resident had a significant weight loss of 45.8 pounds (24.5 percent) from 04/22/22 to 10/05/22 (166 days). Findings include: 1. Record review for Resident #36 revealed this resident was admitted to the facility on [DATE] and had diagnoses including muscle weakness, difficulty walking, mild cognitive impairment, dysphagia, cognitive communication deficit, hearing loss, vision loss, and hypertension. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 07/29/22, revealed this resident had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 10. This resident was assessed to require extensive assistance from one staff member for bed mobility, extensive assistance from two staff members for transfers, and to be dependent upon one staff member for toileting and eating. This resident was assessed to have significant weight loss while not on prescribed weight-loss regimen. Review of the care plan, revised 09/18/22, revealed this resident was at risk for malnutrition. Interventions included adaptive equipment as ordered, assess for signs and symptoms of aspiration, assist with meals as needed, dysphagia guidelines as ordered, monitor consistency of diet served, monitor intake and output as ordered, monitor labs as ordered, obtain food preferences, and offer meal alternate if resident refuses, Review of the care plan, dated 08/23/22, revealed this resident had an Activities of Daily Living (ADL) self-care performance deficit. Interventions included resident dependent on one staff member for eating. Review of the documentation for amount of meal eaten for 09/2022 revealed there was no documentation present for breakfast, lunch, or dinner on 09/02/22, 09/03/22, 09/05/22, 09/06/22, 09/08/22, 09/10/22, 09/11/22, 09/12/22, 09/14/22, 09/15/22, 09/18/22, 09/19/22, 09/20/22, 09/22/22 through 09/26/22, or on 09/29/22. There was no documentation of the amount of the lunch meal consumed on 09/27/22. Review of the documentation for the amount of assistance provided with eating revealed there was no documentation present for 09/08/22, 09/10/22 through 09/12/22, 09/14/22, 09/15/22, or 09/18/22 through 09/29/22. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of documented weights for this resident revealed on 04/22/22 the resident weighed 187.0 pounds, on 06/06/22 the resident weighed 165.0 pounds, on 07/13/22 the resident weighed 159.8 pounds, on 08/11/22 the resident weighed 150.4 pounds, on 09/14/22 the resident weighed 151.0 pounds, and on 10/05/22 the resident weighed 141.2 pounds. Observation on 09/27/22 at 12:15 P.M. revealed the lunch meal trays were delivered to the floor. Resident #52 was observed to be laying in bed sleeping. Two State tested Nursing Assistants (STNA's) were observed delivering lunch meal trays to other residents. The meal tray for Resident #52 was never removed from the cart during lunch meal service. Interview with STNA #212 on 09/27/22 at 12:38 P.M. revealed the employee stated Resident #36 had declined his lunch meal tray. Observation on 09/28/22 at 9:00 A.M. revealed Resident #36 was sitting up in his wheelchair in his room with his breakfast meal tray in front of him on a tray table. There were no staff members present in the room. The resident was observed having difficulty locating the food items on his meal tray. Observation on 09/29/22 at 8:45 A.M. revealed Resident #36 was lying in bed sleeping. The resident's breakfast meal tray was laying on the tray table located a foot away from the resident's bed. Interview with Resident #36 on 09/29/22 at 8:47 A.M. revealed the resident stated he was hungry but he had not been given his breakfast yet. Interview with STNA #215 on 09/29/22 at 9:00 A.M. revealed the employee did not take the breakfast meal tray into the room of Resident #36 as the employee had been passing meal trays at the end of the hallway. STNA #215 stated Resident #36 would normally eat most of his meal if a staff member sat down and assisted him consuming it. STNA #215 was then observed to enter the room of Resident #36, set him up to eat, and assist him to consume his breakfast meal. Interview with Registered Nurse (RN) #145 on 09/29/22 at 1:15 P.M. revealed Resident #36 had to have physical assistance from staff with consuming his meals due to being blind and cognitively impaired. RN #145 stated Resident #36 was able to put food in his mouth if it was handed to him, but had could not see adequately to get the food himself. 2. Record review for Resident #68 revealed this resident was admitted to the facility on [DATE] and had diagnoses including acute respiratory failure with hypoxia, ileus, hypertension, type two diabetes mellitus, dysphagia, schizophrenia, muscle weakness, difficulty walking, and cognitive communication deficit. Review of the quarterly MDS assessment, dated 08/27/22, revealed this resident had moderately impaired cognition evidenced by a BIMS assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting, extensive assistance from two staff members for transfers, and supervision with setup help only for eating. This resident was assessed to have significant weight loss while not on a prescribed weight-loss regimen. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan, revised on 08/29/22, revealed this resident was at risk for malnutrition. Interventions included assist with meals as needed, elevate head of bed as ordered, honor food preferences as able, monitor intake/output as ordered, obtain food preferences, and weights as ordered. Review of documented weights for this resident revealed on 04/05/22 the resident weighed 245.0 pounds and on 10/02/22 the resident weighed 199.2 pounds (a weight loss of 45.8 pounds or 18.69 percent in 180 days). Review of the documentation for amount of meal eaten for 09/2022 revealed there was only documentation of the amount eaten for 14 meals during the month. Review of the Registered Dietitian progress note, dated 10/04/22, revealed the resident had a significant weight loss of 45.8 pounds in 180 days and typically consumed 75 to 100 percent of meals. Observation on 09/29/22 at 9:20 A.M. revealed Resident #68 was in bed with the breakfast meal tray in front of her on the tray table. The eggs and oatmeal on the residents tray had not been touched. Interview with Resident #68 on 09/29/22 at 9:06 A.M. revealed the resident did not care for eggs or oatmeal which was why the resident did not eat them. Resident #68 stated she was still hungry. Observation on 09/29/22 at 9:18 A.M. revealed STNA #215 entered the room of Resident #68 to pick up her breakfast meal tray. STNA #215 asked Resident #68 if she was finished and left the room without offering Resident #68 an alternate food selection, despite the eggs and oatmeal continuing to be left on the tray untouched. Observation and interview with STNA #215 on 09/29/22 at 9:20 A.M. verified the resident's meal ticket did not include any listed dislikes or food preferences on the ticket. Telephone interview with Registered Dietitian (RD) #175 on 10/03/22 at 3:04 P.M. revealed if there was at least a half a month of meal intake documentation present she could get an idea of residents intake patterns but would ideally like more. RD #175 reported it was difficult to determine average intakes for cognitively impaired residents if less than half the months meal intakes were documented. 3. Record review for Resident #52 revealed this resident was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder, anemia, unspecified dementia with behavioral disturbance, polyneuropathy, cerebral infarction, hypotension, adult failure to thrive, hypovolemia, insomnia, and depression. Review of the quarterly MDS assessment, dated 08/17/22, revealed this resident had mildly impaired cognition evidenced by a BIMS assessment score of 08. This resident was assessed to require extensive assistance from one staff member for bed mobility, to be dependent upon two staff members for transfers, to be dependent upon one staff member for eating, toileting, and bathing. Review of the care plan, revised 09/20/22, revealed this resident was at risk of malnutrition/dehydration. Interventions included to encourage compliance with diet guidelines, record intake and output as needed, tube feeding as ordered, and weights as ordered. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the active physicians order, dated 08/02/22, revealed this resident was ordered a pureed diet with thin liquids. Review of the documentation for amount of meal eaten from 09/07/22 through 10/05/22 revealed there was only documentation of the amount eaten for eight meals during the month. Telephone interview with Registered Dietitian (RD) #175 on 10/03/22 at 3:04 P.M. revealed if there was at least a half a month of meal intake documentation present she could get an idea of residents intake patterns but would ideally like more. RD #175 reported it was difficult to determine average intakes for cognitively impaired residents if less than half the months meal intakes were documented. 4. Record review for Resident #32 revealed this resident was admitted to the facility on [DATE] and had diagnoses including unspecified protein-calorie malnutrition, type two diabetes mellitus, anxiety disorder, edema, and major depressive disorder. Review of the quarterly MDS assessment, dated 07/06/22, revealed this resident had moderately impaired cognition evidenced by a BIMS assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting and to be independent with setup help only for eating. Review of the documented weights for this resident revealed on 07/13/22 the resident weighted 115.0 pounds, on 08/05/22 the resident weighed 112.5 pounds, and on 09/16/22 the resident weighed 162.2 pounds. There were not additional weights documented from 09/16/22 through 10/05/22. Review of the Registered Dietitian progress note, dated 09/20/22, revealed there was a weight discrepancy of 162.2 pounds documented on 09/16/22 and a recommendation was made to re-weigh. Review of the progress notes, dated 09/20/22 through 10/05/22, revealed no documentation of the resident refusing to be weighed. Telephone interview with RD #175 on 10/03/22 at 3:04 P.M. revealed she visited the facility once a week for 10 to 12 hours, requested reweighs verbally or through email, and would ideally like the reweighs obtained by the next visit to the facility. RD #175 stated she provided lists of missing weights to the facility and it could be a struggle to get them. Review of the facility policy titled Weight Assessment and Intervention, revised 09/2008, revealed any weight change of five percent or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 43064 5. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including hyperlipidemia, hypertension, blindness in right eye and low vision in left eye, and major depressive disorder. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #28 had a severe cognitive impairment. She required supervision with one-person physical assistance for eating. Review of the plan of care dated 07/04/22 revealed Resident #28 was at risk for malnutrition or dehydration related to diagnoses, obesity, vision impairments, diuretic usage, and antidepressant usage. Weight fluctuations had been noted the last one was on 06/22/22 was a significant weight gain over 30 days and increased nutrient intakes were identified. Interventions included assisting with meals as needed, encouraging the resident to dine in the dining room, medications as ordered, obtaining food preferences, occupational therapist as needed, and weights as needed. Review of the physician's orders for Resident #28 revealed an order dated 02/19/21 for a regular diet with regular texture the instructions revealed a food first program, an order dated 01/19/22 for house pudding supplement 120 ml three times a day, and an order dated 01/19/22 for house supplement plus 120 ml three times a day. Review of Resident #28's weights revealed on 02/08/22 she was 170.8 pounds, on 02/18/22 she was 170.8 pounds, on 02/24/22, she was 171.2 pounds, on 04/12/22 she was 162.5 pounds, on 05/09/22 she was 173. 6 pounds, on 06/01/22 she was 174.5 pounds, on 06/13/22 she was 184.6 pounds, and on 08/08/22 she was 167 pounds. Her last weight of 167 pounds was a 9.5 % weight loss over 30 days. Review of Resident #28's intake records for September 2022 revealed intake was documented on two days for the entire month. On 09/01/22 Resident #28 consumed 51-75% of all three meals, on 09/08/22 Resident #28 consumed 76-100% of all three meals. Review of the progress note dated 06/23/22 revealed Resident #28's weight of 184.6 was a 5.8% increase in 30 days. The resident was on a regular diet with a food first program with all meals, average meal intakes of 50-75%, with supplements in place. No increased edema was reported at that time. Weight gain was suspected to be related to a combination of fluid shifts and increased intakes, no new recommendations were made. Review of the progress note dated 07/11/22 revealed a care conference took place, the family was concerned that Resident #28 was not eating due to not having teeth and that she had been trying to feed herself. Review of the progress note dated 08/08/22 revealed Resident #28's body weight of 167 pounds was a 9.5% weight loss from her previous weight. The note indicated the resident had a history of weight fluctuations and diuretic treatment may contribute to weight fluctuations. A supplement regimen was in place to compensate for variable intake, no recommendations were made. Review of the occupational therapy discharge summary dated 08/13/22 revealed Resident #28 was to be up in a wheelchair for all meals. She was to use adaptive equipment to increase with self-feeding. She was to receive stand by staff assistance after set up with meals. Observation on 09/27/22 from 9:40 A.M. to 10:00 A.M. revealed Resident #28 was in the resident lounge with her breakfast tray in front of her. She was asleep and no staff were present. Observation on 09/27/22 at 12:50 P.M. revealed STNA #131 set up Resident #28's tray, put silverware in her hands, and explained what was on the tray. STNA #131 then left the dining room. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/27/22 at 12:50 P.M. with STNA #131 revealed Resident #28 did not require assistance with eating, she needed oriented to her tray, and silverware placed in her hand. Observation on 09/27/22 at 12:57 P.M. revealed Resident #28 was observed using her hands to eat and licking mashed potatoes off of her fingers. Observation on 09/28/22 starting at 12:30 P.M. revealed Licensed Practical Nurse (LPN) #119 brought Resident #28 her lunch tray in bed, he provided set up assistance and left the room. At 12:42 P.M. Resident #28 was observed using her hands to feel the different foods in the divided plate and eating mashed potatoes. At 12:45 P.M. 50% of the meal on her tray (meat, vegetables, and mashed potatoes) was observed to be absent there was a bowl of pudding on the left side of the tray that had been untouched. At 12:47 P.M. State tested Nursing Aide (STNA) #108 asked the resident if she was done eating and the resident indicated she was. STNA #108 asked the resident if she was sure she did not want her pudding, Resident #28 revealed she was unaware the pudding had been there. Interview on 09/28/22 at 12:47 P.M. with STNA #108 confirmed Resident #28 had been eating food with her hands and had a divided plate. STNA #108 revealed she was not working her usual hallway and was unfamiliar with the resident's needs at meals. Interview on 09/28/22 at 2:13 P.M. with LPN #119 confirmed he had provided Resident #119 with set up assistance at lunch. He reported Resident #28 required set up assistance and oriented to what was on the plate. He confirmed he had seen Resident #28 eat with her hands before. Observation on 09/29/22 from 8:50 A.M. to 9:23 A.M. of the breakfast meal revealed Resident #28 sleeping with her food in front of her. Resident #28's food was in bowls, she had consumed her oatmeal, but had not touched the eggs, coffee, or orange juice. Resident #28 did not receive assistance or queuing during the observation. Further observation at 9:28 A.M. revealed Agency Aide #203 removing Resident #28's tray without asking her if she was done. Agency Aide #203 returned the tray to the dietary cart and confirmed the resident had only consumed the oatmeal. She then grabbed the orange juice and returned it to Resident #28. Observation on 09/29/22 from 9:28 A.M. to 10:00 A.M. revealed Resident #28 drank the entire glass of orange juice. Interview on 09/28/22 at 3:12 P.M. with Occupational Therapist (OT) #181 confirmed the information in the 08/13/22 discharge summary. OT #181 stated Resident #28 was to sit in a chair at meals because the positioning was better for her, she required adaptive equipment at meals which was to mean food in bowls, and the staff should be with her at meals after set up to que her due to her poor eye sight and memory. She reported she works in the evenings, so she lets the nurses know her recommendations and they are to obtain and enter orders. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/03/22 at 3:04 P.M. with Registered Dietitian (RD) #175 revealed she provided nursing management with lists of weekly weights and missing weights every week when she visits, however, it could a struggle to obtain the weights. RD #175 stated she would ideally like more intake documentation, she revealed if there was half a month of intake documentation, she could get an idea of their intake patterns. She reported with cognitively impaired residents if less than half of the intakes were documented it was difficult to determine their intakes, as she was only sometimes able to get information from staff on how the resident was doing. RD #175 confirmed Resident #28's weights were inconsistent and missing. She additionally revealed the food first program the resident was in meant they were to receive fortified foods. Interview on 10/03/22 at 3:45 P.M. with Dietary Manager #161 revealed he did not know what the food first program was and had no residents receiving fortified foods. Review of the policy titled Weight Assessment and Intervention dated September 2008, revealed after admission weights, weights were to be obtained monthly thereafter. Weights were to be recorded in the individuals medical record. 6. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including encephalopathy, anemia, type two diabetes mellitus, rheumatoid arthritis, cognitive communication deficit, anxiety disorder, depression, and chronic kidney disease. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #30 had intact cognition and was on dialysis. She weighed 191 pounds and had no significant weight changes; Resident #30 was on a therapeutic diet. Review of the plan of care dated 06/23/22 revealed Resident #30 was at risk for malnutrition and dehydration related to medical diagnoses, a body mass index (BMI) above 25, therapeutic and mechanically altered diet, diuretic use and edema with anticipated weight fluctuations, and increased metabolic requirements with hemodialysis. As of 06/22/22 she had significant weight loss that was suspected to be related to fluid shifts and dialysis. Interventions included assessing and reporting signs of edema to physician, assisting with meals as needed, providing medications as ordered, providing diet as ordered, and weights as ordered. Review of the physician order for Resident #30 dated 06/01/22 revealed an order for a consistent carbohydrate diet with no added salt. Review of Resident #30's weights revealed she was last weighed on 06/21/22 and was 191 pounds. Review of meal intake records from 09/01/22 to 09/27/22 revealed intake was documented for three meals on 09/01/22, two meals on 09/03/22, three meals on 09/08/22, one meal on 09/09/22, and two meals on 09/17/22. Review of the progress note dated 06/23/22 revealed Resident #30's weight of 191.1 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the nutrition evaluation dated 07/24/22 revealed Resident #30's weight was 191.1 pounds on 06/21/22. A weight variance was identified and addressed previously. No thirty-day change was available with weight history. The resident remained at increased risk for malnutrition due to diagnoses, BMI, and therapeutic diet. The resident remained on hemodialysis three times a week. Her current diet remained appropriate with supplementation due to increased needs, the dietitian's plan was to monitor and follow up as needed. Interview on 10/03/22 at 3:04 P.M. with Registered Dietitian (RD) #175 revealed she provided nursing management with lists of weekly weights and missing weights every week when she visits, however, it could a struggle to obtain the weights. RD #175 stated she would ideally like more intake documentation, she revealed if there was half a month of intake documentation, she could get an idea of their intake patterns. Review of the policy titled Weight Assessment and Intervention dated September 2008, revealed after admission weights, weights were to be obtained monthly thereafter. Weights were to be recorded in the individuals medical record. 7. Review of the medical record revealed Resident #14 admitted on [DATE] with diagnoses including type two diabetes mellitus, hypertension, end stage renal disease with dependence on renal dialysis, cerebral infarction, cognitive communication deficit, gastro-esophageal reflux disease, hypothyroidism, pain in left knee, and insomnia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had intact cognition and received dialysis. Resident #14 weighed 229 pounds, had no significant weight changes, and were on a mechanically altered and therapeutic diet. Review of the plan of care dated 07/06/22 revealed Resident #14 was at risk for malnutrition and dehydration related to medical diagnoses including end stage renal disease on dialysis, a body mass index (BMI) above 25, psychoactive medications that may alter weight or appetite, diuretics that may cause weight fluctuation, and being edentulous with a mechanically altered diet. Interventions included assessing and reporting signs of edema to the physician, assisting with meals as needed, consulting with the dialysis dietitian as needed, educating the resident on diet and risk factors, medications as ordered, and providing diet, supplements, and weights as ordered. Review of Resident #14's weights on 09/26/22 revealed her last weight obtained was 224.3 pounds on 08/12/22. Interview on 10/03/22 at 3:04 P.M. with Registered Dietitian (RD) #175 revealed she provided nursing management with lists of weekly weights and missing weights every week when she visits, however, it could a struggle to obtain the weights. RD #175 stated she would ideally like more intake documentation, she revealed if there was half a month of intake documentation, she could get an idea of their intake patterns. Review of the policy titled Weight Assessment and Intervention dated September 2008, revealed after admission weights, weights were to be obtained monthly thereafter. Weights were to be recorded in the individuals medical record. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	8. Review of the medical record for Resident #55 revealed an admitted [DATE] revealed an admitted chronic diastolic heart failure, type two diabetes mellitus, chronic kidney disease stage two, depression, unspecified dementia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had severely impaired cognition. Review of the plan of care dated 09/18/22 revealed Resident #55 was at risk for malnutrition and dehydration related to diagnoses, a body mass index (BMI) above 25, diuretic use, psychoactive medication use, edema on admission, a therapeutic and mechanically altered diet and as of 09/18/22 she had lost a significant amount of weight over 30 and 90 days. Review of the physician order dated 06/15/22 revealed an order for a mechanical soft diet and a 2000 milliliter (ml) fluid restriction and an order for daily weight every night shift related to chronic heart failure starting 06/08/22. Review of the Medication Administration Record (MAR) daily weight for September 2022 revealed Resident #55 weighed 150.3 pounds for 09/01/22 through 09/09/22, 09/13/22, 09/14/22, and 09/15/22. Resident #55 weighed 148.7 pounds for 09/16/22, and 09/19/22 through 09/22/22. Resident #55 weighed 148.3 pounds for 09/23/22, 09/24/22 and 09/27/22 through 09/29/22. Daily weight was not obtained on 09/11/22, 09/12/22, 09/17/22, 09/18/22, 09/25/22, 09/26/22, and 09/30/22. Review of Resident #55's monthly weights revealed she weighed 236 pounds on 05/24/22, 202.2 pounds on 06/24/22, 171.2 pounds on 07/24/22, 144.9 pounds on 08/25/22, and 148.3 pounds on 09/24/22 which was a 26.6% loss over 90 days. Review of the dietary progress note dated 09/18/22 revealed Resident #55 weighed 148.7 pounds which was a significant weight loss over 30 and 90 days. Weight loss was attributed to diuretic treatment, variable oral intakes at times, edema and diagnoses. The dietitian recommended adding frozen nutritional supplements twice a day. Review of Resident #55's oral intakes for September 2022 revealed no intake was documented. Interview on 10/03/22 at 3:04 P.M. with Registered Dietitian (RD) #175 revealed she provided nursing management with lists of weekly weights and missing weights every week when she visits, however, it could a struggle to obtain the weights. RD #175 stated she would ideally like more intake documentation, she revealed if there was half a month of intake documentation, she could get an idea of their intake patterns. RD #175 revealed Resident #55 had significant fluid shifts. Review of the policy titled Weight Assessment and Intervention dated September 2008, revealed after admission weights, weights were to be obtained monthly thereafter. Weights were to be recorded in the individuals medical record. 44068 9a . Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included cerebral infarction, non-dominant, left side (L)hemiplegia and hemiparesis following a cerebral infarction (CVA), hypertension (HTN), heart disease, and dysphagia. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the comprehensive MDS assessment, dated 08/17/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment) and no documented behaviors. The resident required limited to extensive assistance of one to two or more staff for all Activities of daily Living (ADL's). Review of the resident's weights revealed he was weighed per facility policy on admission which measured 168 pounds (lbs.), but no weight was obtained the next day per policy. Further review of the resident's weights revealed the resident was not weighted again after admission until 12 days later, 08/22/22 when he weighed 168.8 lbs. despite the facility policy stating the resident was to be weighed weekly for two weeks following admission. His third weight was 170.2 lbs. and was not obtained for 22 days after admission and 10 days from the second weight. Further review of the resident's weights revealed he was weighed again on 09/02/22 when his weight remained the same (170.2 lbs.) and again on 09/03/22 when he lost 9.6 lbs. and weighed 160.6 lbs. There was no re-weight documented per facility policy. The next and final documented weight was dated 10/01/22 when the resident lost an additional 5.6 lbs. and weighed 155 lbs. There was no re-weight per facility policy the following day. Review of the email dated 10/06/22 at 11:45 A.M. from Regional RN #165 to the Surveyor confirmed Resident #51 was missing required weights per the facility's policy. 9b. Review of the nutritional evaluation dated 08/15/22 revealed Resident #51 required a regular with mechanic soft textured diet. His weight as of 08/10/22 was 168 pounds (lbs.) and he had no known weight loss or gain. The resident had loss of liquids/solids from his mouth when eating, held food in his mouth/cheeks or residual food in his mouth after meals, and complained of difficulty or pain when swallowing. Further review of the assessment revealed the resident required assistance with eating. Review of physician orders for October 2022 identified orders dated 08/10/22 for monthly weight every shift starting on the 1st and ending on the 3rd every month, 08/17/22 for a regular diet, pureed texture, regular (thin liquids) consistency per the resident request for diet downgrade, the order was discontinued on 08/18/22 when a new order for regular diet, mechanical soft texture, regular (thin liquids) consistency was placed. Review of the progress note dated 09/06/22 at 5:46 P.M. by Dietician #999 revealed the resident had a significant weight loss of five percent over 30 days. Further review of the note revealed adding a house supplement three times per day was recommended to prevent further weight loss and compensate for intake. Review of the physician's order dated 09/08/22 revealed 240 milliliters (ml) of house supplement was ordered two times per day, to promote weight gain. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's order dated 09/28/22 (22 days after Dietician #999's recommendation for house supplement three times per day and 20 days after the house supplement was ordered two times per day) for house supplement at bedtime for weight gain. Review of the plan of care dated 08/15/22 and revised 10/04/22 revealed the resident had the potential for alteration in nutrition and hydration related to a recent CVA with L side weakness, heart disease, HTN, need for an altered diet, and on 10/4/22 had a significant weight loss over 30 days. Interventions included assistance with meals as needed, weights/diet/supplements per orders, and offer food alternatives/preferences. Observation and interview on 09/26/22 at 12:45 P.M. with Resident #51 revealed he needed to be handed his built-up spoon so he could eat, and his plate guard was not on his plate but was laying on his tray. Resident #51 confirmed he needed assistance with eating but was not assisted routinely, was not sure how long his food had been next to him and confirmed he like to use the plate guard. Interview on 10/04/22 at 3:05 P.M. with Resident #51's mother revealed the resident needed assistance with meals but was often left to eat independently and open his food items without help. She confirmed he had visibly lost weight. Review of the task titled, Amount Eaten for 30 days prior to 10/05/22 revealed there was only documented intake for 09/12/22 which revealed the resident ate between 26-50 percent (%) for dinner and 51-75% for breakfast and lunch. Review of the facility provided intakes for the resident revealed one additiona [TRUNCATED]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, resident interview, observations, medical record review, facility policy review, the facility failed to ensure enteral feeding was provided as ordered for Residents #52, #232, and #243. This affected three residents (Residents #52, #232, and #243) of four residents who had a feeding tube. The facility census was 84. Findings include: 1. Review of the medical record for Resident #232 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included displaced intertrochanteric fracture of the right femur, atrial fibrillation (a-fib), Diabetes Mellitus II (T2DM), emphysema, dysphagia, and severe protein-calorie malnutrition. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/22/22, revealed the assessment remained in progress (23 days since the resident's re-entry to the facility). Further review of the MDS revealed the resident had impaired cognition with a Brief Interview of Mental Status (BIMS) score of five out of 15 (severe impairment). The resident required extensive to total assistance of one to two or more staff for all Activities of daily Living (ADL's) and had an eternal feeding tube. Review of the plan of care dated 09/20/22 revealed the resident was at risk for malnutrition/dehydration related to a right femur fracture, a-fib, T2DM, emphysema, dysphagia, severe protein calorie malnutrition, nothing by mouth (NPO), dependence on tube feed (TF), increased metabolic requirements with wounds, and body mass index greater than 25 (BMI >25). Interventions included assess for TF tolerance, compliance with diet guidelines, TF as ordered, weights as ordered, and monitor intake and output. Review of physician orders for September 2022 identified an order dated 09/14/22 to infuse TF, Jevity 1.5 at 50 milliliters per hour (ml/hr) continuously every shift for dysphagia. Further review of the orders revealed an order dated 09/26/22 to flush the resident's feeding tube before and after medication administration with 30 ml of water. A third order dated 09/27/22 revealed to flush the resident's enteral feeding tube every four hours with 150 ml water for hydration. Observation on 09/26/22 at 12:51 P.M. of Resident #232 revealed his tube feeding (TF) bottle was hung and infusing but was unlabeled and undated. The resident also had a piston syringe hanging on the tube feeding pole that was also unlabeled/undated. Observation and interview on 10/03/22 at 12:17 P.M. of Resident #232 revealed his TF bottle not labeled/dated, his flush bag was dated 10/01/22, and the piston syringe bag was dated 09/29/22. The resident confirmed he received medication in the morning on 10/03/22. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 10/03/22 at 12:25 P.M. with Licensed Practical Nurse (LPN) #777 confirmed TF, water flushes, and piston syringes were only good for 24 hours and she gave Resident #232 medication on 10/03/22 using the supplies in the room. LPN #777 also confirmed the undated TF was infusing and confirmed the dates on the syringe and flush bag was over 24 hours. Review of the facility policy titled Enteral Feedings- Safety Precautions revised 05/2014 revealed Closed-system enteral formulas have a hang time of 24-48 hours, per manufacturer's instructions and the administration sets for a closed-system enteral feeding was to be changed according to manufacturer's instructions. Review of the Jevity 1.5 Cal manufacturer instructions dated 2022 revealed the directions for use provided by manufacturer of feeding sets was to be followed and unless a shorter hang time was specified by the set manufacturer, the product was to be hung for up to 48 hours after initial connection when clean technique, and only one new set was used; Otherwise, the product should not be hung for more than 24 hours. Review of the facility policy titled Enteral Nutrition revised 01/2014 revealed TF and supplements were to be administered per Physician orders and based on the recommendations of the Dietitian. Review of the facility provided manufacturer instructions titled, Kangaroo Epump ENPlus Spike with Flush Bag dated 02/25/28 revealed the tubing was not to be used for greater than 24 hours. 2. Review of the medical record for Resident #243 revealed an admitted [DATE]. Diagnoses included post-procedural partial intestinal obstruction, severe protein-calorie malnutrition, post-gastric surgery syndromes, myxedema coma, hypothyroidism, autoimmune thyroiditis, multiple myeloma in remission, anemia, sleep apnea, glaucoma, and vitamin deficiency. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 10/01/22, revealed the assessment was in progress. Further review of the assessment revealed the resident had impaired cognition with a Brief Interview of Mental Status (BIMS) score of 12 out of 15 (moderate impairment). The resident's functional status had not been assessed. Further review of the MDS confirmed the resident complained of difficulty swallowing and she had a feeding tube. Review of the plan of care dated 09/27/22 revealed the resident was at risk for malnutrition/dehydration related to severe protein calorie malnutrition, hypothyroidism, anemia, multiple myeloma, vitamin D deficiency, status post gastric bypass in 2021, anastomotic stricture, dumping syndrome, anastomotic ulcers, electrolyte abnormalities, chronic diarrhea, hypokalemia, [NAME] Tube/Nasal Gastric (DHT/NG) placement on 9/12/22, poor by mouth (PO) intake/weight loss, therapeutic tube feed (TF) formula, absorption issues, and weight fluctuations. Interventions included medications as ordered, weights as ordered, and dysphagia guidelines as ordered. Review of the progress note dated 9/23/22 at 1:50 P.M. by Registered Nurse (RN) #115 revealed the Resident had an order for Vital 1.2 via NG tube continuously but there was no Vital 1.2 in the building. Further review of the progress note revealed she notified the provider on call who informed her to wait for the Dietitian to decide a good substitution for the ordered TF. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes revealed the resident was not seen by the Dietitian until four days later on 9/27/2022 at 9:54 A.M. when Dietician #888 acknowledged the resident extensive history regarding her digestive system, weight loss (close to 200 lbs.), need for total parental nutrition (TPN) during hospital stay, need for an NG tube, need for several vitamins and supplements, history of poor oral intake, and the residents need for Vital AF 1.2 at 90 ml/hr at night from 7:00 P.M. to 7:00 A.M.) or until 1080 ml was infused. The Dietitian did not change the Resident #243's TF order. Review of the physician order dated 09/24/22 revealed the resident was to have Vital AF 1.2 cal liquid (tube feed) running through her NG tube at 90 ml/hr every night. Further review of the orders revealed no orders for weights. Review of the Electronic Medication Administration Record (EMAR) for September 2022 revealed the order for nocturnal tube feeds was not signed off on 09/23/22. Review of the EMAR dated 10/02/22 through 10/04/22 revealed Resident #243's ordered tube feed was marked 9 rather than administered, indicating to see the notes. Review of the progress note dated 10/3/2022 at 9:22 A.M. by Registered Nurse (RN) #125 revealed she informed supply staff about being out of the resident's ordered TF and being informed that the TF had been ordered. Review of the progress note dated 10/03/22 at 11:30 P.M. (day two of no TF) by RN #115 revealed she called and informed the on-call provider of the facility being out of the resident's ordered TF when she was informed that the provider was not trained in the field of TF and recommended the RN to call the pharmacy. The RN called the pharmacy and informed her that the pharmacy was not sure of the equivalence of the resident's ordered tube feeding since the pharmacy was not trained in tube feeding. RN #115 then called and informed the on-call provider who informed RN #115 she and the resident would have to await the delivery of the ordered tube feeding. Review of the progress note dated 10/04/22 and signed on 10/04/22 at 6:36 P.M. by the Certified Nurse Practitioner revealed the resident was to continue nocturnal feedings (12 hours) and had suspected chronic hypotension due to poor oral intake. Review of the progress note dated 10/05/22 at 6:43 A.M. (day four of no TF) by RN #115 revealed the resident's ordered TF was still unavailable and the night shift supervisor was informed. Interview on 09/26/22 at 2:26 P.M. with Resident #243 revealed she had some issues with her TF since admission but stated it was finally figured out, she guessed. She was unsure of specific details. Review of the facility policy titled Enteral Nutrition revised 01/2014 revealed TF was to be administered per Physician orders and based on the recommendations of the Dietitian. 42728 3. Record review for Resident #52 revealed this resident was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder, unspecified dementia with behavioral disturbance, hypotension, adult failure to thrive, hypovolemia, insomnia, and depression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Gahanna	167 North Stygler Road Gahanna, OH 43230

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment, dated 08/17/22, revealed this resident had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 08. This resident was assessed to require extensive assistance from one staff member for bed mobility, to be dependent upon two staff members for transfers, and to be dependent upon one staff member for eating, toileting, and bathing. This resident was assessed to have a feeding tube. Review of the care plan, revised 09/20/22, revealed this resident was at risk of malnutrition/dehydration. Interventions included tube feeding as ordered. Review of the physicians order, dated 08/16/22, revealed an order to administer Two Cal HN at 95 milliliters and hour for 12 hours from 7:00 P.M. to 7:00 A.M. Review of the Medication Administration Record (MAR) revealed documentation Two Cal HN was not administered as ordered on 09/27/22, 09/29/22, 09/30/22, 10/01/22, or 10/02/22. Review of the progress note, dated 09/28/22 and timed 7:03 A.M. revealed Two Cal HN not available, waiting on dietitian to review order. Review of the progress note, dated 09/29/22 and timed 11:12 P.M., revealed Two Cal HN not available, waiting on dietitian to clarify order. Review of the progress note, dated 10/01/22 and timed 5:00 A.M., revealed Two Cal HN not available, waiting on dietitian to clarify order. Review of the progress note, dated 10/02/22 and timed 5:54 A.M., revealed Two Cal HN not available, waiting on dietitian to clarify order. Review of the progress note, dated 10/02/22 and timed 11:33 P.M., revealed Two Cal HN not available, still waiting on dietitian to clarify order. Observation and interview with Licensed Practical Nurse (LPN) #120 on 10/03/22 at 10:45 A.M. verified there was not any Two Cal HN available in the facility to administer to Resident #52. LPN #120 verified there was not an order for another tube feeding solution to be administered on the nights Two Cal HN was not available but would obtain an order for Jevity 1.5 to be administered.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and record review, the facility failed to ensure pain medication was available for administration for Resident #11, Resident #14, and Resident #246. This affected three residents (Residents #11, #14, and #246) of four residents reviewed for pain management. The facility census was 84. Actual harm occurred to Resident #14 who voiced and presented with reports of increased pain without adequate pain management. Findings include: 1. Interview on 09/26/22 at 1:01 P.M. and 1:40 P.M. with Resident #14 revealed the facility had been out of her pain medications for two days. She reported increased abdominal pain. Observation on 09/26/22 at 1:01 P.M. and 1:40 P.M. revealed Resident #14 inhaling sharply and grabbing her abdomen multiple times during her interview. Interview on 09/29/22 at 11:36 A.M. with Resident #14 revealed over the weekend when she was out of pain medications, she had experienced up to a pain of 10 (pain scale of 1-10) and could not sleep. She stated they had been out of her pain medications several times. Review of the medical record revealed Resident #14 admitted on [DATE] with diagnoses including type two diabetes mellitus, hypertension, end stage renal disease with dependence on renal dialysis, cerebral infarction, cognitive communication deficit, gastro-esophageal reflux disease, hypothyroidism, pain in left knee, and insomnia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had intact cognition. Review of the plan of care dated 04/06/22 revealed Resident #14 was at risk for alteration in comfort, however, the care plan did not identify the cause. The interventions included calming music or television, medications as ordered, monitoring for adverse effects of pain medications, monitoring for effectiveness of interventions, monitoring for levels of increased pain and notifying the physician, and using a pain scale as reported by the resident. Review of Resident #14's physician's orders dated 05/05/22 revealed orders for Oxycodone five milligrams two tablets by mouth every four hours as needed for severe pain rated eight to ten and one tablet by mouth every four hours as needed for moderate pain rated four to seven. Review of the controlled drug receipt record dated 08/09/22 revealed the facility received 60 tablets of Oxycodone five milligrams for Resident #14 on 08/09/22 and the last one was used on 09/05/22 at 8:00 P.M. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the controlled drug receipt record dated 09/08/22 revealed the facility received 30 tablets of Oxycodone five milligrams for Resident #14 on 09/08/22 the first dose was administered on 09/09/22 at 8:00 P.M. and the last dose was administered on 09/23/22 at 8:00 P.M. Review of the controlled drug receipt record dated 09/26/22 revealed the facility received 30 tablets of Oxycodone five milligrams for Resident #14 on 09/26/22 the first dose was administered on 09/27/22 at 5:30 A.M. Review of Resident #14's Medication Administration Record (MAR) for September 2022 revealed no Oxycodone was administered on 09/06/22, 09/07/22, 09/08/22, 09/24/22, 09/25/22, and 09/26/22. Oxycodone was administered on 09/27/22 at 5:30 A.M. for a pain of nine. Review of the pain level summary for September 2022 revealed Resident #14's pain was not assessed on 09/04/22, 09/06/22, 09/07/22, 09/08/22, 09/10/22, 09/11/22, 09/14/22, 09/17/22, 09/18/22, 09/20/22, 09/23/22, 09/24/22, 09/25/22, and 09/26/22. Interview on 09/29/22 at 1:43 P.M. with Unit Manager Licensed Practical Nurse (LPN) #120 revealed they had not been aware Resident #14 had been out of pain medication, on either occasion. She stated 'as needed' medications should be called or faxed to the pharmacy when they are three to four days away from running out. She reported the facility did have emergency medication kits, however, there was no evidence medication was pulled for Resident #14. Interview on 09/29/22 at 2:08 P.M. with Regional Director of Clinical Services #165 revealed Resident #14's pain should be monitored every shift. Review of the policy Pain Clinical Protocol revised June 2013, revealed the staff were to reassess the individual's pain and related consequences at regular intervals. At least each shift for acute pain or significant changes in chronic pain. 42728 2. Record review for Resident #11 revealed this resident was admitted to the facility on [DATE] and had diagnoses including fibromyalgia, chronic obstructive pulmonary disease, low back pain, osteoarthritis, pain in right leg, pain in left leg, and depression. Review of the quarterly MDS assessment, dated 06/25/22, revealed this resident had intact cognition evidenced by a BIMS assessment score of 13. This resident was assessed to require supervision from one staff for bed mobility and toileting and to be independent with setup help only for transfers and eating. This resident was assessed to have had pain in the past five days which limited day to day activities. Review of care plan, revised 03/17/20, revealed this resident had the potential for an alteration in comfort. Interventions included to administer medications as ordered to manage pain. Review of the active physicians order, dated 06/16/22, revealed an order to administer one Norco 5-325 milligram tablet three times a day for chronic bilateral leg pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) revealed doses of Norco were not administered as ordered from 09/21/22 through 09/28/22. Review of the narcotic count sheets for Norco 5 - 325 milligram tablets revealed the last dose was pulled from the narcotic card on 09/21/22 at 9:00 A.M. for administration and the next dose was pulled from a new narcotic card on 09/28/22 at 4:00 P.M. for administration. Interview with Resident #11 on 09/26/22 at 12:37 P.M. revealed the resident had not been administered Norco for several days due to the facility not having it and had experienced increased pain levels and vomiting due to the absence of the ordered pain medication. Interview with Licensed Practical Nurse (LPN) #120 on 09/28/22 at 2:15 P.M. verified the Norco ordered for Resident #11 had been unavailable for administration from 09/21/22 through 09/28/22. Review of the facility policy titled Pain - Clinical Protocol, revised 06/2013, revealed the physician would order appropriate non-pharmacological and medication interventions to address the individual's pain. 44068 3. Review of the medical record for Resident #246 revealed an admitted [DATE]. Diagnoses included multiple fracture of the pelvis, cannabis use, fracture of the lumbar vertebra, fracture of a right rib, right kidney injury, schizophrenia, cerebral infarction, ventral hernia without obstruction, acute respiratory failure without hypoxia, and pedestrian on foot collision with automobile. Review of the comprehensive MDS assessment, dated 10/01/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment). The resident required up to extensive assistance of one to two or more staff for all Activities of daily Living (ADL's) except eating which he required set up and supervision. Further review of the MDS confirmed the resident had a known surgical wound that he received surgical wound care for and application of non-surgical dressings. Further review of the MDS confirmed the resident received Opioid medication three of the previous seven days prior to the completion of the MDS. Review of the After Visit Summary for 08/24/22 through 09/24/22 revealed the resident's wound vacuum (vac) to his abdomen was removed for transport to the facility but was to be replaced. Review of the plan of care dated 09/24/22 revealed the resident was at risk for an alteration in comfort with no listed reasoning. Interventions included medications to manage pain per orders. Review of the physician orders dated 09/24/22 revealed orders to give 0.5 tablet of Morphine Sulfate 15 mg by mouth every six hours as needed for moderate to severe pain. There was a second order placed on the same date for one tablet of Morphine Sulfate 15 mg by mouth every six hours as needed for moderate to severe pain. Review of the September Electronic Medication Administration Record (EMAR) revealed the resident received one tablet of morphine on 09/26/22 for a pain rating of 7. He received 0.5 tablet on 09/26/22 for a rating of 5 and 09/27/22 for a rating of 7. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the October EMAR revealed the resident received one tablet of morphine on 10/01/22 for a pain rating of 8 and on 10/02/22 for a pain rating of 7. He received 0.5 tablet on 10/04/22 for a rating of 8, 10/05/22 for a rating of 5 and again for a rating of zero, and 10/07/22 for a pain rating of 3. Interview and observation on 10/03/22 at 1:25 P.M. revealed Resident #246 sitting up in his wheelchair asking for morphine due to complaints of abdominal pain. Licensed Practical Nurse (LPN) #777 confirmed at 1:26 P.M. she was awaiting delivery of the morphine from the pharmacy and had none to administer to Resident #246 until then. Review of the progress note dated 10/03/22 at 6:11 P.M. by Licensed Practical Nurse (LPN) #777 revealed she contacted the nurse practitioner (NP) and informed the NP that LPN #777 had contacted the pharmacy to check on the delivery status of the resident's morphine when she was informed by the pharmacy that the prescription was for six tablets which had been filled and a new prescription was needed. Further review of the progress note confirmed the resident was complaining of abdominal pain at his wound site. LPN #777 then informed the NP of the two orders listed in the resident's chart for morphine to which the NP informed LPN #777 that the resident could not have been getting the two morphine orders and she would have to figure out which morphine order the resident was to receive. Review of the October 2022 EMAR revealed the resident received one tablet of morphine for a pain scale rating of seven out of 10 on 10/02/22 at 6:56 A.M. Resident #246 did not receive any pain medication on 10/03/22, and did not receive any more morphine until a half tablet was administered on 10/04/22 at 4:29 P. M. Interview on 10/04/22 at 9:36 A.M. with the Pharmacist confirmed Resident #246 needed a new prescription for morphine to be filled and delivered and one had not been received yet. Review of the email dated 10/04/22 at 1:25 P.M. from Regional Clinical Director #165 to the Surveyor confirmed the resident's morphine prescription was not sent to the pharmacy until 10/04/22 in the afternoon (specific time not identified). Review of the facility policy titled, Controlled Substances revised 12/2012 revealed the Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties, and shall give the Administrator a written report of such findings. Furthermore, controlled substances must be counted upon delivery and every shift.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review the facility failed to complete pre-dialysis and post-dialysis assessments for Resident #14 and Resident #30. This affected two residents (#14 and #30) of two residents reviewed for dialysis. The facility census was 84. Findings include: 1. Review of the medical record revealed Resident #14 admitted on [DATE] with diagnoses including type two diabetes mellitus, hypertension, end stage renal disease with dependence on renal dialysis, cerebral infarction, cognitive communication deficit, gastro-esophageal reflux disease, hypothyroidism, pain in left knee, and insomnia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had intact cognition and received dialysis. Review of the plan of care dated 03/21/22 revealed Resident #14 received dialysis on Monday, Wednesday, and Friday related to End Stage Renal Disease (ESRD). Interventions included assisting with transfers when going to dialysis and fluid restrictions as ordered. Review of the physician's order for Resident #14 dated 06/13/22 revealed an order for hemodialysis with Fresnius medical care every Monday, Wednesday, and Friday. No chair time was listed. Review of the electronic medical record for Resident #14 from 06/13/22 to 09/28/22 revealed no completed pre-dialysis or post-dialysis assessments. Interview on 09/28/22 at 3:13 P.M. and 3:35 P.M. with Unit Manager Licensed Practical Nurse (LPN) #120 revealed the facility did not complete pre-dialysis and post-dialysis assessments as it had not been the previous management companies' policy to do so. 2. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including encephalopathy, anemia, type two diabetes mellitus, rheumatoid arthritis, cognitive communication deficit, anxiety disorder, depression, and chronic kidney disease. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #30 had intact cognition and was on dialysis. Review of the plan of care dated 05/26/22 revealed Resident #30 received dialysis on Monday, Wednesday, and Friday at Fresnius Kidney Care. Interventions included dialysis as ordered, assisting with transfer needs when going to dialysis, and monitoring dressing to vascular catheter and shunt. Review of Resident #30's physician order dated 06/10/22 revealed they had hemodialysis on Monday, Wednesday, and Friday with a chair time at 11:30 A.M. Review of the electronic medical record for Resident #30 from 06/10/22 to 09/28/22 revealed no completed pre-dialysis or post-dialysis assessments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/28/22 at 3:13 P.M. and 3:35 P.M. with Unit Manager LPN #120 revealed the facility did not complete pre-dialysis and post-dialysis assessments as it had not been the previous management companies' policy to do so.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, record reviews, and review of facility policies, the facility failed to ensure appropriate spacing between bed rails and mattresses was maintained and failed to ensure assessments for the use of bed rails were completed. This affected two residents (Residents #13 and #64) out of the two residents reviewed for use of bed rails during the annual survey. The facility census was 84. Findings include: 1. Record review for Resident #64 revealed this resident was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparalysis affecting the left non-dominant side, depression, and hypertension. Review of the admission Minimum Data Set (MDS) assessment, dated 08/26/22, revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 15. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting and to be dependent upon two staff members for transfers. Review of the active care plans for this resident revealed there was not a care plan or intervention to address the use of bed rails. Review of facility evaluations for this resident revealed there was not an evaluation completed for the use of bed rails. Observation on 09/26/22 at 11:42 A.M. revealed Resident #64 was lying in bed asleep. There was a large gap observed between the edge of the residents mattress and bed rail. Observation and interview with Maintenance Director #148 on 09/26/22 at 4:40 P.M. verified the bed frame for the residents mattress was too large and created a gap which measured five and a half inches between the residents mattress and side rail. Maintenance Director #148 was able to adjust the side rail creating a gap which was observed to be less than one inch from the edge of the mattress to the side rail. Interview with Clinical Director of Regional Services #165 on 09/26/22 at 4:45 P.M. verified there had been no assessment or evaluation completed for the use of bed rails for Resident #64. Regional Director of Clinical Services #165 verified Resident #64 had not incurred any accidents or injuries due to the use of side rails. 43064 2. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, Type two diabetes mellitus, persistent mood disorder, chronic pain syndrome, depression, dysphagia, hyperlipidemia, and cognitive communication deficit. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition. The resident required the extensive assistance of one person for bed mobility and was totally dependent on staff for transfers. Review of the plan of care dated 06/23/22 revealed Resident 13 had an activity of daily living self-care performance deficit related to debility and limited mobility. Interventions included preventative skin care as needed, turning and repositioning as needed, and allowing time for rest breaks. Review of the medical record for Resident #13 revealed no documentation the facility assessed for safety concerns of side rail use. Interview and observation on 09/27/22 at 2:54 P.M. with Resident #13 revealed he had recently received a new bed rail after his previous one had broken in a fall. Observation at that time revealed a side rail in place. Interview on 10/03/22 at 4:57 P.M. and on 10/04/22 at 8:42 A.M. with Unit Manager Licensed Practical Nurse (LPN) #120 stated she thought Resident #13 had a side rail due to his previous mattress. A side rail evaluation for Resident #13 was requested on 10/04/22 at 8:42 A.M. and 4:20 P.M., no evaluation was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, resident interview, observations, record review, and facility policy review, the facility failed to provide sufficient staff to meet resident needs. This had the potential to affect all 84 residents residing in the facility. Findings include: Review of the facility CMS-672 (census and condition information) form revealed the facility census as 84 residents. In the area of bathing, 61 residents required assistance of 1-2 staff members and 20 residents were completely dependent on staff for this task. 1. Review of the medical record for Resident #246 revealed an admitted [DATE]. Diagnoses included multiple fracture of the pelvis, cannabis use, fracture of the lumbar vertebra, fracture of a right rib, right kidney injury, schizophrenia, cerebral infarction, ventral hernia without obstruction, acute respiratory failure without hypoxia, and pedestrian on foot collision with automobile. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 10/01/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment). The resident required up to extensive assistance of one to two or more staff for all Activities of Daily Living (ADL's) except eating which he required set up and supervision. Review of the care plan dated 09/24/22 revealed the resident had an alteration in health maintenance related to unlisted reasons. Interventions included encouraging the resident to remain as independent as possible. Observation and interview on 09/26/22 at 3:07 P.M. revealed Resident #246' s call light was going off upon entry to the resident's room. The resident stated his call light had been on for about 10 minutes prior to the Surveyor's entrance. Resident #246 stated he wanted his abdominal wound dressing changed and he often had to wait long times for his call light to be answered. Observation on 09/26/22 at 3:21 P.M. revealed the resident's call light remained on. Observation on 09/26/22 at 3:40 P.M. revealed the resident's call light remained on. The call light was cleared after surveyor intervention by State tested Nurse Aide (STNA) #444 on 09/26/22 at 3:41 P.M. (34 minutes after the surveyor began watching the light). Interview on 09/26/22 at 3:46 P.M. with Registered Nurse (RN) #125 revealed she had just returned from lunch and was not sure how long his call light had been going off. Interviews on 10/04/22 at 10:56 A.M. with RN #145, 10/04/22 at 11:01 A.M. with RN #125, and STNA #108 confirmed residents often have to wait long amounts of time to have their call lights answered and care provided because of the facility being understaffed. Interviews on 10/04/22 at 1:29 P.M. with Resident #11 and Resident #234 confirmed residents often have to wait long times for their call lights to be answered and assisted with care. (continued on next page)

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	366094	A. Building B. Wing	10/13/2022

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Staffing revised 04/2007 revealed the facility maintained adequate staffing on each shift to ensure resident's needs and services were met. 2. Record review for Resident #68 revealed this resident was admitted to the facility on [DATE] and had diagnoses including acute respiratory failure with hypoxia, ileus, hypertension, type two diabetes mellitus, dysphagia, schizophrenia, muscle weakness, difficulty walking, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/22, revealed this resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 04. This resident was assessed to be dependent upon one staff member for bathing. Review of the care plan, dated 07/18/22, revealed this resident had an ADL self care performance deficit. Interventions included to provide extensive assistance to total assistance with showering two to three times a week and as necessary. Review of the facility provided shower schedule, not dated, revealed this resident was scheduled to receive a shower or bath every Wednesday and Sunday on night shift. Review of the facility Skin Monitoring: Comprehensive Shower Review sheets for 08/2022 and 09/2022, provided by the facility, revealed there were only sheets completed for Resident #68 on 09/07/22 and 09/21/22. Review of the State tested Nursing Assistant (STNA) documentation of bathing provided in the residents medical record for 08/2022 and 09/2022 revealed documentation bathing was completed for the resident on 08/03/22, 08/22/22, 09/09/22, 09/16/22, and 09/17/22. Review of the progress notes, dated 08/01/22 through 09/30/22, revealed no documentation of refusals of care or services including bathing. Observation of Resident #68 on 09/26/22 at 12:47 P.M. revealed the resident was observed lying in bed in a hospital gown. The residents hair was observed to appear greasy and uncombed. Interview with Resident #68 on 09/26/22 at 12:47 P.M. revealed the resident could not remember the last bath or shower received and stated she would like to have one because she felt dirty. Observation of Resident #68 on 09/27/22 at 12:32 P.M. revealed the resident was lying in bed in a hospital gown. The residents hair continued to appear greasy and uncombed. Observation of Resident #68 on 09/28/22 at 9:45 A.M. revealed the resident was lying in bed in a hospital gown. The residents hair continued to appear greasy and uncombed. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with Registered Nurse (RN) #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with RN #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the residents medical record. 3. Record review for Resident #59 revealed this resident was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, mitral valve prolapse, mild cognitive impairment, muscle weakness, unspecified dementia with behavioral disturbance, and hypertension. Review of the admission MDS assessment, dated 08/15/22, revealed this resident had moderately impaired cognition evidenced by a BIMS assessment score of 04. This resident was to be dependent upon one staff member for bathing. Review of the care plan, revised 09/27/22, revealed this resident had an ADL self-care deficit. Interventions included to provide extensive assistance by one staff member with bathing. Review of the facility provided shower schedule, not dated, revealed this resident was scheduled to receive a shower or bath every Wednesday and Sunday on day shift. Review of the facility Skin Monitoring: Comprehensive Shower Review sheets for 08/2022 and 09/2022, provided by the facility, revealed the only sheet completed for Resident #59 on 09/20/22. Review of the State tested Nursing Assistant (STNA) documentation of bathing provided in the residents medical record for 08/2022 and 09/2022 revealed there was no documented showers or baths completed for this resident. Review of the progress notes, dated 08/08/22 through 09/30/22, revealed no documentation of refusals of care or services including bathing. Observation on 09/26/22 at 3:45 P.M. revealed Resident #59 was sitting in the hallway in his wheelchair and was observed to have on a gray shirt and jacket. The resident had dried food debris on his face and was not clean shaven. The residents hair appeared greasy and was uncombed. Observation on 09/27/22 at 9:21 A.M. revealed Resident #59 was sitting in his wheelchair in the lobby sleeping. The resident still had the same gray shirt and jacket on from the day before, had dried food debris on his face, and was not clean shaven. The residents hair continued to appear greasy and be uncombed. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with RN #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with RN #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the residents medical record. 4. Record review for Resident #52 revealed this resident was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder, unspecified dementia with behavioral disturbance, adult failure to thrive, and depression. Review of the quarterly MDS assessment, dated 08/17/22, revealed this resident had mildly impaired cognition evidenced by a BIMS assessment score of 08. This resident was assessed to be dependent upon one staff member for bathing. Review of the care plan, revised 08/19/21, revealed this resident had an alteration in ADL performance. Interventions included to encourage resident participation while performing ADL's. Review of the facility provided shower schedule, not dated, revealed this resident was scheduled to receive a shower or bath every Monday and Thursday on day shift. Review of the facility Skin Monitoring: Comprehensive Shower Review sheets for 08/2022 and 09/2022, provided by the facility, revealed there had not been any sheets completed for this resident. Review of the State tested Nursing Assistant (STNA) documentation of bathing provided in the residents medical record for 08/2022 and 09/2022 revealed there was no documented showers or baths completed for this resident. Review of the progress notes, dated 08/08/22 through 09/30/22, revealed no documentation of refusals of care or services including bathing. Observation of Resident #52 on 09/26/22 at 12:15 P.M. revealed the resident was lying in bed in a hospital gown and to not be clean shaven. The residents hair appeared to be greasy and was uncombed. Observation on 09/27/22 at 9:16 A.M. revealed Resident #52 continued to lie in bed in a hospital gown and was not clean shaven. The residents hair continued to appear greasy and was uncombed. Observation on 10/03/22 at 11:00 A.M. revealed Resident #52 continued to lie in bed in a hospital gown and was not clean shaven. The residents hair continued to appear greasy and was uncombed. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with RN #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with RN #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the residents medical record. 5. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, Type two diabetes mellitus, persistent mood disorder, chronic pain syndrome, depression, dysphagia, hyperlipidemia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition. The resident was totally dependent on one person for physical assistance for bathing. Review of the plan of care dated 06/23/22 revealed Resident #13 had an activity of daily living self-care performance deficit related to debility and limited mobility. Interventions included preventative skin care as needed, weekly skin inspection, allowing time for rest breaks, and staff assistance as needed. Review of the facility provided shower schedule, not dated, revealed Resident #13 was to receive a shower or bath every Monday and Thursday on night shift. Review of the facility Skin Monitoring: Comprehensive Shower review sheets for August 2022 and September 2022 provided by the facility revealed there were no sheets for Resident #13. Review of the electronic medical record bathing documentation for August 2022 and September 2022 revealed Resident #13 had received a bath on 08/22/22, bathing was listed as not applicable on night shift on 08/21/22, 08/22/22, 08/27/22, and on 09/16/22. Interview on 09/26/22 at 12:45 P.M. with Resident #13 revealed he could not recall the last time he received a bed bath. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with Registered Nurse (RN) #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. Interview on 10/04/22 at 4:22 P.M. with Registered Nurse (RN) #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the resident's medical record. 6. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including hyperlipidemia, hypertension, blindness in right eye and low vision in left eye, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 had a severe cognitive impairment. She required supervision with one-person physical assistance for eating. Review of the plan of care dated 05/23/22 revealed Resident #28 had an alteration in activity of daily living (ADL) performance related to generalized weakness, decreased strength, endurance, and activity tolerance, unsteady gait, and poor safety awareness. Resident #28 required physical staff assistance with bed mobility, transfers, toileting, hygiene, and bathing. Interventions included encouraging resident participation, supervision with meals, encouraging resident to attend activities, staff to anticipate and assist as needed, and reporting declines in resident activities of daily living to physician. Review of the facility provided shower schedule, not dated, revealed Resident #28 was to receive a shower or bath every Wednesday and Sunday on night shift. Review of the Skin Monitoring: Comprehensive Shower review sheets for August 2022 and September 2022 provided by the facility revealed one shower sheet for Resident #28 dated 09/22/22 it stated 'she wants to take it later'. Review of the electronic medical record bathing documentation for August 2022 and September 2022 revealed it was documented on 08/26/22 that bathing was not applicable and on 09/22/22 a shower was completed. Observation on 09/26/22 at 12:43 P.M. of Resident #28 revealed her fingernails were observed to be long, curled at the end, and dirty. Observation 09/28/22 at 12:47 P.M. with State tested Nursing Aide (STNA) #108 revealed Resident #28's nails remained long and dirty, she was eating food with her hands. The observation was confirmed by STNA #108 at that time. Interview with STNA #201 on 10/03/22 at 2:40 P.M. revealed showers had not been completed for any residents during day shift due to there not being enough staff present to complete them. Interview with Registered Nurse (RN) #145 on 10/04/22 at 10:56 A.M. revealed staffing shortages resulted in resident care going undone. Interview with RN #125 on 10/04/22 at 11:01 A.M. revealed staffing shortages caused care such as showers to go undone. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/04/22 at 4:22 P.M. with Registered Nurse (RN) #165 confirmed all available shower documentation for August 2022 and September 2022 was provided. Review of the facility policy titled Shower/Tub Bath, revised 10/2010, revealed the date and time the shower/tub bath was performed, the name and title of the person completing the bath, and any refusal of the resident to take a bath should be recorded in the resident's medical record. 7. Review of the medical record for Resident #235 revealed an initial admitted [DATE] and a re-entry date of 09/13/22. Diagnoses included type 2 Diabetes without complications, asthma, gastro-esophageal reflux disease (GERD), atherosclerotic heart disease of native coronary artery without angina pectoris, old myocardial infarction, hypothyroidism, primary pulmonary hypertension, personal history of immunosuppression therapy, rheumatoid arthritis, thoracic aortic aneurysm, unsteadiness on feet, difficulty walking, muscle weakness, cognitive communication deficit, dysphagia, cerebral infarction, and COVID-19. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/27/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 13 out of 15 (no impairment). The resident required up to extensive assistance of one staff for all Activities of Daily Living (ADL's) except eating which she required set up help and supervision. She was able to physically help in part of bathing and required one staff's physical assistance with bathing. Review of the facility provided shower schedule dated 04/26/22 revealed Resident #235 was to be showered on Tuesday and Fridays during dayshift. Interview and observation on 09/26/22 at 1:20 P.M. with Resident #235 revealed the resident had greasy hair and her skin appeared shiny. She was observed in bed with yellow fluid on her gown and soiled tissues on her chest where she had attempted to clean the yellow fluid off of herself. The resident confirmed the yellow fluid was emesis. She also revealed staff did not care for her but would not provide specifics. Interviews on 10/04/22 at 10:56 A.M. Registered Nurse (RN) #145, 10/04/22 at 11:01 A.M. with RN #125, and 10/04/22 at 11:08 A.M. with State tested Nursing Assistant (STNA) #108 confirmed showers were often left uncompleted as a result of short staffing. Review of Resident #235's care plan dated 10/05/22 revealed no care plan regarding bathing. Review of the task titled, Bathing for a look back period of 30 days from 10/06/22 revealed only two documented bathes on 09/16/22 and 09/23/22. Review of the requested shower documentation, from the resident admitted to her discharge date , provided by the Administrator on 10/11/22 at 2:22 P.M. confirmed documentation for only two showers during the resident's admission on 09/16/22 and 09/23/22.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42728 Based on staff interview and review of facility policies, the facility failed to ensure the time frames for addressing pharmacy recommendations contained time frames for completion. This had the potential to affect all 84 residents residing in the facility who received medications from the facility. The facility census was 84. Findings include: Review of the facility policy titled Medication Regimen Reviews, not dated, revealed time frames for the physician to review pharmacy recommendations and time frames for the facility to implement the physicians changes were not included in the policy. Interview with Regional Director of Clinical Services #165 on 10/04/22 at 4:20 P.M. verified the facility policy for medication regimen reviews did not include time frames for the physician to review pharmacy recommendations or time frames for the facility to implement physician changes.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observation, record review, policy review, and staff interviews, the facility failed to ensure pharmacy recommendations were accurately reviewed by the physician, failed to ensure physician approved pharmacy recommendations were implemented, and failed to ensure medications were necessary. This affected three residents (#32, #51, and #59) out of the five residents reviewed for unnecessary medications during the annual survey. The facility census was 84. Findings include: 1. Record review for Resident #32 revealed this resident was admitted to the facility on [DATE] and had diagnoses including anxiety disorder, hyperlipidemia, hypertension, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/06/22, revealed this resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting and to be independent with setup help only for eating. Review of the active physicians order, dated 09/27/21, revealed an order to administer six milligrams of melatonin at bedtime for insomnia. Review of the pharmacy recommendation, dated 02/02/22, revealed the pharmacy recommended a dose reduction for the residents melatonin. The physician reviewed and signed the recommendation on 03/02/22 and ordered the melatonin to be changed from scheduled to as needed. Review of the pharmacy recommendation, dated 04/05/22, revealed the pharmacy recommended a dose reduction for the resident melatonin. The physician reviewed and signed the recommendation on 05/13/22 and ordered the melatonin dosage to be decreased from six milligrams to three milligrams. Interview with Regional Director of Clinical Services #165 on 10/04/22 at 4:20 P.M. verified the physicians orders, based upon pharmacy recommendations, had not been implemented by the facility. 2. Record review for Resident #59 revealed this resident was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, cognitive communication deficit, hyperlipidemia, unspecified dementia with behavioral disturbances, and depression. Review of the admission MDS assessment, dated 08/15/22, revealed this resident had moderately impaired cognition evidenced by a BIMS assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and transfers and to be dependent upon one staff member for toileting. Review of the active physicians order for this resident, dated 08/08/22, revealed an order to administer one 100 milligram capsule of Nitrofurantoin Macrocrystal (Macrodantin) one daily. The order did not specify an indication for usage. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy recommendation, dated 09/02/22, revealed the Certified Nurse Practitioner (CNP) had reviewed and signed the recommendation on 09/08/22 and had marked to disagree with the recommendation due to the medication not currently being ordered. Interview with Regional Director of Clinical Services #165 on 10/05/22 at 4:20 P.M. verified Resident #59 was ordered Macrodantin at the time the pharmacy recommendation was made and reviewed by the CNP and the documentation of not currently ordered was inaccurate. 44068 3. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included cerebral infarction, non-dominant, left side (L)hemiplegia and hemiparesis following a cerebral infarction (CVA), hypertension (HTN), heart disease, and dysphagia. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 08/17/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment) and no documented behaviors. The resident required limited to extensive assistance of one to two or more staff for all Activities of daily Living (ADL's). Review of the plan of care dated 08/15/22 revealed no care plan regarding behaviors. Review of the skilled nursing note dated 09/12/22 at 9:40 A.M., 09/13/22 at 10:42 A.M. and 11:10 P.M., 09/14/22 at 3:48 P.M. and 11:05 P.M., 09/16/22 at 11:21 P.M., 09/17/22 at 10:02 A.M. and 11:25 P.M., 09/19/22 at 10:36 A.M., 09/20/22 at 10:45 A.M. and 11:19 P.M., 09/21/22 at 10:49 A.M. and 11:57 P.M., and 09/22/22 at 11:13 P.M. revealed Resident #51's mood/affect was described as cooperative and/or pleasant and there were no documented behaviors. Observations on 09/26/22 at 12:45 P.M., 10/03/22 at 12:28 P.M., 10/04/22 at 3:05 P.M. and 10/04/22 at 3:15 P.M. of the resident, revealed no behaviors. Review of the task titled, Nursing Behavior Record (12) for 30 days prior to 10/05/22 revealed there was only documentation for three days out of the past 30 and all days the resident had no behaviors. Review of physician orders for October 2022 identified an order dated 08/17/22 for cimetidine 400 mg two times daily for hypersexuality. Review of the Electronic Medication Administration Record (EMAR) for August, September, and October 2022 revealed the resident was administered cimetidine twice a day for hypersexuality per orders with documented refusals at bedtime on 08/17/22 (first offered dose), 09/01/22, and 10/03/22. Review of the progress notes dated 08/16/22 by Certified Nurse Practitioner (CNP) signed 08/19/22 at 6:56 P.M. 08/23/22 signed on 08/26/22 at 11:25 A.M., 08/30/22 signed on 09/02/22 at 1:47 P.M., 09/06/22 signed on 09/09/22 at 11:56 P.M., 09/13/22 signed on 09/16/22 at 1:22 P.M. revealed the resident had no new mood changes or behavioral concerns noted. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note for 08/17/22 by Medical Director (MD) signed on 08/20/22 at 11:20 P.M. and revealed nursing staff had concerns for inappropriate, sexual, behavior with staff. Review of the progress note for 09/14/22 signed by the MD on 09/17/22 8:10 P.M. revealed no new mood changes or behavioral concerns noted. Interview on 10/04/22 at 2:17 P.M. with Unit Manager Licensed Practical Nurse (LPN) #120 confirmed the only documented behavior for the resident was on 08/17/22 when the nursing staff revealed concerns for inappropriate, sexual, behavior with staff. She confirmed she believed the inappropriate behavior occurred more than once but stated there was no further documented evidence outside of the provider note dated 08/17/22. Interview on 10/04/22 at 3:00 P.M. by Registered Nurse (RN) #145 revealed she had not seen any hypersexual behaviors from the resident but had heard from other employees that he had inappropriate behaviors. Review of the facility policy titled, Medication Utilization and Prescribing-Clinical Protocol revised 07/2016 revealed symptoms were to be characterized in sufficient detail (onset, duration, frequency, intensity, location, etc.) to help identify whether a problem exists or whether a symptom is just a variation of normal. Furthermore, a symptom (confusion, pain, etc.) may have diverse causes, so it is usually relevant to try to identify likely causes and pertinent non-pharmacological interventions.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review the facility failed to ensure Resident #55's 'as needed' psychotropic medication did not exceed 14 days and was used with appropriate monitoring. This affected one resident (#55) of five residents reviewed for unnecessary medication. The facility census was 84. Findings include: Review of the medical record for Resident #55 revealed an admitted [DATE] revealed an admitted chronic diastolic heart failure, type two diabetes mellitus, chronic kidney disease stage two, depression, unspecified dementia, dysphagia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 had severely impaired cognition. Review of the plan of care dated 05/13/22 revealed Resident #55 received a psychoactive medication. Interventions included giving medications as ordered, monitoring for effectiveness, observing and reporting any changes in mental status, and a resident specific behavior intervention. Review of the physician order dated 06/20/22 to 09/26/22 revealed Resident #55 had an order for Ativan tablet 0.5 milligrams (mg) one tablet by mouth every eight hours as needed for agitation. Review of the Medication Administration Record (MAR) for June, July, August, September 2022 revealed Resident #55 received 'as needed' Ativan on 06/20/22, 06/21/22, 06/30/22, 07/01/22, 07/03/22, 07/04/22, 07/05/22, twice on 07/07/22, 07/08/22, 07/11/22, twice on 07/13/22, 07/19/22, 07/20/22, 07/22/22, 07/23/22, twice on 07/27/22, 07/30/22, 08/03/22, 08/04/22, 08/13/22, 08/15/22, 08/16/22, 08/17/22, 08/19/22, 08/21/22, 08/23/22, 08/24/22, 08/25/22, twice on 08/28/22, 08/29/22, 08/30/22, 09/01/22, 09/02/22, 09/05/22, 09/06/22, 09/07/22, 09/09/22, 09/11/22, 09/12/22, 09/14/22, 09/15/22, 09/16/22, 09/17/22, twice on 09/18/22, 09/21/22, and 09/25/22. Review of the electronic MAR progress notes and nursing progress notes from 06/20/22 to 09/24/22 revealed behavior was only documented on 18 occasions, and non-pharmacological interventions were only documented on seven occasions. Interview on 10/04/22 at 11:36 A.M. with Unit Manager Licensed Practical Nurse (LPN) #120 confirmed non-pharmacological interventions and behaviors should be documented with medication administration. She also confirmed Resident #55's Ativan order exceeded 14 days.

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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** 07316 Based on medical record review and staff interview, the facility failed to ensure a resident was free from significant medication errors when medications ordered for treatment of cerebral infarction, anemia, kidney disease, hypertension were not given as ordered on days the resident went out for dialysis. This affected one of three residents (#14) reviewed for dialysis. The facility census was 88. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE] and a diagnosis of end stage renal disease. The resident had a physician's order for hemodialysis three times a week at an outside dialysis center. Review of physician's orders and medication administration records for January 2023 and February 2023 revealed orders for Aspirin daily at noon due to cerebral infarction, iron 325 milligrams daily at noon due to anemia, Lasix 80 milligrams daily at noon due to end stage kidney disease, miralax in the AM on Monday, Wednesday, Friday, and Sunday, and hydralazine, an antihypertensive medication at noon. Review of the medication administration records revealed the resident routinely did not receive these medications on dialysis days. The Aspirin not given on 01/13/23, 01/16/23, 01/18/23, 01/20/23, 01/23/23, 01/25/23, or 01/28/23. The Iron was not given on 01/13/23, 01/16/23, 01/18/23, 01/20/23, 01/23/23, 01/25/23, or 02/01/23. The Lasix was not given on 01/13/23, 01/16/23, 01/18/23, 01/20/23, 01/23/23, 01/25/23, or 02/01/23. The Miralax was not given on 01/13/23, 01/16/23, 01/18/23, 01/20/23, 01/23/23, 01/25/23, 02/01/23 or 02/03/23. The Hydralazine was not given on 01/13/23, 01/16/23, 01/18/23, 01/20/23, 01/23/23, 01/25/23, 01/28/23, or 02/01/23. Interview with the Director of Nursing on 02/06/23 at 2:00 P.M. confirmed the medications were not given and stated they should not be scheduled during times the resident was at dialysis when the medications could not be given.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, resident interview, observations, medical record review, and facility policy review, the facility failed to keep medications in locked containers and the facility failed to ensure prescription creams and ointments were not expired. This affected two residents (Resident #235 and #243). The facility census was 84. Findings include: 1. Review of the medical record for Resident #235 revealed an initial admitted [DATE] and a re-entry date of [DATE]. Diagnoses included type 2 Diabetes without complications, asthma, gastro-esophageal reflux disease (GERD), atherosclerotic heart disease of native coronary artery without angina pectoris, old myocardial infarction, hypothyroidism, primary pulmonary hypertension, personal history of immunosuppression therapy, rheumatoid arthritis, thoracic aortic aneurysm, unsteadiness on feet, difficulty walking, muscle weakness, cognitive communication deficit, dysphagia, cerebral infarction, and COVID-19. Review of the comprehensive Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 13 out of 15 (no impairment). The resident required up to extensive assistance of one staff for all Activities of daily Living (ADL's) except eating which she required set up and supervision. Review of physician orders for [DATE] identified an order dated [DATE] for two sprays of fluticasone Propionate Suspension 50 mcg/act in both nostrils every morning for nasal congestion. Observation and interview on [DATE] at 1:20 P.M. with Resident #235 revealed two bottles of medication on her chest and on her over the bed table. State tested Nurse Aide (STNA) #139 confirmed the resident had two bottles of medication on her bedside table but stated she was only an aide and did not know what the medications were. The resident stated the medications were her Flonase and the STNA did not dispute the resident. A request was made on [DATE] at 11:21 A.M. to Regional Registered Nurse (RN) #165, Unit Manager LPN #120, and the Administrator via email with no success in obtaining the residents self-medication administration assessment. 2. Review of the medical record for Resident #243 revealed an admitted [DATE]. Diagnoses included post-procedural partial intestinal obstruction, severe protein-calorie malnutrition, post-gastric surgery syndromes, myxedema coma, hypothyroidism, autoimmune thyroiditis, multiple myeloma in remission, anemia, sleep apnea, glaucoma, and vitamin deficiency. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive Minimum Data Set (MDS) assessment, dated [DATE], revealed the assessment was in progress. Further review of the assessment revealed the resident had impaired cognition with a Brief Interview of Mental Status (BIMS) score of 12 out of 15 (moderate impairment). The resident's functional status had not been assessed. Further review of the MDS confirmed the resident complained of difficulty swallowing and she had a feeding tube. Review of the plan of care dated [DATE] revealed the resident was at risk for malnutrition/dehydration related to severe protein calorie malnutrition, hypothyroidism, anemia, multiple myeloma, vitamin D deficiency, status post gastric bypass in 2021, anastomotic stricture, dumping syndrome, anastomotic ulcers, electrolyte abnormalities, chronic diarrhea, hypokalemia, [NAME] Tube/Nasal Gastric (DHT/NG) placement on [DATE], poor by mouth (PO) intake/weight loss, therapeutic tube feed (TF) formula, absorption issues, and weight fluctuations. Interventions included medications as ordered, weights as ordered, and dysphagia guidelines as ordered. Review of physician orders for [DATE] identified an order dated [DATE] for Vitamin A Capsule three milligram (MG) (10000 Units (UT)) one capsule via nasal-gastric (NG) tube in the afternoon for supplement. Interview and observation on [DATE] at 2:26 P.M. with Resident #243 revealed a clear, yellow, medication capsule, in a medication cup on the bedside table of the resident. There were no staff present. The resident confirmed her Vitamin A was left in the cup for her to take by mouth (PO) when she was ready. Interview and observation on [DATE] at 3:42 P.M. with Registered Nurse (RN) #125 confirmed the vitamin A at the resident's bedside. The RN confirmed the medication was left on the resident's bedside per the resident's request to take it PO instead of per her nasal gastric (NG) tube. The RN confirmed medications were not to be left at bedside and were to be stored in a locked container when not being monitored. Review of the facility policy titled, Storage of Medications revised ,d+[DATE] revealed the nursing staff was responsible for maintaining medication storage and compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 42728 3. Observation on [DATE] at 11:45 A.M. revealed the treatment cart located outside of room [ROOM NUMBER] was observed to be unlocked and had a bottle of povidone iodine solution sitting on top of it. There were no staff members observed in the hallway the treatment cart was located on. Inside the unlocked treatment cart was an bottle of Nystatin 100,000 unit per gram powder which had been opened and did not have a label containing a residents name, expiration date, or date opened. There was also a container of Dermaphor Ointment which had been opened and labeled with a dispensed date of [DATE] and a discard by date of [DATE]. Observation and interview with the Assistant Director of Nursing on [DATE] at 11:55 A.M. verified the observations. The Assistant Director of Nursing then placed the bottle of povidone iodine solution inside the treatment cart and locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Storage of Medications, revised ,d+[DATE], revealed the facility should not use discontinued, outdated, or deteriorated drugs or biological's and all such drugs should be returned to the pharmacy or destroyed. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44068 Based on staff interview, resident interview, medical record review, and facility policy review, the facility failed to failed to ensure resident medical records contained complete and accurate information. This affected four of 29 residents reviewed (Residents #14, #32, #237, and #246). The facility census was 84. Findings include: 1. Review of the medical record for Resident #237 revealed an admitted [DATE]. Diagnoses included acute embolism and thrombosis of unspecified deep veins of the right lower extremity, atherosclerotic heart disease, syncope and collapse, idiopathic gout, hypertension (HTN), arthritis, sickle-cell trait, peripheral vascular disease (PVD), chronic kidney disease (CKD), alcohol dependence, tobacco use, hyperlipidemia, obstructive sleep apnea (OSA), hematemesis, and nausea. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 09/22/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment). The resident required supervision and set up for all Activities of daily Living (ADL's). Further review of his MDS revealed he received opioid medication. Review of the care plan dated 10/05/22 revealed the resident was at risk for an alteration in comfort related to PVD, gout, and arthritis. The interventions included medications as ordered to manage pain. Review of physician orders for October 2022 identified an order dated 09/20/22 for two oxycodone five milligram (mg) tablets one time only for pain rated six through 10. The order was discontinued after the dose was provided on 09/20/22. A new order was placed on 09/21/22 for two oxycodone give five mg tablets for pain rated five through six every four hours as needed. The order was discontinued on 09/21/22 and a new order was placed on 09/21/22 for oxycodone 10 mg every four hours as needed for pain rated six through 10. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Electronic Medication Administration Record (EMAR) for September 2022 revealed the resident was provided no doses of oxycodone on 09/10/22. However, according to the Controlled Drug Receipt/Record/Disposition Form dated 09/10/22 revealed a dose of the resident's oxycodone was signed out on 09/10/22 at 11:00 P.M. The EMAR revealed the resident received his pain medication three times on 09/11/22 but the Controlled Drug Receipt/Record/Disposition Form revealed five doses of the resident's oxycodone was signed out. Further review of the EMAR revealed the resident received two doses of oxycodone on 09/16/22 but the Controlled Drug Receipt/Record/Disposition Form revealed four doses were signed out on 09/16/22. The EMAR revealed the resident received one dose of his oxycodone on 09/18/22 but the Controlled Drug Receipt/Record/Disposition Form revealed there were three doses of oxycodone signed out on 09/18/22. On 09/19/22 the EMAR revealed the resident received four doses of his oxycodone while the Controlled Drug Receipt/Record/Disposition Form revealed only three doses were signed out on 09/19/22. The EMAR on 09/20/22 revealed the resident received one dose of oxycodone while the Controlled Drug Receipt/Record/Disposition Form did not have any oxycodone signed out on 09/20/22. The EMAR revealed three doses oxycodone was administered to the resident on 09/21/22 but the Controlled Drug Receipt/Record/Disposition Form revealed four doses of the oxycodone was signed out on 09/21/22. There were two documented oxycodone administrations to the resident on 09/24/22 on the EMAR while the Controlled Drug Receipt/Record/Disposition Form revealed three were signed out on 09/24/22. There were no documented oxycodone administrations to the resident on 09/25/22 on the EMAR while the Controlled Drug Receipt/Record/Disposition Form revealed three doses were signed out on 09/25/22. There were two documented oxycodone administrations to the resident on 09/27/22 on the EMAR while the Controlled Drug Receipt/Record/Disposition Form revealed four doses were signed out on 09/27/22. There were two documented oxycodone administrations to the resident on 09/28/22 on the EMAR while the Controlled Drug Receipt/Record/Disposition Form revealed three doses were signed out on 09/28/22. There were no documented oxycodone administrations to the resident on 09/29/22 on the EMAR while the Controlled Drug Receipt/Record/Disposition Form revealed three doses were signed out on 09/27/22. There were two documented oxycodone administrations to the resident on 09/30/22 on the EMAR while the Controlled Drug Receipt/Record/Disposition Form revealed three doses were signed out on 09/30/22. Review of the Electronic Medication Administration Record (EMAR) for October 2022 revealed the resident was administered his ordered oxycodone one time on 10/02/22 but the Controlled Drug Receipt/Record/Disposition Form revealed the resident was administered two times on 10/02/22. Further review of the Controlled Drug Receipt/Record/Disposition Form dated 09/20/22 revealed prior to the first dose of oxycodone being administered on 10/02/22 there were two tablets remaining. Nursing staff signed out one of the two tablets on 10/02/22 on the Controlled Drug Receipt/Record/Disposition Form but wrote zero for remaining doses and no further medication was signed out on the Controlled Drug Receipt/Record/Disposition Form dated 09/20/22. The second dose of oxycodone was signed out on a new Controlled Drug Receipt/Record/Disposition Form dated 10/02/22 at 9:30 P.M. Review of the progress note dated 10/02/22 at 12:28 A.M. by Licensed Practical Nurse (LPN) #1111 revealed the resident requested pain medication but none was available for the resident. LPN #1111 reviewed the Controlled Drug form to discover the oxycodone count was incorrect. The form revealed the resident had two pills available and one should have been given to have a remaining one pill but there were zero remaining doses/tablets. The supervisor was informed of the situation, pharmacy was called but the facility revealed it was too early for a refill of the medication. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/03/22 at 1:28 P.M. with Resident #237 revealed on 10/01/22 his last remaining oxycodone tablet went missing from the medication cart. He stated he informed the Supervising nurse on 10/01/22 but he could not recall her name and was informed that an investigation would be conducted. Review of the Controlled Drug forms and packing slips dated 09/10/22, 09/14/22, 09/20/22, and 10/02/22 for Resident #237's oxycodone revealed he received a quantity of 30 each time and on 9/30/22 had 2 left, one administered on 10/2/22 but remainder was zero so one was missing. Interview on 10/03/22 at 5:06 P.M. with Unit Manager LPN #120 confirmed a missing dose of oxycodone from 09/30/22 to 10/02/22 when one tablet was documented as administered and the remaining doses went from two to zero. She stated she was looking into it since it was brought to her attention by the Surveyor. Review of the progress note date 10/03/22 at 6:11 P.M. by Unit Manager LPN #120 revealed Resident #237's narcotic sheet was reviewed with the nurse who worked 10/01/22 on Lavender hall. The nurse confirmed she administered two doses of 10 milligrams (mg) of oxycodone instead of his prescribed order of one tablet. Furthermore, the nurse stated the resident had an order for one to two tablets of five mg oxycodone. The Certified Nurse Practitioner (CNP) and Resident #237 was notified of the discrepancy. No new orders were received, and no residual effects noted from the medication error. Interview on 10/04/22 at 9:18 A.M. with Regional Clinical Director #165 and Unit Manager LPN #120 revealed they spoke with the Nurse #222 who signed out the last dose of the resident's Oxycodone and she admitted to giving the resident two tablets instead of the ordered one tablet, so it was a medication error, and a medication error investigation was completed. Interview on 10/04/22 at 9:48 A.M. with Nurse #222 (the assigned nurse who documented one tablet of oxycodone provided and the count went from two to one) revealed she administered two tablets of Oxycodone ten mg to the resident on 10/02/22 per the resident's request despite the order being for one tablet. She stated she must have documented one tablet was administered on the sign out sheet by mistake. 2. Review of the medical record for Resident #246 revealed an admitted [DATE]. Diagnoses included multiple fracture of the pelvis, cannabis use, fracture of the lumbar vertebra, fracture of a right rib, right kidney injury, schizophrenia, cerebral infarction, ventral hernia without obstruction, acute respiratory failure without hypoxia, and pedestrian on foot collision with automobile. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 10/01/22, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment). The resident required up to extensive assistance of one to two or more staff for all Activities of daily Living (ADL's) except eating which he required set up and supervision. Further review of the MDS confirmed the resident had a known surgical wound that he received surgical wound care for and application of non-surgical dressings. Further review of the MDS confirmed the resident received Opioid medication three of the previous seven days prior to the completion of the MDS. Review of the After Visit Summary for 08/24/22 through 09/24/22 revealed the resident's wound vacuum (vac) to his abdomen was removed for transport to the facility but was to be replaced. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366094	A. Building B. Wing	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Gahanna	167 North Stygler Road Gahanna, OH 43230

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 09/24/22 revealed the resident was at risk for an alteration in comfort with no listed reasoning. Interventions included medications to manage pain per orders. Review of the physician orders dated 09/24/22 revealed orders to give 0.5 tablet of Morphine Sulfate 15 mg by mouth every six hours as needed for moderate to severe pain. There was a second order placed on the same date for one tablet of Morphine Sulfate 15 mg by mouth every six hours as needed for moderate to severe pain. Review of the narcotic sheet and pharmacy packing slip dated 09/24/22 revealed no signature for last dose of morphine on 10/02/22 for Resident #246, quantity was 6 but crossed out to say 5. Review of the Proof of Delivery revealed the resident's wound vac was delivered on 09/27/22 at 9:32 A.M. but review of the progress note dated 09/28/22 at 5:15 P.M. by LPN #136 revealed the resident wound vac was placed, over 24 hours after receiving the wound vac, by the RN on duty. Interview on 10/04/22 at 2:17 P.M. with Unit Manager LPN #120 confirmed the resident's wound vac was delivered on 09/27/22 at 9:32 A.M. and she was not sure how nursing staff was documenting the application of the wound vac prior to it being delivered or how multiple different dressings were being documented as completed at the same time. Review of the physician orders revealed an order for a wound vac dressing was placed 09/24/22, and an order for a wet to dry dressing was initiated 09/25/22 until the wound vac arrived. Review of the ETAR for September and October 2022 revealed the wet to dry treatment order was signed off per orders beginning on 09/25/22. Further review of the September 2022 ETAR revealed the order for the wound vac was signed off 09/26/22 (before the wound vac delivery). Review of the progress note dated 09/28/22 at 5:15 P.M. by LPN #136 revealed the resident's wound vac dressing was done by the RN on duty. Review of the progress note dated 09/28/22 at 9:29 P.M. revealed the resident requested the wound vac to be turned off due to discomfort and despite education. The provider was notified. Review of the progress note dated 9/28/22 at 11:30 P.M. revealed the resident continued to complain about the wound vac so it was removed, and a dressing was applied until the resident could be evaluated by the CNP. Review of the wound progress note by the Certified Nurse Practitioner (CNP) dated 09/29/22 at 6:02 P.M. revealed the resident declined the wound vac in the facility and the wounds were superficial and were to be cleaned, patted dry, and a clean and dry dressing was to be applied daily and as needed. Review of the September 2022 ETAR revealed the order for the wound vac was signed off as completed on 09/30/22 in addition to the wet to dry dressing. Interview on 10/04/22 at 9:18 A.M. with Regional Clinical Director #165 and Unit Manager LPN #120 confirmed inaccurate documentation regarding Resident #246's Oxycodone and wound vac/wound dressings. Review of the facility policy titled, Charting and Documentation revised 07/2017 revealed documentation in the medical record was to be objective (not opinionated or speculative), complete, and accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42728 3. Record review for Resident #32 revealed this resident was admitted to the facility on [DATE] and had diagnoses including unspecified protein-calorie malnutrition, anxiety disorder, edema, urinary incontinence, hypertension, overactive bladder, and major depressive disorder. Review of the quarterly MDS assessment, dated 07/06/22, revealed this resident had moderately impaired cognition evidenced by a BIMS assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting and to be independent with setup help only for eating. This resident was assessed to not have received hospice services during the review period. Review of the active physicians order, dated 09/30/21, revealed this resident was admitted to Hospice Service #1. Review of the active physicians order, dated 07/19/22, revealed an order to consult Hospice Service #2 for evaluation and start of care. Review of the progress note, dated 07/19/22, revealed the residents representative came to the facility and requested the resident be discontinued from receiving services from Hospice Service #1. Facility staff spoke with a representative from Hospice Service #1 and the resident services were discontinued as of the same day. A referral was to be sent to Hospice Service #2. Interview with Licensed Practical Nurse (LPN) #120 on 10/04/22 at 4:20 P.M. verified Resident #32 was discontinued from Hospice Service #1 on 07/19/22 and the order for the hospice service should have been discontinued. 43064 4. Review of the medical record revealed Resident #14 admitted on [DATE] with diagnoses including type two diabetes mellitus, hypertension, end stage renal disease with dependence on renal dialysis, cerebral infarction, cognitive communication deficit, gastro-esophageal reflux disease, hypothyroidism, pain in left knee, and insomnia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had intact cognition and received dialysis. Review of Resident #14's physician's orders dated 05/05/22 revealed orders for Oxycodone five milligrams two tablets by mouth every four hours as needed for severe pain rated eight to ten and one tablet by mouth every four hours as needed for moderate pain rated four to seven. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the controlled drug receipt record and disposition forms from 09/01/22 to 09/28/22 revealed oxycodone five milligrams was pulled for Resident #14 on 09/01/22 at 8:00 P.M., 09/02/22 at 8:00 P.M., 09/03/22 at 9:00 A.M. at 8:00 P.M., 09/04/22 at 11:00 A.M. and 8:00 P.M., 09/05/22 at 8:00 P.M., 09/09/22 at 8:00 P.M., 09/10/22 at 6:00 A.M., and 10:00 P.M., 09/11/22 at 10:00 P.M., 09/12/22 at 9:30 P.M., 09/13/22 at 8:00 P.M., 09/14/22 at 9:00 P.M., 09/15/22, at 9:00 P.M., 09/16/22 at 8:00 P.M., 09/17/22 at 9:00 P.M., 09/18/22 at 10:00 P.M., 09/19/22 at 10:00 P.M., 09/20/22 at 9:00 P.M., 09/21/22 at 8:00 P.M., 09/22/22 at 8:00 P.M., 09/23/22 at 8:50 P.M., 09/27/22 at 5:30 A.M., 12:30 P.M., and 10:00 P.M., and on 09/28/22 at 3:00 P.M., and 10:00 P.M. Review of the Medication Administration Record (MAR) for September 2022 revealed Resident #14 was documented has having been administered oxycodone five milligrams on 09/01/22, 09/02/22, twice on 09/03/22, 09/05/22, 09/09/22, 09/12/22, 09/13/22, 09/15/22, 09/16/22, 09/19/22, 09/21/22, and three times on 09/27/22. Resident #14 was not documented has having been administered oxycodone five milligrams on 09/04/22, 09/10/22, 09/11/22, 09/14/22, 09/17/22, 09/18/22, 09/20/22, 09/22/22, 09/23/22, and 09/28/22. Interview on 09/29/22 at 2:08 P.M. with Registered Nurse (RN) #165 revealed the facility had identified documentation concerns. RN #165 reported the narcotics were administered when it was documented they were pulled, however, the nursing staff did not accurately reflect this in the MAR.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, staff and resident interviews, and record reviews, the facility failed to ensure resident call lights were in good working order. This affected one resident (#68) out of the four residents reviewed for call lights during the annual survey. The facility census was 84. Findings include: Record review for Resident #68 revealed this resident was admitted to the facility on [DATE] and had diagnoses including acute respiratory failure with hypoxia, ileus, hypertension, type two diabetes mellitus, dysphagia, schizophrenia, muscle weakness, difficulty walking, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/27/22, revealed this resident had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 04. This resident was assessed to require extensive assistance from one staff member for bed mobility and toileting, extensive assistance from two staff members for transfers, and supervision with setup help only for eating. Observation on 09/26/22 at 12:47 P.M. revealed the call light attached to Resident #68's hospital gown was missing the red button used to activate the call light to request staff assistance. Interview with Resident #68 at the time of the observation revealed the call light button had been missing for approximately one week. Observation and interview with Maintenance Director #148 on 09/26/22 at 2:40 P.M. verified the call light for Resident #68 was missing the red button used to activity the call light and was not in good, functional order.