STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	02/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 26706 Based on resident funds review, interview, and policy review, the facility failed to adequately notify resident and/or representative to assure they received spend-down notifications and reimburse overage due to the possibility of lost Medicaid eligibility for reaching and exceeding the maximum resource limit. This affected one of two current residents reviewed for facility-managed funds (#19) spend-down notice. The facility managed 18 resident accounts. The total resident census was 39. Findings include: Resident funds review revealed Resident #19 had $3268.39 in their personal funds account as of 02/09/23. Review of the quarterly statements since June 2022 revealed the account had been over the Medicaid limit since 06/03/22 when the account had $3154.76, ($954.76 over the funds limit allowed taking into account the grace period for government stimulus check). Review of the account revealed the balance had not dropped below the $2200.00 limit since 06/03/22. Review of the quarterly statements revealed they were signed by the resident's representative. A spend-down letter dated 07/18/22 addressed to Resident #19 informed the resident their balance was within $200.00 or exceeding what was allowable under Medical Assistance. The letter directed Resident #19 to contact the Social Worker within the next seven days to discuss ways to assure continuance of Medicaid benefits. Review of the facility Resident Personal Funds policy (revised 09/2017) included Notice of Balance Medicaid recipients are subject to strict resource limits to remain eligible for the Medicaid program. Therefore, the facility will notify each resident that receives Medicaid when the amount in the resident's account reaches $200.00 less than the Medicaid resources limit to ensure no loss of eligibility. Interview on 02/21/23 at 5:26 P.M. with the Business Office Manager (BOM) #233 revealed she spoke to the resident's representative prior to sending the July 2022 notice. On 07/19/22, $922.00 was spent on clothing for Resident #19. The account was brought down to $2655.51 with this expenditure, however still remained over the allowed limit. BOM #233 had no further contact with the representative to inform her Resident #19's account was still over the allowed limit. On 02/14/23, a spend-down letter was sent with the same verbiage as the 07/18/22 letter. The account remained over the $2200.00 limit from 06/03/22 through current.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on record review, staff interview and policy review the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) form to Resident #28 when the resident was cut from skilled nursing services and remained in the facility. This affected one resident (#28) of three residents reviewed for cut letters. The census was 39. Findings include: Review of Resident #28's medical record revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, diabetes, and schizoaffective disorder. The resident/resident representative was notified on 02/01/23 that skilled services would end on 02/03/23. There was no appeal of the notice and Resident #28 remained in the facility to current date for long term care. There was no evidence the facility provided a SNFABN as required to allow the resident to choose to continue the services when the resident was discharged from skilled care. On 02/16/23 at 5:18 P.M. interview with Social Service Designee (SSD) #209 verified the resident was cut from skilled services, remained in the facility and was not provided an SNFABN as required. Review of the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) And Advanced Beneficiary Notice (ABN) Standards of Practice Policy and Procedure dated 04/01/18 revealed the SNFABN provides information to the beneficiary so that he or she can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of a self reporting incident (SRI), resident interview, staff interview and policy review, the facility failed to ensure a resident's concerns/ grievance was resolved timely by the facility. This affected one (#26) of two residents reviewed for personal property. Findings include: A review of Resident #26's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included morbid obesity due to excess calories, muscle wasting and atrophy, muscle weakness, and difficulty walking. A review of Resident #26's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. No behaviors was noted during the seven day assessment period. A review of Resident #26's care plans revealed he did not have any care plans in place that indicated he was known to have any behaviors or make false accusations. A review of Resident #26's progress notes revealed a nurse's note dated 09/04/22 at 12:00 P.M. by the Director of Nursing (DON) that indicated the resident reported he noticed his CVS gift card and 20 dollars were missing from his wallet. The last time he saw it was prior to his recent hospitalization . He gave permission for them to check his room in case it was misplaced. The items were not able to be found. A nurse's note dated 09/13/22 revealed Resident #26 was offered a lock box with a key for his valuables. It did not indicate the resident was reimbursed for the amount he had reported was lost. No additional progress notes were noted that pertained to any further follow up of his reports of missing money/ gift card. A review of the facility's missing item log for the past six months revealed there were only two entries of missing items during the past six months. One of the two entries pertained to Resident #26's reports of missing money and gift card. The entry was made on 09/08/22. A review of a quick response report dated 09/04/22 for an incident occurring at 12:00 P.M. revealed the staff handed Resident #26 his wallet so he could get money out for his lunch. He wanted to order Chinese for his lunch. There was a 20 dollar bill and a CVS gift card worth 50 dollars that was missing from his wallet. He kept his wallet in a plastic bowl along with other items on his bedside stand. The last time he saw the gift card was the weekend of 08/06/22. That was the weekend before he went out to the hospital. He was taken to the hospital for cellulitis on 08/11/22 and returned to the facility on [DATE]. Permission was given to the staff to check his room to make sure the items were not misplaced. No cash or gift card was able to be found. The outcome of the incident was that the resident's money would be reimbursed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of SRI #226546 dated 09/09/22 revealed an allegation of misappropriation with the date of discovery of 09/04/22 was made. The initial source of the allegation was from a resident/ victim. The alleged perpetrator was unknown. A brief description of the allegation indicated the resident reported he lost 20 dollars and a gift card. Resident #26 was indicated to have been able to provide meaningful information when interviewed. A narrative summary of the incident revealed the date/ time/ location of the occurrence was 09/04/22 at 12:00 P.M. in the resident's room. The resident and staff were interviewed for any knowledge of the situation or additional missing items. No additional information was identified. The resident stated he hadn't seen his money since he went to the hospital on 08/11/22. He returned on 08/18/22 and he just then opened his wallet on 09/04/22. The resident had been ordering food to be delivered on almost a daily basis because he had money available. Recently, he no longer had money available and it was unusual for him not to order food. It was thought to be unlikely that he went two weeks before he opened his wallet or ordered take out food. In the past, he had also been known to try to sell his gift card because he was unable to use the gift card in that rural area. The facility unsubstantiated the allegation of misappropriation as the evidence was inconclusive and misappropriation was not suspected. As a result of the investigation, the facility provided the resident a locked box. Staff were educated on the abuse policy and the DON was educated to save and submit when submitting an SRI. The facility denied Resident #26 had a personal funds account with them and did not have any way to track his transactions made pertaining to any money he may have had. They did not have a way to track what money he received or what money he spent on ordering food from outside sources. On 02/14/23 at 10:53 A.M., an interview with Resident #26 revealed he did have a 20 dollar bill and a 50 dollar gift card that came up missing from his wallet when he was out to the hospital. He thought the money was missing around September or October of 2022. He reported it missing to staff and indicated the facility's DON filled out the report. He denied he received any follow up on his reports of missing money and was not reimbursed for the money or the value of the gift card that went missing. On 02/14/23 at 4:50 P.M., an interview with the DON confirmed Resident #26 did report a gift card and 20 dollars missing. She stated he reported the items missing upon return from a hospitalization . She confirmed they did give him a lock box to keep in his room for safekeeping of any valuables. She was asked if the resident was reimbursed for the reported missing items. She stated they were not able to show he had those items prior to reporting them missing, therefore they were not reimbursed. On 02/15/23 at 10:10 A.M., a follow up interview with the DON and the Administrator revealed Resident #26 was reimbursed for the value of the missing CVS gift card and the 20 dollars. They were unable to find evidence of where that money had been pulled from to reimburse the resident. They checked with the business office manager, who indicated without the resident having funds with the business office, they would not have pulled any cash from their petty cash fund to give to the resident. The Administrator indicated they had another petty cash fund in which that money was pulled from, but they did not have documentation to prove that. She denied there was any type of paper trail that showed the resident was given 70 dollars (value of gift card and the 20 dollar bill) after he reported them missing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/15/23 at 10:15 A.M., a follow up interview with Resident #26 revealed the resident was adamant he was not reimbursed for the amounts of his gift card and the 20 dollars (70 dollars total) as indicated by the facility. He stated he received the 50 dollar gift card at CVS from his MCD insurance and the 20 dollars was sent to him by his sister. A review of the facility's policy on Missing Items (undated) revealed the facility strived to reasonably safeguard the personal belongings of the residents. The policy indicated when a resident reported an item missing, that staff member was to notify the social service coordinator or the DON/ Administrator in their absence. Social services would then interview the resident regarding the missing item and would complete the missing item report. A thorough investigation would be conducted by the social service coordinator, the appropriate department supervisor, and the Administrator. The outcome would be documented on the missing item report form. The social service coordinator would notify the responsible party and/ or family members of the outcome of the investigation. The Administrator would review each case and determine the need to replace missing items, as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure Resident #7 was free from abuse when Resident #29, a resident with a known history of aggressive behaviors and homicidal ideations abused the resident. This affected one resident (#7) of two residents reviewed for abuse. Actual physical and psychosocial harm occurred, applying the reasonable person concept, on 11/05/22 to Resident #7, a resident with impaired cognition, when Resident #29 struck Resident #7 multiple times in the face, was found with a choke hold around the resident's throat and threatened to kill the resident. Findings include: A review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia with behavioral disturbances, unspecified psychosis, and senile degeneration of the brain. A review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had clear speech and adequate hearing. She was usually able to make herself understood and was able to understand others. Her cognition was severely impaired and she was not known to have any behaviors during the seven day assessment period. A review of Resident #7's care plans revealed she had a care plan in place for mood and behaviors related to her cognitive decline, restlessness and agitation. She was known to become anxious at meal time and would yell out to be served. Interventions included attempting to identify what triggered her behaviors. They were to introduce the resident to other residents on unit of similar status and compatibility. They were also to observe and report any changes in her mental status, provide one on one sessions with the resident as needed, and to refer her to counseling/psychiatry as needed. A review of Resident #7's progress notes revealed a nurse's note dated 11/05/22 at 12:00 P.M. that indicated a staff member witnessed another male resident (Resident #29) become physically aggressive with the resident putting her in a choke hold. The male resident verbalized he was going to kill the resident. The two residents were immediately separated to ensure safety. Resident #7 was assessed for injury with none being noted. She later was not able to respond to questions asked regarding the previous incident. The facility staff reinforced to the resident that they would not let that happen again and she was safe. She smiled with no response or complaints voiced. A review of Resident #29's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included post traumatic stress disorder (PTSD), pre-excitation syndrome, bipolar disorder, and homicidal ideations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #29's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues. His cognition was moderately impaired. No behaviors were indicated to have been noted during the seven days of the assessment period. He required an extensive assist of two for transfers and required supervision with one person physical assist for locomotion on and off the unit. A wheelchair was used as a mobility device. A review of Resident #29's progress notes revealed he had active care plans in place for being at risk for alteration in mood/ behavior. He was known to have hit a staff member at a prior facility. He had a history of assaulting care givers. His care plan was updated on 10/27/22 to reflect he was known to be yelling at other peers that have impaired cognition. The care plan was updated again on 11/06/22 that indicated he was at risk for physical behaviors due to a history of behaviors. The interventions included monitoring his mood/ behavior, remove him from areas of escalation, and one on one to monitor behaviors. He had a care plan for the use of antipsychotic medications related to depression, bipolar, PTSD, outburst of frustration, mumbles/ [NAME] to self and yelling out at others. The interventions for that care plan included administering medications as ordered. A review of Resident #29's progress notes revealed he was documented as having behaviors in the facility beginning on 10/22/22. The staff heard a verbal altercation coming from the activity room and upon entering witnessed the resident agitated drawing back his right closed fist while threatening a female resident. He continued to yell and get closer to the female resident before being separated by staff and redirected. A nurse's note dated 10/27/22 revealed Resident #29 was heard yelling at a female resident for coming into his room. He was calling the female resident names and was threatening to hit her if she did not leave his room. He was given an order for Haldol (an antipsychotic) 0.5 milligrams (mg) by mouth three times a day and Ativan 1 mg three times a day by mouth as needed. A nurse's note dated 10/31/22 revealed Resident #29 was noted with behavioral outbursts in the activity room related to staff and other residents talking to one another. The resident screamed out, used foul language because he stated they should all shut the f*** up so he could hear the community TV rather than watching the one in his room. A nurse's note dated 11/04/22 revealed Resident #29 was noted to be very agitated yelling and cursing, threatening another resident with physical harm. Multiple staff attempted to decrease the resident's agitation, but he stated he didn't care he will kill him as he pounded his fist in his hand. He attempted to wheel himself towards the other resident, but was taken to the social service office to cool down. He was educated on not making threats towards other residents and that it was not acceptable. They also informed him, if he made physical contact with others, that would result in the police being called. The Director of Nursing (DON) informed him, if he wanted to stay in the facility to receive the care he needed to be able to return home, the aggressive behavior needed to cease. He stated understanding but continued to make verbal threats to kill anyone who messed with him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 11/05/22 revealed Resident #29 became agitated towards another female resident due to the other resident repeatedly yelling. He became physically aggressive placing her in a choke hold. Staff immediately intervened and removed Resident #29 placing him in the common area for his meal so he could be monitored. He was sent to the emergency room for an evaluation but was sent back three hours after he was sent with no new orders. He was sent back to the hospital for further evaluation at the direction of the resident's psychiatrist's nurse practitioner. Information was sent to the crisis team at the hospital and the facility shared their concerns with the safety of other residents. He returned the following day. He was transported to another hospital on 11/06/22 where he remained until he was readmitted to the facility on [DATE]. A review of facility self-reported incident (SRI), tracking number 228879 revealed an SRI was submitted on 11/05/22 for an allegation of physical abuse. The alleged perpetrator was Resident #29 and the resident/ victims were identified as Resident #29 and Resident #7. No witnesses were identified in the SRI. The date of discovery was 11/05/22 and the brief description of the allegation/ suspicion was a resident to resident altercation. The initial source of the allegation was staff. Resident #7 was not able to provide meaningful information. Her diagnoses included a stroke, dementia with behavioral disturbances, and altered mental status. Resident #29 was noted to be able to provide meaningful information. His diagnoses included Post Traumatic Stress Disorder (PTSD) and homicidal ideations. The narrative summary of the incident revealed Resident #29 had suspected had borderline personality disorder and antisocial disorder. Resident #7 had a history of behavioral disturbances. During the facility's investigation they interviewed both residents and staff regarding the resident-to-resident altercation. Witness statements said Resident #7 kept repeatedly yelling she was hungry and she wanted food in dining room. Resident #29 became frustrated by the repetitive statements and he started yelling at her. He then slapped Resident #7 in the face and proceeded to wrap his arm around her. Resident #29 was unable to stand and was strictly confined to a wheelchair. Staff members separated the residents and diffused the situation. Resident #29 started yelling threatening statements and Resident #7 continued to yell as well. Resident #29 was removed from the area and placed on one on one. Resident #29 was sent out for a psychiatric evaluation at a local hospital. Resident #7 was standing up at the time of the incident and was yelling at Resident #29. She did not cry or show any emotion. She did not have any marks or bruises. The facility unsubstantiated the allegation of physical abuse stating the evidence was inconclusive and abuse was not suspected. The facility indicated as a result of their investigation they did the following: Resident #29 was treated at the hospital for acute illness. He will have medication changes prior to or on admissions. Resident #29 would remain on one on one status until his behaviors were stable. His care plan was updated to recommend or encourage quiet-low traffic areas. Resident #7 had a medication change as well and her care plan was updated appropriately. The facility's investigation file included a SRI Form for an initial report. It indicated the incident was witnessed by STNA #300 on 11/05/22 at 12:05 P.M. and occurred in the dining room. Resident #29 reported all specifics and details regarding the incident. He did not show any remorse for what he had done. He sat calmly eating a snack while he spoke of what he did. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview statement from Resident #29, after the witnessed incident in the dining room on 11/05/22, was obtained by the DON. The DON asked Resident #29 what happened at lunch in the dining room. He reported another resident in the dining room kept yelling out like she always did. He stated he was tired of hearing her and that no one was doing anything about her. She asked him if he noticed any staff members and he said no. He said he told the other resident if she yelled one more time, he was coming to kick her f****** a**. He reported the other resident said that she did not care. He then indicated he went after her, slapped her, and put her in a choke hold. He said that she started screaming and scratched him on his face. He also said that she had no f****** right to be in there yelling like that and he was going to f****** kill her because she had no right to act that way. He said the nurses took him to another room and let that b**** stay in the dining room. He said he f****** took care of her and he got punished. The DON asked him if he was aware that the other resident was confused at times and did not know what was going on. He said she knew more that they thought, and he did not care if she was confused. He was going to kick her a**. A witness statement from STNA #300 dated 11/05/22 revealed she went to the kitchen to get lunch for the assisted living residents. A kitchen staff member said he had a hold of her. She went to the dining room to see Resident #29 have Resident #7 in what looked like a choke hold. She told him to let go, he had a strong grip on her. She had to pry his hands from her and then took him out to the common area. While taking him out, he kept cursing you f****** b****, I'll do it again. The nurse was made aware and came in while she was separating the residents. She then went back to make sure Resident #7 was okay and she stated she was. She returned to her unit (assisted living) and told her nurse what had happened. She asked her nurse if she should call the DON and was advised to do so. She called the DON after speaking with her nurse. A personal witness statement from RN #320 dated 11/05/22 revealed she heard a loud noise (yelling) coming from the dining room. The nurse immediately responded and found female resident leaning towards a male resident. Staff separated the two residents as stated the female resident had been yelling, which agitated the male resident. He became physically aggressive and put the female resident in choke hold. The male resident was heard threatening to murder the female resident. Male resident was brought to the common area seated by himself. He continued to threaten to murder. Male resident was identified as Resident #29 and the female resident was identified as Resident #7. A personal witness statement from STNA #310 regarding the incident occurring on 11/05/22 revealed she was bringing another resident to the dining room and heard Resident #7 yell. She heard other residents yelling for them and was saying Resident #29 had Resident #7 in a headlock. By the time she got to the dining room, the nurse was wheeling Resident #29 out of the dining hall and he had a bloody nose. The facility's investigation indicated Resident #7 was not able to respond to any questions asked regarding the assault. A personal witness statement from Resident #1 dated 11/05/22 revealed the DON spoke with him about the lunch incident. He wasn't able to verbalize the incident. He showed her with his arms. He grabbed the DON around the neck and said choke, then he pointed towards Resident #7. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A personal witness statement from Resident #33 dated 11/05/22 revealed the DON spoke with the resident regarding the lunch incident. The resident reported he was sitting at the same table as Resident #29. Resident #29 was mad because Resident #7 was yelling she wanted her food. He said Resident #29 told her (Resident #7) to shut the f*** up or he was going to shut her up. The resident stated Resident #29 turned around and started slapping her and got her in a choke hold. Then the nurse came running in. A personal witness statement from Resident #6 dated 11/05/22 revealed the DON spoke with him about the incident occurring in the dining room. The resident reported Resident #7 was asking repeatedly for her food and drink. Resident #29 yelled at her to shut the f*** up or he was coming after her. He said Resident #29 went over and slapped her four to five times and then he grabbed her around the neck in a choke hold. He immediately started yelling for the nurses and they came running in. Nurses took Resident #29 out of the room. On 02/16/23 at 5:10 P.M., an interview with the DON revealed she did participate in the investigation into the allegation of physical abuse that occurred on 11/05/22 between Resident #7 and #29. She was asked how the facility determined that physical abuse did not occur or that they did not have sufficient evidence that was conclusive to show physical abuse had occurred. The facility's investigation showed staff and other residents in the dining room witnessed the incident and confirmed Resident #29 threatened, slapped and put Resident #7 in a choke hold. She was not able to provide a rationale as to why the physical abuse allegation was not substantiated. A review of the facility's Abuse Policy revised September 2020 revealed the facility prohibited mental or physical abuse. Residents would not be subjected to abuse by anyone. Abuse was defined as the willful infliction of injury with resulting physical harm, pain, or mental anguish. Verbal abuse was defined as the use of oral language that willfully included disparaging and derogatory terms to residents or within their hearing distance. Physical abuse included but was not limited to hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. Residents identified to be potentially abusive shall have individualized care plans with interventions in an effort to prevent abuse. After all possible interventions were implemented, if the potentially abusive resident continued to be considered threatening to other residents, then the facility will issue a transfer in accordance with government regulations. The facility recognized its obligation to keep its residents safe and to protect them from any harm to whatever extent possible and within acceptable standards of practice.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of a self reporting incident (SRI), resident interview, staff interview and policy review, the facility failed to ensure allegations of misappropriation was reported to the state survey agency timely as required. This affected one (#26) of two residents reviewed for misappropriation. Findings include: A review of Resident #26's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included morbid obesity due to excess calories, muscle wasting and atrophy, muscle weakness, and difficulty walking. A review of Resident #26's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. No behaviors was noted during the seven day assessment period. A review of Resident #26's care plans revealed he did not have any care plans in place that indicated he was known to have any behaviors or make false accusations. A review of Resident #26's progress notes revealed a nurse's note dated 09/04/22 at 12:00 P.M. by the Director of Nursing (DON) that indicated the resident reported he noticed his CVS gift card and 20 dollars were missing from his wallet. The last time he saw it was prior to his recent hospitalization . He gave permission for them to check his room in case it was missed placed. The items were not able to be found. A nurse's note dated 09/13/22 revealed Resident #26 was offered a lock box with a key for his valuables. It did not indicate the resident was reimbursed for the amount he had reported was lost. No additional progress notes were noted that pertained to any further follow up of his reports of missing money/ gift card. A review of the facility's missing item log for the past six months revealed there were only two entries of missing items during the past six months. One of the two entries pertained to Resident #26's reports of missing money and gift card. The entry was made on 09/08/22. A review of a quick response report dated 09/04/22 for an incident occurring at 12:00 P.M. revealed the staff handed Resident #26 his wallet so he could get money out for his lunch. He wanted to order Chinese for his lunch. There was a 20 dollar bill and a CVS gift card worth 50 dollars that was missing from his wallet. He kept his wallet in a plastic bowl along with other items on his bedside stand. The last time he saw the gift card was the weekend of 08/06/22. That was the weekend before he went out to the hospital. He was taken to the hospital for cellulitis on 08/11/22 and returned to the facility on [DATE]. Permission was given to the staff to check his room to make sure the items were not misplaced. No cash or gift card was able to be found. The outcome of the incident was that the resident's money would be reimbursed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of SRI #226546 dated 09/09/22 revealed an allegation of misappropriation with the date of discovery of 09/04/22 was made. The initial source of the allegation was from a resident/ victim. The alleged perpetrator was unknown. A brief description of the allegation indicated the resident reported he lost 20 dollars and a gift card. Resident #26 was indicated to have been able to provide meaningful information when interviewed. A narrative summary of the incident revealed the date/ time/ location of the occurrence was 09/04/22 at 12:00 P.M. in the resident's room. The resident and staff were interviewed for any knowledge of the situation or additional missing items. No additional information was identified. The resident stated he hadn't seen his money since he went to the hospital on 08/11/22. He returned on 08/18/22 and he just then opened his wallet on 09/04/22. The resident had been ordering food to be delivered on almost a daily basis because he had money available. Recently, he no longer had money available and it was unusual for him not to order food. It was thought to be unlikely that he went two weeks before he opened his wallet or ordered take out food. In the past, he had also been known to try to sell his gift card because he was unable to use the gift card in that rural area. The facility unsubstantiated the allegation of misappropriation as the evidence was inconclusive and misappropriation was not suspected. As a result of the investigation, the facility provided the resident a locked box. Staff were educated on the abuse policy and the DON was educated to save and submit when submitting an SRI. The facility denied Resident #26 had a personal funds account with them and did not have any way to track his transactions made pertaining to any money he may have had. They did not have a way to track what money he received or what money he spent on ordering food from outside sources. On 02/14/23 at 10:53 A.M., an interview with Resident #26 revealed he did have a 20 dollar bill and a 50 dollar gift card that came up missing from his wallet when he was out to the hospital. He thought the money was missing around September or October of 2022. He reported it missing to staff and indicated the facility's DON filled out the report. He denied he received any follow up on his reports of missing money and was not reimbursed for the money or the value of the gift card that went missing. On 02/14/23 at 4:50 P.M., an interview with the DON confirmed Resident #26 did report a gift card and 20 dollars missing. She stated he reported the items missing upon return from a hospitalization . She confirmed they did give him a lock box to keep in his room for safekeeping of any valuables. She was asked if the resident was reimbursed for the reported missing items. She stated they were not able to show he had those items prior to reporting them missing, therefore they were not reimbursed. She verified the SRI with tracking #226546 was not initially reported to the Ohio Department of Health (ODH) until 09/09/22 (5 days after allegation was made). She also verified the SRI showed staff were educated on the abuse policy and she received education to save and submit when submitting an SRI. On 02/15/23 at 10:10 A.M., a follow up interview with the DON and the Administrator revealed Resident #26 was reimbursed for the value of the missing CVS gift card and the 20 dollars. They were unable to find evidence of where that money had been pulled from to reimburse the resident. They checked with the business office manager, who indicated without the resident having funds with the business office, they would not have pulled any cash from their petty cash fund to give to the resident. The Administrator indicated they had another petty cash fund in which that money was pulled from, but they did not have documentation to prove that. She denied there was any type of paper trail that showed the resident was given 70 dollars (value of gift card and the 20 dollar bill) after he reported them missing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/15/23 at 10:15 A.M., a follow up interview with Resident #26 revealed the resident was adamant he was not reimbursed for the amounts of his gift card and the 20 dollars (70 dollars total) as indicated by the facility. He stated he received the 50 dollar gift card at CVS from his MCD insurance and the 20 dollars was sent to him by his sister. A review of the facility's policy on Missing Items undated revealed the facility strived to reasonably safeguard the personal belongings of the residents. The policy indicated when a resident reported an item missing, that staff member was to notify the social service coordinator or the DON/ Administrator in their absence. Social services would then interview the resident regarding the missing item and would complete the missing item report. A thorough investigation would be conducted by the social service coordinator, the appropriate department supervisor, and the Administrator. The outcome would be documented on the missing item report form. The social service coordinator would notify the responsible party and/ or family members of the outcome of the investigation. The Administrator would review each case and determine the need to replace missing items, as needed. A review of the facility's Abuse, Neglect, Exploitation, and Misappropriation of Property policy revised September 2020 revealed misappropriation of resident property was defined of depriving, defrauding, or otherwise the real or personal property of a resident by any means prohibited by the Revised Code. It was also the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without a resident's consent. All alleged violations concerning abuse, neglect, or misappropriation of property were to be immediately reported to the Administrator/ designee. Reporting of all allegations not involving abuse or serious bodily injuries must not exceed 24 hours. The results of a thorough investigation of the allegation would be reported to ODH within five working days of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on record review and staff interviews the facility failed to ensure allegations of abuse were thoroughly investigated. This affected one resident (#29) of two residents reviewed for abuse. The census was 39. Findings include: Review of Resident #29's medical record revealed an admitted [DATE] with diagnoses including diabetes with foot ulcer, chronic ulcer of the left foot, post-traumatic stress disorder and homicidal ideations. Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. The resident also displayed physical and verbal behavioral symptoms directed toward others. The resident required extensive assistance of one to two staff members with activities of daily living. Review of Self-Reported Incident Number 230304 dated 12/19/22 revealed at 2:00 P.M. the resident stated he got $2.00 out of his wallet on 12/17/22 in the evening and still had $93.00 remaining. The resident stated he put his wallet back in the drawer Saturday evening and did not take it back out until first thing Monday morning (12/19/22). The resident went to take additional money from his wallet to take the transit bus to town and all of the money was gone, $93.00. An investigation was initiated, statements would be obtain and an SRI to be completed. Further review of the SRI revealed the facility unsubstantiated the allegation because the evidence was inconclusive. Abuse, neglect or misappropriation was not suspected. The facility replaced the resident's money and provided the resident with a lock box for valuables safekeeping. No other residents were affected by this incident or had missing items. Education was provided to the staff. Review of the facility's investigation revealed no evidence of staff interviews except for Licensed Practical Nurse (LPN) #213 (the nurse who received the allegation from the resident), the Administrator in training (AIT) and Social Services Designee #209. No other staff members were interviewed or provided a statement. No other residents were interviewed to determine if other residents were affected by potential misappropriation. On 02/15/23 at 5:18 P.M. interview with the AIT revealed she was the primary investigator and verified the facility had no documented evidence other residents and other staff were interviewed. The AIT verified this would not be a thorough investigation.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on record review, staff interview and policy review the facility failed to provide residents with the bed hold notice prior to a transfer to an acute care setting. This affected one resident (#39) of one resident reviewed for hospitalization . The census was 39. Findings include: Review of the closed medical record for Resident #39 revealed an admitted [DATE] with diagnoses including encephalopathy, acute and chronic respiratory failure with hypoxia, alcoholic cirrhosis and anxiety. Review of the five day Minimum Data Set (MDS) dated [DATE] revealed the resident had severe cognitive impairment and required staff assistance with activities of daily living. Review of the progress notes revealed on 01/31/23 at 7:00 P.M. Resident #39 was transferred to the emergency room for evaluation of altered mental status. Further review of the medical record revealed no evidence a bed hold notice was provided to the resident or responsible party when the resident was transferred to the hospital. On 02/15/23 at 10:35 A.M. interview with Social Service Designee (SSD) #209 revealed the resident was provided information of the bed hold policy/notice upon admission to the facility but did not receive the notice again after he was transferred to the hospital. The SSD verified the resident did not return to the facility. Review of the Bed Hold Policy dated 03/16 and reviewed on 04/19 revealed the facility will offer Medicaid residents the opportunity to hold the bed for a maximum of 30 days per calendar year. After admission to the nursing home, and before a resident is transferred, or leaves the facility, the facility will provide the resident and/or their sponsor with the following information in writing: the bed hold policy of the State.

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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** 45440 Based on record review, interview, and facility policy review the facility failed to ensure a resident's Pre-admission Screening and Resident Review (PASARR) was updated after mental health diagnoses additions. This affected one resident (#6) of two residents reviewed for PASARR. The facility census was 39. Findings included: Review of Resident #6's medical record revealed an admitted [DATE] with diagnoses including bipolar disorder entered on 08/20/22, schizoaffective (psychotic) disorder, bipolar type entered on 08/22/22, and anxiety disorder entered on 08/22/22. Review of Resident #6's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 11/22/22, revealed he was cognitively independent and had active psychiatric disorders of anxiety, bipolar, and schizophrenia. Review of Resident #6's most recent Pre-admission Screening and Resident Review (PASARR), dated 08/18/22, revealed in Section E: indication of Serious Mental Illness, the only disorder marked was mood disorder. The box beside other psychotic disorder was not marked. Interview on 02/14/23 at 10:40 A.M. with Social Services Designee (SSD) #209 verified the PASARR dated 08/18/22 was the most recent PASARR for Resident #6. Interview on 02/14/23 at 4:38 P.M. with SSD #209 verified the most recent PASARR is not accurate and based on Resident #6's psychiatric diagnoses and he may be eligible for services. She reported she would complete a new PASARR for Resident #6. Review of the facility policy titled, PAS/RR, undated, revealed all level I and Level II residents with newly diagnosed or possible serious mental disorder, intellectual disability, or a related condition for level II will be referred for resident review to the Ohio Department of Aging or appropriate required organization upon significant change in status assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45440 Based on record review, interview and facility policy review the facility failed to ensure care conferences were completed quarterly. This affected one resident (#23) of two residents reviewed for care planning. The facility census was 39. Findings included: Review of Resident #23's medical record revealed she was admitted to the facility on [DATE] with the diagnoses of type two diabetes, unilateral primary osteoarthritis, and essential hypertension. Review of Resident #23's quarterly Minimum Data Set (MDS) 3.0 Assessment, dated 01/04/23, revealed she was mildly cognitively impaired. Review of Resident #23's Multidisciplinary Care Conferences dates documented in the electronic health record revealed she had conferences completed on 07/01/21, 08/16/21, 05/09/22, 08/02/22, and 12/02/22. There was no documentation of care conferences between 08/16/21 and 05/09/22. An interview on 02/14/23 at 7:47 A.M. with Resident #23 revealed she did not remember having care conferences every three months. An interview on 02/14/23 at 11:08 A.M. with Social Services Designee (SSD) #209 revealed care conferences were documented in the electronic health record titled, Multidisciplinary Care Conference. She was not aware of any paper documentation for care conferences. An interview on 02/14/23 at 4:00 P.M. with SSD #209 verified there was no care conference documentation between 08/16/21 and 05/09/22 and care conferences are to be done quarterly. Review of the facility policy titled, Care Conference, undated, revealed the health care facility will conduct routine and scheduled care conferences to evaluate and re-evaluate each resident's plan of care to determine whether the established goals are appropriate and being met by the resident or if changes to the goals are necessary.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on observation, record review, shower list review, staff and resident interview and policy review the facility failed to ensure residents were assisted with shaving as needed. This affected one resident (#32) of one resident reviewed for activities of daily living. The census was 39. Findings include: Review of Resident #32's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's Disease, major depression and schizoaffective disorder. Review of the shower sheets revealed the resident showered: 10/27/22 shower and shave documented 01/30/23 refused to be shaved but had a shower 01/31/23 had a shower (no shave documented) 02/02/23 had a shower (no shave documented) 02/07/23 resident refused 02/09/23 had a shower (no shave documented) 02/10/23 had a shower (no shave documented) 02/13/23 refused three times Review of the activity of daily living for personal hygiene electronic health record documentation revealed the resident required independence to limited assistance with personal hygiene every day documented except 02/06/23 when the resident required extensive staff assistance with personal hygiene. The documentation did not isolate particular activity of personal hygiene (comb hair, brush teeth, shaving, washing/drying face and hands: excluding baths and showers). Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderate cognitive impairment and required supervision with bed mobility, transfers, dressing, toilet use and personal hygiene. Review of the I have an activities of daily living self-care performance deficit related to needing assist, impaired cognition dated 10/31/22 revealed interventions including: I require extensive assistance of one staff with bathing/showering and I require limited assistance by one staff with personal hygiene and oral care. Further review of the care plans revealed no evidence of a shaving refusal or the amount of facial hair the resident preferred care plan in place. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the un-dated shower list revealed Resident #32 was to shower on Monday and Thursday night shift (7:00 P.M. to 7:00 A.M.) On 02/14/23 at 10:00 A.M. Resident #32 was observed seated on the edge of his bed. The resident had approximately one forth an inch facial hair growth noted. The resident was asked what his facial hair preference was and the resident stated he preferred to be clean shaven. The resident was observed to have four disposable razors lying on his bedside table. The resident stated he purchased the razors but was unable to see to shave himself. An additional observation at 4:00 P.M. revealed the same. On 02/15/23 at 9:58 A.M. and 11:00 A.M. Resident #32 remained unshaved. On 02/15/23 at 4:58 P.M. interview with the Director of Nursing (DON) revealed residents are to be showered twice a week and a shower sheet is completed with each shower. Staff document any skin alterations and if nail care or shaving was provided and the nurse would also sign the sheet once the task was completed. On 02/15/23 at 6:30 P.M. interview with State tested Nursing Assistant (STNA) #300 verified the resident needed to be shaved and she also verified with Resident #32 he preferred to be clean shaven. On 02/15/23 at 6:30 P.M. interview with STNA #50 revealed residents are to be showered twice per week. Shaving and nail care is to be completed with showering and residents are to be assisted with shaving. On 02/16/23 at 11:00 A.M. Resident #32 was observed walking around the dining room. The resident had been shaved and a mustache sa present. The resident verified he had been shaved but he did not want the mustache to remain. He stated the female staff member began to shave him and then stated she had to do something else and she would be back to remove the mustache. The resident stated she had not returned. On 02/16/23 at 11:16 A.M. interview with the DON revealed her expectation would be for male residents to be assisted with shaving and to be offered with ADLs. She verified male residents are not expected to be able to shave themselves independently. Review of the Personal Care/Bathing Policy (not dated) revealed the residents of the facility will receive personal care in the facility according to the resident's plan of care to promote dignity, cleanliness and general well-being. Shaving is offered to (the) resident daily during the routine bathing process.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45440 Based on record review and interview the facility failed to ensure residents with orders for constipation treatment were assessed and provided intervention. This affected two residents (#23 and #24) of five residents reviewed for unnecessary medications. The facility census was 39. Findings included: 1. Review of Resident #23's medical record revealed she was admitted to the facility on [DATE] with the diagnoses of type two diabetes, unilateral primary osteoarthritis, and essential hypertension. Review of Resident #23's quarterly Minimum Data Set (MDS) 3.0 Assessment, dated 01/04/23, revealed she was mildly cognitively impaired. Review of Resident #23's physician order dated 01/20/21 revealed Dulcolax suppository 10 mg insert one suppository rectally as needed for daily constipation and Milk of Magnesia Suspension (400 milligrams/5 milliliters) give 30 milliliters by mouth as needed daily for constipation, and Fleet Enema 7-19 grams/118 milliliters insert one application rectally every 24 hours as needed for constipation, may administer Fleets Enema if no BM on the subsequent shift after suppository, may repeat times one. Review of Resident #23's State tested Nurse Assistant (STNA) documentation for the past 30 days for bowel movements revealed no bowel movements on 02/01/23, 02/02/23, 02/04/23, 02/05/23, 02/06/23, or 02/07/23. Review of Resident #23's Medication Administration Record (MAR) for February 2023 revealed no administration of Dulcolax suppository, Milk of Magnesia, or Fleets Enema as ordered. Interview on 02/14/23 at 7:47 A.M. with Resident #23 revealed the resident did have constipation at times. Interview on 02/16/23 at 4:30 P.M. with the Director of Nursing (DON) verified the STNA documentation for Resident #23's bowel movements revealed no bowel movements 02/01/23, 02/02/23, 02/04/23, 02/05/23, 02/06/23, or 02/07/23 and review of the Resident #23's MAR for February 2023 revealed no administration of Dulcolax suppository, Milk of Magnesia, or Fleets Enema as ordered. The DON verified Resident #23 should have received one of the above interventions for constipation on 02/05/23. 2. Review of Resident #24's medical record revealed an admitted [DATE] with diagnoses including encounter for other orthopedic aftercare, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and essential hypertension. Review of Resident #24's quarterly MDS 3.0 assessment, dated 01/11/23, revealed she was cognitively independent. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's physician orders dated 12/22/22 revealed give Milk of Magnesia Suspension (1200 milligrams/15 milliliters) 30 milliliters by mouth daily for complaint of constipation or no bowel movement for three days. Review of Resident #24's STNA documentation for the past 30 days for bowel movements revealed no bowel movements on 01/31/23, 02/01/23, 02/02/23, 02/03/23, 02/04/23, 02/06/23, 02/07/23, 02/08/23, or 02/09 /23. Review of Resident #24's MAR for February 2023 revealed no administration of Milk of Magnesia as ordered. Interview on 02/14/23 at 3:51 P.M. with Resident #24 revealed her bowel movements are not regular and sometimes she goes days without a bowel movement. Interview on 02/15/23 at 10:15 A.M. with the DON verified the STNA documentation for Resident #24's bowel movements revealed no bowel movements on 01/31/23, 02/01/23, 02/02/23, 02/03/23, 02/04/23, 02/06/23, 02/07/23, 02/08/23, and 02/09 /23 and review of the Resident #24's MAR for February 2023 revealed no administration of Milk of Magnesia for no bowel movement for three days. The DON verified Resident #24 should have received Milk of Magnesia on 02/03/23 and on 02/09/23.

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F 0686 Level of Harm - Minimal harm or potential for 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** 45440 Based on record review, interview, and policy review the facility failed to ensure a resident with a pressure ulcer had comprehensive pressure ulcer assessments completed to determine the status of the ulcer to include progression or healing of the ulcer and the potential need to alter treatment. This affected one resident (#11) of three residents assessed for pressure ulcers. The facility census was 39. Findings included: Review of Resident #11's medical record revealed he was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included mechanical complications of other internal orthopedic devices, a non-pressure chronic ulcer of the back with necrosis of bone, paraplegia, and unspecified protein-calorie malnutrition. Review of Resident #11's Significant Change Minimum Data Set (MDS) 3.0 assessment, dated 01/25/23, revealed he was cognitively impaired and was at risk for pressure ulcers, had a pressure ulcer, and had a Stage III unhealed pressure ulcer (defined as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss). Review of Resident #11's coccyx pressure ulcer documentation revealed his coccyx pressure ulcer was not comprehensively assessed at least weekly to include: location and staging; size (perpendicular measurements of the greatest extent of length and width of the PU/PI), depth; and the presence, location and extent of any undermining or tunneling/sinus tract; exudate, if present: type (such as purulent/serous), color, odor and approximate amount; pain, if present: nature and frequency (e.g., whether episodic or continuous); wound bed: color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate. Specifically, the review revealed wound clinic documentation (Stage III) on 07/07/22 and no documentation until 08/01/22, facility documentation (pressure ulcer not healed) on 08/01/22 and no documentation until 08/15/22, facility documentation (pressure ulcer not healed) on 08/22/22 and no documentation until 09/07/22, facility documentation (pressure ulcer not healed) on 09/13/22 and no documentation until 09/26/22, facility documentation (pressure ulcer not healed) on 09/27/22 and no documentation until 10/14/22, wound clinic documentation on 11/25/22 and no documentation until 12/09/22, and wound clinic documentation on 12/23/22 and no documentation until 01/06/23. Interview on 02/16/23 at 4:41 P.M. with the Director of Nursing (DON) revealed there was no other documentation in the electronic health record for the dates missing in evaluations skin grid pressure. Interview on 02/17/23 at 12:35 A.M. with the Administrator revealed there was no other documentation from the wound clinic for the dates missing weekly assessments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Skin Measurement/Skin Grid, undated, revealed the facility will maintain an active record of any pressure ulcer/wound that are discovered upon admission or that develop during the course of the resident's stay. This is to monitor the progress of healing of the pressure ulcer and determine the need for alternative treatment methods.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45440 Based on observation, interview, and record review the facility failed to ensure resident's oxygen was administered as ordered. This affected one resident (#24) of two residents reviewed for respiratory care. The facility census was 39. Findings included: Review of Resident #24's medical record revealed an admitted [DATE] with diagnoses including encounter for other orthopedic aftercare, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and essential hypertension. Review of Resident #24's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/11/23, revealed she was cognitively independent, had active diagnoses of asthma (chronic obstructive pulmonary disease or chronic lung disease), respiratory failure and received oxygen. Review of Resident #24's physician order, dated 12/10/22, revealed she was to have oxygen at three liters per minute (L/min) via a nasal cannula continuously every shift for shortness of breath. Review of Resident #24's current comprehensive care plan revealed a focus of alteration in respiratory function related to chronic obstructive pulmonary disease. Interventions included provide oxygen as per medical doctor's orders. Observation on 02/14/23 at 8:41 A.M. revealed Resident #24 lying in bed with her oxygen being administered at five L/min via a nasal cannula. Observation on 02/14/23 at 12:52 P.M. revealed Resident #24 sitting in wheelchair with her nasal cannula in her nose, but the oxygen concentrator was turned off. Observation on 02/14/23 at 1:31 P.M. revealed Resident #24 sitting in the dining room and her oxygen was being administered at four L/min via nasal cannula. Observation on 2/14/23 at 3:51 P.M. revealed Resident #24 lying in bed and her oxygen being administered between three and one half and four L/min. Interview on 02/14/23 at 3:53 P.M. with Licensed Practical Nurse #234, after she observed Resident #24's oxygen flow rate, verified Resident #24's oxygen was not being administered at the correct flow rate of three L/min.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on daily staffing posting review, schedule review, Facility Assessment review and staff interview the facility failed to ensure registered nurse services were provided eight hours daily, seven days per week. This had the potential to affect all 39 residents residing in the facility. Findings include: Review of the Facility assessment dated [DATE] revealed the facility's staffing levels are based upon the acuity of their residents and resident population. The staffing pattern may fluctuate depending upon daily census and residents' needs. The facility provides a Registered Nurse at least eight hours daily. Review of the daily staffing postings from 12/16/22 through 02/16/23 revealed no registered nurse coverage on the following dates: 12/17/22, 12/18/22, 12/19/22, 12/21/22, 12/22/22, 12/23/22, 12/24/22, 12/31/22, 01/01/23, 01/02/23, 01/07/23, 01/08/23, 01/14/23, 01/15/23, 01/21/23, 01/22/23, 01/23/23, 01/24/23, 02/03/23, 02/04/23, 02/05/23, and 02/12/23. Review of the January and February 2023 Nursing Staff Schedule revealed the only RN employed by the facility was the Director of Nursing. On 02/16/23 at 5:37 P.M. interview with Social Service Designee (SSD) #209 verified the daily staff postings provided did not have registered nurse hours listed and she stated the Administrator In Training (AIT) verified she was unable to provide evidence of RN coverage on the days indicated. On 02/16/23 at 5:50 P.M. interview with the AIT verified the only RN currently employed/working at the facility to provide the required RN coverage was the DON. The AIT stated she was actively looking for an RN but the one they previously had employed resigned. The AIT verified the facility did not provide RN coverage eight hours a day, seven days a week.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on observation, record review, resident and staff interview the facility failed to create a comprehensive behavioral health plan to assist the resident in achieving his highest practical level of well-being while keeping the other residents safe. This affected one resident (#29) of one residents reviewed for mood and behavior. The census was 39. Findings include: Review of Resident #29's medical record revealed an admitted [DATE] with diagnoses including post-traumatic stress disorder (PTSD), bipolar disorder, major depressive disorder and homicidal ideations. Review of the hospital documents from 06/28/22 through 08/26/22 revealed the resident was admitted to the hospital with PTSD in addition to depressive disorder and had homicidal ideation and aggressive behavior on admission but not anymore. Review of the at risk for alteration in mood/behavior care plan- at former facility hit staff member, shaking fist in the air, secondary to potential body image concerns related to a right below the knee amputation, have a history of assaulting care givers, yelling at peers that have impaired cognition initiated 09/08/22 with interventions including: allow the resident to voice feelings with staff, away from residents and give support as needed; educate on inappropriateness of threatening behavior; encourage him to be polite to other peers; encourage mindful breathing to calm self; encourage resident to express any feelings/concerns. Allow him time to talk, reassure as needed; I will eat my meals in either my room or common area to diminish dining area triggers; may consult with psych and/or counseling services as indicated; monitor resident's mood/behavior. Notify physician of any changes/alterations as indicated;; psychiatrist aware of uptick in behaviors and will adjust meds as needed; remove him from areas of escalation; specialty appointments as directed and a resolved intervention of resident is on 1:1 to monitor behaviors resolved on 11/15/22. Review of the risk for impaired social interaction care plan related to history of rape, post-traumatic stress disorder related to war; death of a spouse, suicide attempt dated 08/29/22 with interventions including encourage positive communication with others; encourage verbalization of feelings; medications per physician orders; notify the physician as indicated; offer psych services and encourage participation and support; provide positive reinforcement; social services to provide education regarding outpatient community resources and support groups, set up as indicated. Review of the physician orders revealed ativan one milligram orally every eight hours as needed for anxiety, cymbalta (antidepressant) 90 mg orally in the morning. Review of the progress notes revealed on 08/26/22 at 10:00 P.M. the resident was admitted to the facility. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Practitioner Progress Note dated 09/24/22 revealed the resident was seen in the hospital from 06/28/22 through 08/27/22 for aggressive behavior, PTSD flare up with homicidal ideation and was pink slipped On 10/31/22 at 5:39 P.M. the resident was noted with behavioral outbursts in (the) activity room related to staff and other residents talking to one another. The resident screams out, uses foul language because he states they should all Shut the (expletive) up so he can hear the community television rather than watching the one in his room. On 11/04/22 at 8:53 A.M. the resident was currently sitting quietly in the social services office, on the phone, approximately 30 minutes ago, the resident was very agitated, yelling and cursing, threatening other residents with physical harm, upset that another resident had made a statement about him that he thought was a lie. Numerous attempts by the nurse, DON and writer to decrease the resident's agitation The resident states that he doesn't care. He will kill him and pounded his fist in his hand., attempted to wheel away towards the resident, was eventually in agreement to come to the social services office to cool down. The resident was educated to not be making threats towards others and that is not acceptable. He was advised that in order to stay in the facility where he can get the care he needs, the aggressive behavior needs to cease. He voices understanding yet still makes threats of killing anyone who (expletive) with him. The SSD and DON advise the resident to come to them with concerns and to practice a peaceful attitude. He agrees that is the best course of action. Further review of the progress notes dated 11/05/22 at 12:00 P.M. revealed the resident becomes agitated towards another female resident due to her repeated yelling and becomes physically aggressive placing the resident in a choke hold. Staff immediately intervene and remove the male resident from the dining room and place him in the common area to eat alone and be monitored. At 12:33 P.M. the physician was notified and orders were received to send the resident to the emergency room for a psychiatric evaluation. The resident went to a local hospital twice for psychiatric evaluation before going to another hospital for a five day stay. The resident returned on 11/11/22. Review of the progress notes from 11/06/22 at 12:46 P.M. Social Services came to the facility to speak with the power of attorney of the resident, Resident #7, who was assaulted by Resident #29. A Sheriff Deputy was also present. It was decided by the deputy that Resident #29 would be charged with assault. Review of the medical record revealed the family of Resident #28 and Resident #29 are awaiting trial for the assault charges. Review of the progress notes on 11/26/22 at 3:50 P.M. revealed Resident #29 was having words with another resident in the day room. The resident was very loud and threatening with his fists up in the air when social services arrived. The resident was redirected by nursing staff. Review of the progress note dated 11/26/22 at 4:50 P.M. revealed Resident #29 was wheeling himself into the aide charting room to talk with the State tested Nursing Assistant (STNA) and the nurse. A confused resident ambulated up behind Resident #29 and has repeated conversation as she is confused. This resident becomes angry and attempts to back up into the confused female resident. The resident was informed this was inappropriate behavior and the female resident was immediately redirected for safety. Resident #29 sits in the aide charting room and continues to converse with the STNA. Staff monitors closely, (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 01/27/23 at 1:38 P.M. the resident was up in his wheel chair in the common area waiting for the afternoon activity group. A female peer, Resident #28 was sitting in her wheelchair next to Resident #29. Resident #28 speaks to Resident #29 and Resident #29 states you better shut up twice as Resident #29 takes his wheel chair and begins ramming it into Resident #28 forcefully and aggressively. LPN #234 attempted to separate the residents and Resident #29 begins resisting redirection and uses his wheel chair to ram LPN #234. Resident #29 refuses intervention from staff so a call was placed to the county sheriff's office for assistance. One on one was provided to the resident while waiting for police assistance. On 01/27/23 at 2:00 P.M. the sheriff and two deputies arrived. LPN #234 and SSD #209 witness extensive conversation and education provided by the deputies. Resident #29 assured the deputy he will change his behavior. The resident was redirected back to his room for a quiet environment. On 01/27/23 at 2:49 P.M. Social Service Director (SSD) #209 walked out into the dayroom area as the nurse called for her assistance. Resident #29 is actively pushing his wheel chair backwards into the nurse who was preventing him from hitting another resident. The resident is verbally belligerent and aggressive in nature. The SSD #209 helps nurse by moving the other resident so she is out of way. The nurse then goes to Resident #29's room where he, a nurse and the Administrator convene. The staff speak to the resident about his inappropriate behavior to no avail. The resident deflects the conversation and takes no responsibility in his actions. The sheriff and deputies arrive to speak with the resident and tell him that his actions are criminal in nature and that he needs to behave accordingly or face the consequences of his actions. Resident #29 continues to project and deny guilt. The resident was taken to his room and will be on 15 minute checks. Review of the Quick Response Form dated 01/27/23 revealed Resident #29 was sitting up in his wheel chair in the common area, waiting for activities to begin. Resident #28 was seated in her wheel chair beside Resident #29. Resident #28 speaks to Resident #29 and Resident #29 states You better shut up twice. Resident #29 starts ramming his wheel chair into Resident #28 forcefully and aggressively. The nurse attempts to separate the residents. Resident #29 resists redirection and begins to ram LPN #234 with his wheelchair. The nurse notifies the police depart Review of the Nurse Practitioner Progress Note dated 02/03/23 at 9:47 P.M. revealed the certified nurse practitioner (CNP) #500 documented the resident is prone to violent outbursts and he is only readmitted because the facility supposedly has to take him over the objections of myself and the staff. He will be closely watched. The danger of more impulsive assaults on staff and residents is well recognized. Review of the Behavioral Health Note dated 02/08/23 revealed with homicidal ideation/violence: The resident (#29) has a history of violence. He assaulted another resident on 11/05/22 and ended up putting her in a headlock. The facility found out the resident has another warrant out for assault outstanding, On 02/14/23 at 11:17 A.M. observation revealed Resident #29 was seated in his wheel chair in the dining room. Activity Director #207 was also in the dining room. Resident #28 was propelling herself and taking in a louder voice than the other residents. Resident #29 immediately looks up from the table and tells Resident #28 Shut up. No one wants to hear you. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/16/23 at 12:20 P.M. interview with SSD #209 revealed she was new to her position when Resident #29 was admitted to the facility. She, the DON and Administrator review information sent to the facility but she doesn't remember if anyone had concerns with his admission or why he came to them being from the Columbus area. On 02/16/23 at 3:48 P.M. interview with Resident #29 revealed he doesn't know what happens to trigger his anger and ram his chair into residents or place them into head locks or yell at them using profanity. The resident stated he wanted to live somewhere closer to home and this would be in the Columbus area. He said he was living in a nursing home in Columbus and he had to go to the hospital and he took his personal belongings to the hospital. He thought they ran out of room for him but he wasn't sure. But this facility hasn't done much to help him get transferred. On 02/16/23 at 7:27 P.M. interview with SSD #209 and the Administrator in Training (AIT) verified Resident #29 had a diagnosis of homicidal ideations and he had many altercations with other residents, specifically vulnerable females in wheel chairs. The AIT verified the incident on 01/27/23 was not submitted as a self-reported incident because the facility didn't feel it was physical abuse as the resident was ramming his wheel chair into Resident #28's wheel chair. The facility felt they were unable to discharge the resident as they would be abandoning him but were also aware the resident posed a threat to other residents and staff. The SSD and AIT stated they had been actively seeking alternate placement for the resident who may be more suited to meet the resident's needs such as a behavior unit however they had no evidence to show who they had contacted or spoke with. The AIT also verified that the plan of care for behaviors and/or behavior, cognition did not have resident specific interventions and had not been updated with new interventions after the early November 2022 physical altercation. The AIT and SSD verified they had not contacted other advocacy programs for assistance for Resident #29 and the other residents in the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45440 Based on record review, interview, and policy review the facility failed to ensure an attending physician reviewed the Medication Regimen Review (MRR) for pharmacy recommendations and took action on recommendations or provided a rationale if no action was taken. This affected one resident (#24) of five residents reviewed for unnecessary medications. The facility census was 39. Findings included: Review of Resident #24's medical record revealed an admitted [DATE] with diagnoses including encounter for other orthopedic aftercare, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, essential hypertension, and anxiety disorder. Review of Resident #24's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/11/23, revealed she was cognitively independent and had an active diagnosis of anxiety. Review of Resident #24's physician order dated 12/22/22 to 01/12/23 revealed Alprazolam (Xanax, an antianxiety medication) tablet 0.25 milligram (mg) by mouth every 10 hours as needed (PRN) for anxiety. Further review of the orders dated 01/12/23 and no stop dated revealed Alprazolam (Xanax) tablet 0.25 mg by mouth every 12 hours PRN for anxiety. Review of Resident #24's Medication Regimen Review titled, Note to Attending Physician/Prescriber, dated 01/18/23, revealed to comply with the regulation please provide a duration of therapy for the following PRN medication: PRN Xanax. Review of the form also revealed that all PRN psychoactive medications (pharmacotherapeutic agent that possesses action to alter mood, behavior, cognitive processes, or mental stress) require a duration of therapy. This form had not been reviewed by Resident #24's physician and no actions or rationale for no action taken was provided. On 02/15/23 at 4:00 P.M. an interview with the Director of Nursing (DON) revealed the physician did not review the 01/18/23 pharmacy recommendation timely, or take the action recommended or provide a rationale for no action taken. Review of the facility policy titled, Psychotropic Drug Use, undated, revealed the consulting pharmacist will report any irregularities specific to psychotropics and unnecessary medications to the attending physician and the facility's medical director as well as the facility's director of nursing as irregularities are identified. These reports must be acted upon in a timely manner. Irregularities may include but are not limited to any drug that meets the criteria set forth for unnecessary drugs, i.e., psychotropic medications.

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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** 32799 Based on observation, record review and staff interview the facility failed to ensure residents did not receive medications in excessive doses. This affected one resident (#29) of five residents reviewed for unnecessary medications. The census was 39. Findings include: Review of Resident #29's medical record revealed an admitted [DATE] with diagnoses including hypertension, diabetes, homicidal ideations and bipolar disorder. Review of the physician orders revealed metoprolol succinate (antihypertensive) 50 milligrams (mg) give 50 mg daily in the morning dated 11/11/22 and metoprolol succinate 100 mg give 100 mg by mouth in the morning for elevated blood pressure dated 12/22/22. Review of the progress notes dated 12/22/22 at 12:38 P.M. revealed Licensed Practical Nurse (LPN) #54 documented the resident's physician ordered metoprolol succinate 100 mg orally daily. Further review of the medical record revealed both doses of metoprolol succinate were administered concurrently since 12/23/22. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had moderate cognitive impairment and the resident had an active diagnosis of hypertension. On 02/15/23 at 7:37 A.M., medication administration observation was completed for Resident #29. Medications were administered by Licensed Practical Nurse (LPN) #54. The resident received medications including Metoprolol Succinate 100 mg and Metoprolol Succinate 50 mg orally. Review of the progress notes dated 02/15/23 at 10:14 A.M. revealed the resident's physician ordered to continue the metoprolol succinate 100 mg and discontinue the 50 mg daily. The physician orders reflected the same. On 02/15/23 at 10:30 A.M. interview with LPN #54 revealed she contacted Resident #29's physician and verified it was the physician's intent for the resident to receive metoprolol 100 mg daily and discontinue the 50 mg.

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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** 45440 Based on record review, interview, and policy review the facility failed to ensure as needed (PRN) psychoactive medications were limited to 14 days unless the attending physician documented a rationale to extend the medication. This affected one resident (#24) of five residents reviewed for unnecessary medications. The facility census was 39. Findings included: Review of Resident #24's medical record revealed an admitted [DATE] with diagnoses including encounter for other orthopedic aftercare, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, essential hypertension, and anxiety disorder. Review of Resident #24's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/11/23, revealed she was cognitively independent and had an active diagnosis of anxiety. Review of Resident #24's physician order dated 12/22/22 to 01/12/23 revealed Alprazolam (Xanax, an antianxiety medication) tablet 0.25 milligram (mg) by mouth every 10 hours PRN for anxiety. Further review of the orders dated 01/12/23 and no stop dated revealed Alprazolam (Xanax) tablet 0.25 mg by mouth every 12 hours PRN for anxiety. Review of Resident #24's Medication Administration Records (MARs) dated December 2022 revealed she received seven doses of the Xanax, dated January 2023 revealed she received 20 doses of the Xanax, and dated February 2023 revealed she received eight doses of the Xanax Review of practitioner notes dated 12/29/22 to 01/19/23 revealed no justification for the continuation of the as needed psychotropic medication. On 02/15/23 at 4:00 P.M. an interview with the Director of Nursing (DON) verified the physician ordered a PRN psychoactive medication for longer than 14 days. Review of the facility policy titled, Psychotropic Drug Use, undated, revealed PRN orders for psychotropic medications will be limited to 14 days with the exception that the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. If so in the case, the physician or prescribing practitioner will document their rationale in the resident clinical record and indicate the duration of the PRN order.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on record review and staff interview the facility failed to ensure laboratory studies were completed per physician orders. This affected one resident (#39) of one resident reviewed for hospitalization . The census was 39. Findings include: Review of the closed medical record for Resident #39 revealed an admitted [DATE] with diagnoses including encephalopathy, acute and chronic respiratory failure with hypoxia, alcoholic cirrhosis, anxiety and unspecified convulsions. Review of the five day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severe cognitive impairment and required staff assistance with activities of daily living. Review of the progress notes dated 01/30/23 at 11:20 A.M. revealed the resident was presenting with increased confusion at times. Presents with odd behaviors and was emptying a soda bottle to make a booby trap. Continuously manipulating post-surgical drain. State tested Nurse Aide (STNA) assisting with care as much as the resident will allow. The resident propels himself down the hall with soiled clothing and throws them at a male resident and yells expletives at the male resident. The resident's physician was notified and laboratory tests were ordered. The order was placed through the lab, requisition was printed and placed in the paper chart. No ETA for the lab technician was provided at this time. Further review of the medical record revealed no physician order for the lab work, but the progress note stating the physician ordered stat labs on 01/30/23. Review of the lab requisition dated 01/30/23 revealed lab studies including a complete blood count and metabolic panel. Review of the progress note dated 01/31/23 at 4:39 P.M. revealed stat (immediate) labs were ordered by the physician on 01/30/23. According to the lab requisition, the labs were obtained on 01/31/23 but results have yet to be reported to the facility. The nurse attempted to call the lab twice on 01/31/23 but there was extensive wait time with no response. Further review of the progress notes revealed on 01/31/23 at 5:00 P.M. the physician was notified and ordered for the resident to be evaluated in the emergency room . A progress note dated 01/31/23 at 5:30 P.M. revealed the resident left for the emergency room . (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/15/23 at 6:00 P.M. interview with the Director of Nursing verified there were stat labs ordered on 01/30/23 to include a CBC and metabolic panel. There was no evidence of a physician order but there was a lab requisition on the medical/paper chart and this proved the labs were entered into the lab computer system. The DON also confirmed the facility never received results from the lab because the labs were never drawn despite being stat and the DON stated this would definitely be the same day or usually within a few hours. She also verified the facility was unsure why the labs weren't completed and the facility did not follow up with the lab to determine the reason. Lastly, the DON confirmed the resident was sent to the hospital on 01/31/23 and did not return to the facility.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45440 Based on record review and interview the facility failed to ensure the Dietary Manager met the requirements for the position. This had the potential to affect all 39 residents residing in the facility and receiving food from the kitchen. Findings included: Review of the kitchen staff ServSafe Certifications revealed the following staff were certified: Dietary Cook (DC) #204, DC #232, Dietary Aide (DA) #211, and DA #218. There was no documentation to support Dietary Manager (DM) #52 had ServSafe certification. Interview on 02/15/23 at 11:25 A.M. with DM #52 verified he did not have a ServSafe Certification or a Food Protection Certification. Interview on 02/16/23 at 7:35 A.M. with DM #52 verified there was no full-time dietitian or diet tech in the facility. He verified he did not meet the requirements as director of food and nutrition services. He reported he had more than two years of experience in the position of director of food and nutrition services in a nursing facility setting but had not completed a course of study in food safety and management. He reported he has had ServSafe certifications over the years but not now and no management course completion. DM #52 reported he started a college course but did not finish it.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45440 Based on observation, interview, record review and policy review the facility failed to ensure food was stored and prepared under sanitary conditions. This had the potential to affect all 39 residents residing in the facility and receiving food from the kitchen. Findings included: 1. Observation on 02/13/23 at 6:18 P.M. revealed one gallon of apple cider vinegar one-half full and one gallon of paint propping the pantry door open. Interview on 02/13/23 at 6:25 P.M. with Dietary Aide (DA) #211 verified a container of apple cider vinegar was on the floor and food items are not to be on the floor and a gallon of paint should not be in the pantry. 2. Observation on 02/13/23 at 6:19 P.M. revealed a container of brown sugar in the pantry with a plastic spoon in the container. Interview on 02/13/23 at 6:25 P.M. with DA #211 verified there should not be a spoon in the brown sugar. 3. Observation on 02/13/23 at 6:21 P.M. revealed both ovens in the range were noted to be dirty with burnt food. Interview on 02/13/23 at 6:25 P.M. with DA #211 verified the ovens were dirty and had been dirty for a while. Interview on 02/15/23 at 11:05 A.M. with the Dietary Manager (DM) #52 revealed the kitchen did have a cleaning schedule. He also revealed the ovens in the range have not worked for three months. Review of the facility's kitchen cleaning schedule for the month of February revealed oven cleaning was not on a schedule. 4. Observation of puree process on 02/15/23 at 10:50 A.M. by Dietary Cook (DC) #232 revealed the chicken and dumplings were pureed first. DC #232 then ran the Robot Coupe through the chemical dishwasher prior to pureeing the peas. She did not let the Robot Coupe completely dry prior to placing the peas in the Robot Coupe and pureeing them. Interview on 02/15/23 at 11:20 A.M. with DC #232 verified she did not let the Robot Coupe completely air dry prior to using it for the peas and should have. Review of the facility policy titled, Food Safety and Sanitation, copyrighted 2021, revealed stored food is handled to prevent contamination and growth of pathogenic organisms: food stored in dry storage will be placed on clean racks at least six inches above the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, staff interview, policy review, the facility failed to ensure dressing changes were performed following acceptable infection control practices. This affected one (#31) of three residents observed for dressing changes. The facility's census was 39. Findings include: 1. A review of Resident #31's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included a Stage IV pressure ulcer (full thickness skin loss exposing underlying muscle, tendon, cartilage, or bone) of the coccyx. A review of Resident #31's physician's orders revealed she had an order in place for the wound to her coccyx to be packed with Alginate Silver then covered with an absorbent dressing. The treatment was to be done daily in the afternoon and as needed. The order had been in place since 01/03/23. A review of Resident #31's care plans revealed she had a care plan in place for having been admitted with actual impaired skin integrity/ Stage IV pressure ulcer to her coccyx. The interventions included monitor the wound for signs and symptoms of infection. They were to provide wound care per the physician's orders. On 02/15/23 at 2:48 P.M., an observation of Resident #31's pressure ulcer dressing change was completed as performed by Licensed Practical Nurse (LPN) #54. The nurse was observed to gather the supplies from the treatment cart in the hall that was needed to perform the resident's ordered treatment. She had disposable gloves on when gathering the supplies and removed the gloves before heading to the resident's room. She did not wash her hands before donning new gloves after entering the resident's room. She sat the treatment supplies directly on the resident's bed beside the resident. She was observed to remove the old dressing from the resident's wound indicating that the dressing had a moderate amount of a yellowish-colored drainage. She placed the old dressing on the resident's incontinent pad that was under her. She then cleansed the wound with wound cleanser before she applied the Alginate Silver and applied a foam border dressing over the wound to secure the Alginate Silver in place. She did not doff her disposable gloves, wash her hands, and don new gloves after removing the old dressing prior to cleansing the wound and applying the Alginate Silver/ foam dressing. The old dressing and other dressing supplies were disposed of in the resident's trash can. She kept the same disposable gloves on throughout the treatment procedure and did not remove them until she washed her hands before leaving the room. Findings were verified by LPN #54. On 02/15/23 at 3:05 P.M., an interview with LPN #54 confirmed she wore the same pair of disposable gloves throughout the entire treatment procedure. She denied she removed her gloves and washed her hands after removing the old dressing before she cleansed the wound and applied a new dressing. She also confirmed she laid the old dressing she removed on the resident's bed without placing it into a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Dressing Change policy/ procedure for a clean dressing revealed the purpose of the policy/ procedure was to provide guidelines for the proper application of a dry, clean dressing. The procedure instructed the nurse to place her treatment supplies on the bedside stand arranging them so they could be easily reached. They were then to tape a biohazard or plastic bag on the bedside stand or open on the bed. After setting up the supplies, they were to wash and dry their hands and apply clean gloves to loosen and remove the soiled dressing. The nurse was instructed to pull the glove over the dressing and discard it into the plastic or biohazard bag. They were then to wash their hands again, and don new gloves before cleansing the wound and completing the treatment as ordered.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 26706 Based on observation, interview, maintenance request review, the facility failed to ensure the commercial washing machine remained in service. This had the potential to affect all the residents in the facility. Findings include: Observation of the laundry room on 02/15/23 at 1:46 P.M. revealed the only commercial washing machine had a broken sign on it. Interview on 02/15/23, at the time of the observation, with Laundry #221 included the facility laundry had one Electrolux W5240H commercial washing machine and two residential washing machines. The commercial washing machine was currently broken. The service company will not service it any longer. Maintenance is aware. Since there is only one commercial washer when it is out of service staff can not keep up with the washing of personals and linens for the facility. Interview on 02/15/23 at 2:27 P.M. with Housekeeping/Laundry Supervisor (HLS) #201 included the industrial washing machine had been really bad the last year. HLS #201 affirmed occupational therapy and assisted living washer and dryers are used to provide enough clean linen for the facility. Review of the TELLS maintenance request included one undated entry for the staff being locked out of the big washing machine. The washing machine keeps getting stuck in the drain mode. Interview on 02/16/23 at 5:42 P.M. with Maintenance #205 verified the industrial washing machine had repeatedly been out of service.