STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366150	A. Building B. Wing	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Cincinnati	3627 Harvey Avenue Cincinnati, OH 45229

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 39703 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure residents had access to outside communication via the telephone. This had the potential to affect all 82 residents residing in the facility. The census was 82. Findings include: Interview on 10/31/22 at 4:18 P.M. with the Administrator confirmed it was brought to her attention on 10/17/22 that incoming calls to the facility were going to voicemail rather than to the directory. Administrator confirmed she reached out to information technology (IT) personnel and that problem was corrected on 10/20/22. Administrator provided surveyor with phone number used by resident family members to call when they needed to reach a resident in the facility. Observation on 11/01/22 at 6:18 A.M. revealed when the number to the facility provided by the Administrator was called, there was a greeting announcing the facility name. Caller was then prompted to press one for marketing, two for administration or three for nursing. Caller pressed three for nursing. Caller then pressed one for the 100 Hall nurses' station. There was a voice greeting which said, There is no one available to answer your call, and then the facility phone system disconnected the call. Observation on 11/02/22 at 6:20 A.M. revealed a call to the main number of the facility was made. The facility name was announced. Caller pressed three for nursing and two for the 200 Hall nurses' station. The phone rang for approximately one minute and then the facility phone system disconnected the call. Observation on 11/02/22 at 6:35 A.M. revealed a call to the main number of the facility was made. The facility name was announced. Caller pressed three for nursing and three for the 300 Hall nurses' station. The phone rang for approximately one minute and then the facility phone system disconnected the call. Observation on 11/02/22 at 6:39 A.M. revealed a call to the main number of the facility was made. The facility name was announced. Caller pressed three for nursing and four for the 400 Hall nurses' station. The phone rang for approximately one minute and then the facility phone system disconnected the call. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/01/22 at 3:33 P.M. with the Administrator confirmed the problems with making incoming calls to the facility. Review of the facility policy titled Resident Rights dated December 2016 revealed residents had the right to communication and access to people and services both in and outside the facility and residents had the right to access to a telephone. This deficiency represents non-compliance investigated under Complaint Numbers OH00137009, OH00136942 and OH00136916.

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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** 39703 Based on record review, review of hospital records, review of facility Self-Reported Incidents (SRI's), staff interview, and review of facility policy, the facility failed to ensure residents were free from abuse. This resulted in Actual harm when Resident #83 was physically assaulted by another resident (Resident #22) in the facility and Resident #83 was transported to the hospital immediately following the assault and was admitted with a fracture to his rib and bruising to both eyes and right side of his face. This affected one (#83) out of three residents reviewed for abuse. The census was 82. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE] with a diagnosis of undifferentiated paranoid schizophrenia. Review of the Minimum Data Set (MDS) assessment for Resident #83 dated 09/21/22 revealed the resident was severely cognitively impaired. Activities of daily living (ADL's) were not assessed. Review of the care plan for Resident #83 dated 09/15/22 revealed the resident was weight bearing and ambulatory. Review of the admission note for Resident #83 dated 09/15/22 revealed the resident was admitted to the secured men's behavioral unit and exhibited increased anxiety. Resident #83 was a wanderer, was non-cooperative, and walks into other rooms in the unit and refused care sometimes. Review of the nurse's progress note for Resident #83 dated 10/17/22 revealed the resident was in bed most of the shift but was noted going in and out of rooms on the unit during the meal hour. Review of the next nurse's progress note for Resident #83 dated 10/19/22 timed at 11:09 P.M. revealed per report the resident was sent to the emergency room due to being assaulted by another resident (Resident #22). Review of the hospital note for Resident #83 dated 10/20/22 revealed the resident had a history of catatonic schizophrenia and was nonverbal at baseline and presented to the hospital on 10/19/22 following a physical assault at the facility by another resident. Resident #83 had dried blood covering his face, bruising to both eyes, and swelling to the right eye and right side of face. X-ray revealed an acute right rib fracture. Review of the medical record for Resident #22 revealed an admitted [DATE] with a diagnosis of paranoid schizophrenia. Review of MDS assessment for Resident #22 dated 10/17/22 revealed the resident was cognitively intact and required supervision and set up with ADL's. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the nurse's progress note for Resident #22 dated 10/19/22 revealed the resident assaulted another resident (Resident #83) who had to be sent to the hospital for evaluation of injuries. Resident #22 was sent to the hospital via nine-one-one (911) for a psychological evaluation due to his behavior. Review of the hospital note for Resident #22 dated 10/20/22 revealed the resident reported to hospital staff that he got into an altercation last night at the facility after another resident touched his arm several times before he acted. Review of the facility SRI dated 10/19/22 revealed the facility conducted an investigation of alleged physical abuse between Resident #83 and Resident #22. The Administrator interviewed Resident #22 who stated that Resident #83 got about an inch from his face and was antagonizing him. He asked him to step back and leave him alone. Resident #22 stated that Resident #83 then hit him in the arm and then he hit Resident #83 back. The altercation was unwitnessed, but staff heard commotion in the activity area, and separated both residents. Resident #83 was sent to the hospital for assessment of his injuries and was not able to be interviewed. Resident #22 was assessed and had no injuries and was sent to the hospital for a psychological evaluation due to his behavior. The facility did not substantiate abuse. Review of the witness statement from agency State tested Nursing Assistant (STNA) #475 dated 10/19/22 revealed the aide called her into the room and said, He's beating him. Review of the statement revealed STNA #475 saw Resident #83 on the floor in the dining room with blood dripping down his face and he was unable to verbalize what happened. The statement revealed the aide felt Resident #83's injuries were serious, so they called 911. Resident #22 said Resident #83 had hit him, so he hit him back. Review of the witness statement from Licensed Practical Nurse (LPN) #155 revealed she was called to the unit and saw Resident #83 walking with blood coming from his face and eyes and she assisted with getting the resident sent to the hospital via 911 for an evaluation of his injuries. Resident #83 was nonverbal and unable to give an account of what happened. Resident #22 had no injuries and said he beat Resident #83 because he kept going into his room. Interview on 11/01/22 at 3:33 P.M. with the Administrator confirmed Resident #22 sustained no injuries in the altercation with Resident #83 on 10/19/22. Administrator confirmed when she interviewed Resident #22, he admitted he hit Resident #83 and that he did so in response to Resident #83 hitting him on the arm. Administrator confirmed she was not aware of the severity of Resident #83's injuries (rib fracture, black eyes, facial contusion) because she had not reviewed the hospital notes at the time of the SRI investigation. Review of the facility policy titled Resident Rights dated December 2016 revealed residents had the right to be free from abuse. Review of the facility policy titled Abuse and Neglect - Clinical Protocol dated March 2018 revealed Abuse was defined as the willful infliction of injury. The word willful as used in the definition of abuse meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The facility management and staff would institute measures to address the needs of residents and minimize the possibility of abuse and neglect. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00136846.

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure that residents were assessed for appropriateness for placement on a secured behavioral unit prior to being moved to the unit. This affected one (#79) of three residents reviewed for placement on a secured unit. The census was 82. Findings include: Review of the medical record for Resident #79 revealed an admitted [DATE] with a diagnoses including anxiety disorder, post-traumatic stress disorder (PTSD), schizoaffective disorder, and acute kidney failure. Review of the Minimum Data Set (MDS) for Resident #79 dated 10/11/22 revealed the resident was cognitively intact and required extensive assistance of one to two staff with activities of daily living (ADL's). Resident #79 was coded negative for the presence of behavioral symptoms. Review of the consent form for secured unit for Resident #79 dated 10/17/22 revealed it included the resident's signature and date of signing. The form was not signed by a facility representative. The space at the bottom of the form for a Registered Nurse (RN), Director of Nursing (DON), licensed representative, Medical Director, or resident's physician, who explained-the risk and benefits of restraint use to the resident to sign was left blank. Further review of the form revealed it noted the resident had been assessed by the IDT interdisciplinary team, and the assessment revealed resident had medical symptoms which warranted placement on the facility's 400 Hall unit which was a specialized locked unit that restricted resident's movement throughout the facility. Review of the physician orders for Resident #79 revealed there were no physician orders for resident to reside on the secured unit. Review of the care plan for Resident #79 dated 09/26/22 revealed the care plan did not include documentation regarding behaviors or the need for placement on a secured unit. Review of the nurse progress note for Resident #79 dated 10/18/22 revealed resident returned from dialysis and was moved to a room on the secured unit. Review of the nurse progress notes for Resident #79 dated 09/26/22 through 10/18/22 revealed there were no behavioral issues documented for resident. Review of the nurse progress note for Resident #79 dated 09/30/22 revealed the resident was adjusting well to facility. Review of the nurse progress note for Resident #79 dated 10/01/22 revealed the resident called 911 because she couldn't find the call light and resident was complaining of pain and was concerned their urinary catheter was infected. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse progress note for Resident #79 dated 10/09/22 revealed the resident was alert and oriented times three and was able to state needs. Review of nurse practitioner (NP) note for Resident #79 dated 10/12/22 revealed the resident complained of pain to her hips and shoulders and was tearful and upset. Resident #79 was crying, sad, and talking again about past traumatic events. Review of NP note for Resident #79 dated 10/18/22 revealed the resident appeared comfortable, was alert with no anxiety noted and in no acute distress. Review of the medical record for Resident #79 revealed there was no assessment for placement on a secured unit. Interview on 11/01/22 at 12:17 P.M. with the Director of Nursing (DON) confirmed Resident #79 did not have a physician's order to move to secured unit. DON confirmed Resident #79's care plan did not include documentation of behaviors or need for secured unit. DON confirmed Resident #79's progress notes did not include documentation of behaviors which would warrant need for a secured unit. DON confirmed Resident #79's record did not include an assessment for placement of Resident #79 on a secured unit. Interview on 11/01/22 at 12:20 P.M. with Social Service Designee (SSD) #135 revealed Resident #79 was moved to first floor of the facility to the secured women's behavioral unit on the second floor on 10/18/22. SSD #135 confirmed the facility had not completed an assessment regarding appropriateness for placement on the secured unit. SSD #135 confirmed she told Resident #79 on 10/17/22 that they wanted to move her upstairs and that resident signed the consent form. SSD #135 confirmed the consent form did include a signature indicating a licensed professional such as a nurse or physician had explained the risks and benefits of placement in a locked unit. SSD #135 confirmed they had a discussion in the morning meeting about Resident #79's behaviors which she was told included throwing herself on the floor, picking at her dialysis port, and calling 911 for non-emergent reasons. SSD #135 confirmed she had not completed a social service or behavioral assessment for resident Interview on 11/01/22 at 3:33 P.M. with the Administrator confirmed Resident #79 had been moved from the first floor of the facility to the locked unit on the 400 Hall on 10/18/22. Administrator confirmed she had not been involved in the decision to move the resident to the unit. Administrator confirmed Resident #79's record did not include an assessment regarding the resident's appropriateness for the unit. Review of the facility policy titled Behavioral Health Unit dated 01/2022 revealed behavioral health unit referred to a special care, secured unit for residents who might benefit from increased structure and supervision. The interdisciplinary team (IDT) would determine if placement on the Behavioral Healthcare Unit (BHU) was appropriate. Other factors considered in the determination for placement on the BHU included the following: behavioral history prior to any present incident or crisis, general coping skills, compliance with medication, conflict resolution/problem solving skills, compliance with therapy interventions, insight (awareness, understanding of one's own behavior and ability to positively adapt in the future). Each resident's needs would be evaluated on an individual basis and residents would not be automatically placed on BHU following a behavioral incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Numbers OH00137009 and OH00136916

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed to implement a baseline care plan based on resident's risk for falls. This affected one (#26) of three residents reviewed for falls. The census was 82. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including diabetes mellitus (DM) and epilepsy. Review of the admission Minimum Data Set (MDS) for Resident #26 dated 08/16/22 revealed the resident was severely cognitively impaired and required limited physical assistance of staff with activities of daily living (ADL's). Review of the care area assessment worksheets (CAA) for Resident #26 revealed the resident triggered for falls. Review of the worksheet narrative revealed resident was recently admitted and risks for falls was noted. Staff would monitor for decline and increased need for assistance. Staff will continue to assist and provide therapy as needed, interventions for prevention are placed as needed. Staff were to proceed to care plan for resident. Review of the fall risk assessment for Resident #26 dated 08/14/22 revealed the resident was at high risk for falls. Review of the medical record for Resident #26 revealed it did not include a baseline care plan. Review of the nurse progress note for Resident #26 dated 10/03/22 revealed the nurse was alerted by the aide that resident was on the floor in the dining room. Fall was unwitnessed and resident was unable to tell staff how she fell . Resident had no injuries and neurochecks revealed no negative findings. Review of the facility fall investigation dated 10/03/22 revealed the nurse was alerted by the aide that resident was on the floor in the dining room. Fall was unwitnessed and resident was unable to tell staff how she fell . Resident #26 had no injuries and neurochecks revealed no negative findings. There was a checklist of predisposing factors which could have contributed to the fall and the box indicating none was checked. The investigation did not include a determination as to the root cause of the fall nor did it include a review of the resident's care plan to determine if it needed to be updated with new interventions to prevent recurrence. Interview on 11/02/22 at 11:55 A.M. with the Director of Nursing (DON) confirmed Resident #26 was at risk for falls. DON confirmed the facility had not completed a baseline care plan for Resident #26. The DON confirmed part of preventing falls for residents was to assess residents for individual risk factors for falls and implement a baseline care plan upon admission with interventions to prevent falls. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Fall Policy dated 07/10/22 revealed each resident will be evaluated for safety risks, including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in preventing falls. Review of the facility policy titled Baseline Care Plan policy dated 11/28/17 revealed a base line plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. This deficiency represents non-compliance investigated under Complaint Number OH00136942.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed to implement a baseline care plan based on resident's risk for falls. This affected one (Resident #26) of three residents reviewed for falls. The census was 82. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including diabetes mellitus (DM) and epilepsy. Review of the admission Minimum Data Set (MDS) for Resident #26 dated 08/16/22 revealed the resident was severely cognitively impaired and required limited physical assistance of staff with activities of daily living (ADL's). Review of the care area assessment worksheets (CAA) for Resident #26 revealed the resident triggered for falls. Review of the worksheet narrative revealed resident was recently admitted and risks for falls was noted. Staff would monitor for decline and increased need for assistance. Staff will continue to assist and provide therapy as needed, interventions for prevention are placed as needed. Staff were to proceed to care plan for resident. Review of the fall risk assessment for Resident #26 dated 08/14/22 revealed resident was at high risk for falls. Review of the comprehensive care plan for Resident #26 dated revealed it did not include a care plan for fall risk. Review of the nurse progress note for Resident #26 dated 10/03/22 revealed the nurse was alerted by the aide that resident was on the floor in the dining room. Fall was unwitnessed and resident was unable to tell staff how she fell . Resident had no injuries and neurochecks revealed no negative findings. Review of the facility fall investigation dated 10/03/22 revealed the nurse was alerted by the aide that resident was on the floor in the dining room. Fall was unwitnessed and resident was unable to tell staff how she fell . Resident #26 had no injuries and neurochecks revealed no negative findings. There was a checklist of predisposing factors which could have contributed to the fall and the box indicating none was checked. The investigation did not include a determination as to the root cause of the fall nor did it include a review of the resident's care plan to determine if it needed to be updated with new interventions to prevent recurrence. Interview on 11/02/22 at 11:55 A.M. with the Director of Nursing (DON) confirmed Resident #26 was at risk for falls. DON confirmed the facility had not developed and implemented a comprehensive care plan for fall risk for Resident #26. The DON confirmed part of preventing falls for residents was to assess residents for individual risk factors for falls and develop a comprehensive care plan for residents at risk for falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Fall Policy dated 07/10/22 revealed each resident will be evaluated for safety risks, including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in preventing falls. Review of the facility policy titled Comprehensive Care Plans dated 09/26/22 revealed the facility would develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This deficiency represents non-compliance investigated under Complaint Number OH00136942.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed conduct thorough investigations to determine root cause analysis to identify potential hazards and resident-specific interventions to reduce and/or eliminate falls and falls with injury. This affected three (#22, #26, #67) of three residents reviewed for falls. The census was 82. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE] with a diagnosis of paranoid schizophrenia. Review of the Minimum Data Set (MDS) for Resident #22 dated 10/17/22 revealed the resident was cognitively intact and required supervision and set up with activities of daily living (ADL's.) Review of the admission nursing assessment for Resident #22 dated 10/10/22 revealed the resident was at risk for falls. Review of the care plan for Resident #22 dated 10/10/22 revealed the resident was at risk for falls. The care plan had one intervention: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Review of the nurse progress note for Resident #22 dated 10/18/22 timed at 9:57 P.M. revealed the resident's wheelchair rolled back and resident fell after the smoke break. The resident denied hitting his head. Review of the nurse practitioner (NP) progress note for Resident #22 dated 10/19/22 revealed NP evaluated resident for an unwitnessed fall out of his wheelchair on 10/18/22. Resident #22 had no injuries. Review of the facility fall investigation for Resident #22 dated 10/19/22 revealed the resident's wheelchair rolled back and resident fell out of his wheelchair after the smoking break per the aide. Resident #22 denied hitting his head. Resident #22 had no injuries and staff assisted him back into his wheelchair. Resident #22 was assessed for pain and had no pain. The resident's wheelchair was unlocked and there was clutter and crowding to the area where the fall occurred. The investigation did not include a determination as to the root cause of the fall nor did it include a review of the resident's care plan to determine if it needed to be updated with new interventions to prevent recurrence. 2. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including diabetes mellitus (DM) and epilepsy. Review of the MDS for Resident #26 dated 10/24/22 revealed the resident was severely cognitively impaired and required limited physical assistance of staff with ADL's. (continued on next page)

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Astoria Place of Cincinnati	3627 Harvey Avenue Cincinnati, OH 45229

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the fall risk assessment for Resident #26 dated 08/14/22 revealed the resident was at high risk for falls. Review of the care plan for Resident #26 dated revealed it did not include a care plan for fall prevention. Review of the nurse progress note for Resident #26 dated 10/03/22 revealed the nurse was alerted by the aide that resident was on the floor in the dining room. Fall was unwitnessed and resident was unable to tell staff how she fell . Resident #26 had no injuries and neurochecks revealed no negative findings. Review of the facility fall investigation dated 10/03/22 revealed the nurse was alerted by the aide that resident was on the floor in the dining room. Fall was unwitnessed and resident was unable to tell staff how she fell . Resident #26 had no injuries and neurochecks revealed no negative findings. There was a checklist of predisposing factors which could have contributed to the fall and the box indicating none was checked. The investigation did not include a determination as to the root cause of the fall nor did it include a review of the resident's care plan to determine if it needed to be updated with new interventions to prevent recurrence. 3. Review of the medical record for Resident #67 revealed an admitted [DATE] with a diagnosis of schizoaffective disorder. Review of the MDS for Resident #67 dated 07/18/22 revealed the resident was cognitively intact and required supervision and set up with ADL's. Review of the fall risk assessment for Resident #67 dated 07/08/22 revealed resident was at high risk for falls. Review of the care plan for Resident #67 last updated 08/30/19 revealed resident was at risk for falls related to psychoactive medications, unsteady gait, dementia, osteoarthritis, delusional disorder, use of insulin, and history of falls. Interventions included the following: call light kept within reach, monitor bipolar disorder, monitor for changes in mood, behavior, monitor blood sugars as ordered, monitor side effects of medications, re-educate resident to only wear non-slip socks or proper footwear when ambulating as needed, staff is to get her up before breakfast daily, staff will assist with transfers as needed, staff will provide a clear pathway, clutter free environment, therapy will treat as ordered, staff will assist with ambulation as needed with use of assistive devices. Review of the nurse progress note for Resident #67 dated 10/13/22 revealed the nurse found resident on the floor in her bathroom and she had vomited. Resident was lethargic and slurring her words and reported she felt weak when transferring herself from the toilet to the wheelchair. Resident was sent to the hospital for an evaluation. Review of hospital notes for Resident #67 dated 10/21/22 revealed resident had an inpatient stay at the hospital and was returning to the facility. Resident #67 sustained no injuries related to the fall on 10/13/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the fall investigation for Resident #67 dated 10/13/22 revealed the nurse found resident on the floor in her bathroom and she had vomited. Resident #67 was lethargic and slurring her words and reported she felt weak when transferring herself from the toilet to the wheelchair. Resident #67 was sent to the hospital for an evaluation. There was a checklist of predisposing factors which could have contributed to the fall and the box indicating drowsiness was checked. The investigation did not include a determination as to the root cause of the fall nor did it include a review of the resident's care plan to determine if it needed to be updated with new interventions to prevent recurrence. Interview on 11/01/22 at 12:17 P.M. with the Director of Nursing (DON) confirmed the fall investigations for Residents #22, #26, and #67 had not been fully completed. DON confirmed the nurse documenting the falls had started the investigation by providing a narrative summary of the fall and completing a checklist of predisposing factors. DON further confirmed the rest of the investigations had not been completed. DON confirmed the facility interdisciplinary team (IDT) was supposed to determine the root cause of the resident's fall, the IDT should determine if the interventions in the resident's care plan were in place at the time of the fall and should also determine if the residents' care plan needed to be updated to prevent possible recurrence of falls and minimize risk of injury. Interview on 11/01/22 at 3:33 P.M. with the Administrator confirmed the facility fall investigations for Residents #22, #26, and #67 had been started by the nurse documenting the falls but complete fall investigations had not been completed for the residents. Review of the facility policy titled Fall Policy dated 07/10/22 revealed each resident will be evaluated for safety risks, including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in preventing falls. All falls are to be investigated and monitored. The Interdisciplinary Plan of Care (IPOC) team will meet within the same period and discuss the causative factors, interventions to prevent another fall, make therapy referral as necessary, and revise the care plan if necessary. This deficiency represents non-compliance investigated under Complaint Number OH00136942. This deficiency represents ongoing non-compliance from the survey dated 10/18/22.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, review of hospital records, staff interview, and review of the facility policy, the facility failed to investigate resident incidents of self-harm/suicide attempts. This affected two (#32 and #79) of three residents reviewed for self-harm/suicide attempts. The census was 82. Findings include: 1. Review of the medical record for Resident #79 revealed an admitted [DATE] with a diagnoses including anxiety disorder, post-traumatic stress disorder (PTSD), schizoaffective disorder, and acute kidney failure. Review of the Minimum Data Set (MDS) for Resident #79 dated 10/11/22 revealed the resident was cognitively intact and required extensive assistance of one to two staff with activities of daily living (ADL's). Resident #79 was coded negative for the presence of behavioral symptoms. Review of the care plan for Resident #79 dated 09/26/22 revealed it did not address behavioral or psychiatric issues. Review of the MDS for Resident #79 dated 10/23/22 revealed the resident was discharged from the facility with a return not anticipated. Review of the hospital note for Resident #79 dated 10/24/22 revealed the resident had damaged her hemodialysis cath catheter prior to admission to the facility with both hubs of the catheter severed. Resident #79 had to have the dialysis catheter removed and new catheter surgically implanted. Review of hospital note for Resident #79 dated 10/25/22 revealed the resident presented to the hospital on 10/23/22 for an attempt at self-harm by cutting her hemodialysis catheter. Resident #79 was transferred to the inpatient psychiatric unit following surgery. Suicidal ideation was one of the problems treated at the hospital. Resident #79 had a bedside sitter and was placed on suicide precautions during her stay. Resident #79 reported having emotional difficulties throughout her life and suffered from bullying and practiced self-cutting in adolescence. Resident #79 reported episodes of hopelessness with active suicidal ideation since her mom passed away five years ago. Interview on 11/01/22 at 3:33 P.M. with the Administrator confirmed she heard Resident #79 was sent to the hospital on 10/23/22 due to attempting to cut her dialysis catheter. Administrator confirmed she was unsure if resident cut the catheter in the facility or at the dialysis clinic. Administrator confirmed she wasn't sure if the resident was sent to the hospital from the facility or from the dialysis clinic, but she had learned the resident had decided not to return to the facility. Administrator confirmed the facility had not completed an investigation regarding the self-harm incident for Resident #79. Administrator confirmed Resident #79's record did not include a description of the incident. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/02/22 at 1:29 P.M. with the Director of Nursing (DON) conferred Resident #79's record did not have a description of the incident involving self-harm on 10/23/22. DON confirmed on 10/23/2022 at approximately 1:45 P.M. Resident #79 was transferred to the hospital via 911 due to suicidal ideation as evidenced by tampering with her dialysis access device. Resident #79 approached the direct care staff and stated Look what I did while gesturing to her port and then told staff if they didn't send her to the hospital, she would rip the port out of her body. 2. Review of the medical record for Resident #32 revealed an admitted [DATE] with a diagnosis of schizoaffective disorder. Review of the MDS for Resident #32 dated 09/30/22 revealed the resident was cognitively impaired and required supervision and set up with ADL's. Review of the care plan for Resident #32 dated 12/11/28 revealed resident had feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by; ineffective coping, low self-esteem, tearfulness, motor agitation, withdrawal from care/ activities related to feelings of failure as evidenced by suicide attempts. Interventions included the following: acknowledge resident moods in one-on-one interactions, remove resident to quiet room and spend 15 minutes to reassure, administer medications as prescribed. Encourage resident to attend group activities, encourage verbalization, offer assistance with activities only after resident attempts activity on own, realistically discuss resident's weaknesses and determine options to improve with resident. Review of the nurse progress note for Resident #32 dated 10/19/22 revealed the nurse was alerted that resident had slit his wrist. Nurse applied pressure to the resident's wrist to control the bleeding and called 911 and sent resident to the hospital. Review of the hospital note for Resident #32 dated 10/21/22 revealed the resident was admitted to the hospital after intentionally cutting his left wrist with a shard of glass at the facility. Resident #32 remembered cutting his wrist and was not sure how he did it. Resident #32 reported he had been feeling depressed and anxious and that the devil had been speaking to him. Interview on 11/01/22 at 3:33 P.M. with the Administrator confirmed Resident #32 was sent to the hospital on 10/19/22 due to a suicide attempt. Resident #32 had slit his wrists with a sharp object-she was unsure what he used. Administrator confirmed the facility had not conducted an investigation regarding Resident #32's suicide attempt. Interview on 11/04/22 at 11:00 A.M. with the Administrator confirmed the facility did not have a policy regarding suicidal ideation/threats. Review of the facility policy titled Behavioral Management Policy dated March 2019 revealed the interdisciplinary team would evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. This deficiency represents non-compliance investigated under Complaint Numbers OH00137009 and OH00136992.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, staff interview, and review of facility policy, the facility failed to ensure residents received medications as ordered by the physician. This affected one (#83) of three residents reviewed for medications. The census was 82. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE] with a diagnosis of undifferentiated paranoid schizophrenia. Review of the Minimum Data Set (MDS) for Resident #83 dated 09/21/22 revealed resident was severely cognitively impaired. Activities of daily living (ADL's) were not assessed. Review of the care plan for Resident #83 dated 09/15/22 revealed resident had an order for anti-anxiety medication use. Goal of care plan was for the resident to be free from discomfort or adverse reactions related to anti-anxiety therapy. Interventions included the following: administer anti-anxiety medications as ordered by physician, educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of the medication. Review of the admission physician orders for Resident #83 revealed an order dated 09/15/22 for resident to receive Ativan three times daily routinely for anxiety disorder. Review of nurse progress notes for Resident #83 dated 09/16/22, 09/17/22, 09/18/22, and 09/21/22 revealed the resident did not receive Ativan as ordered due to the medication was not available. Review of the September 2022 Medication Administration Record (MAR) for Resident #83 revealed Ativan was not administered on 09/15/22 through 09/21/22. Review of the medical record for Resident #83 revealed there were no controlled substance count sheets for Ativan for Resident #83 for 09/15/22 through 09/21/22. Interview on 11/01/22 at 12:17 P.M. with the Director of Nursing (DON) confirmed Resident #83 did not receive Ativan as ordered three times daily on 09/15/22 through 09/21/22 due to medication was not available. DON confirmed resident's record did not include documentation of physician notification regarding the missed doses. DON confirmed the facility was unable to locate controlled substance count sheets for Ativan for Resident #83 for 09/15/22 through 09/21/22. Review of the facility policy titled Administering Medications dated December 2012 revealed med's administered in a safe and timely manner and as prescribed. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure residents were free from unnecessary medications by ensuring residents were free of duplicate medications. This affected one (#59) of three residents reviewed for medications The census was 82. Findings include: Review of the medical record for Resident #59 revealed an admitted [DATE] with a diagnosis of dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) for Resident #59 dated 10/03/22 revealed the resident was cognitively intact. Activities of daily living (ADL's) were not assessed. Review of October 2022 monthly physician orders for Resident #59 revealed an order dated 09/13/22 for the resident to receive Macrobid (also known as nitrofurantoin) 100 milligrams (mg) by mouth once daily for prevention of urinary tract infection (UTI). Review of the September, October, and November 2022 Medications Administration Records (MAR's) for Resident #59 revealed resident received daily dose of Macrobid as ordered. Review of urinalysis for Resident #59 dated 10/05/22 revealed urine was turbid and positive for protein, leukocytes, and a moderate number of bacteria. A culture and sensitivity were not completed. Review of physician orders for Resident #59 revealed an order dated 10/28/22 to obtain a urine specimen STAT (immediately) and send to the lab for urinalysis and culture and sensitivity and for resident to receive nitrofurantoin 100 mg twice daily for five days for UTI symptoms. Review of the nurse practitioner (NP) progress note for Resident #59 dated 10/28/22 revealed Resident #59 had an abnormal urinalysis on 10/05/22 which indicated presence of a UTI, but a culture and sensitivity was not completed by the lab at that time. Review of NP note revealed an order for nitrofurantoin twice daily for five days and for the facility to obtain a stat urine specimen and send to the lab for urinalysis and culture and sensitivity. Review of the medical record for Resident #59 revealed it did not include results of urinalysis or culture and sensitivity ordered on 10/28/22. Review of the October and November 2022 MAR's for Resident #59 revealed resident received nitrofurantoin twice daily from 10/28/22 to 11/01/22. Observation on 11/01/22 at 8:43 A.M. of medication administration for Resident #59 per Registered Nurse (RN) #470 revealed Resident #59 had a card of Macrobid tablets 100 mg in the cart with instructions to administer once daily for prophylaxis and a card of nitrofurantoin tablets 100 mg in the cart with instructions to administer twice daily for five days starting on 10/28/22. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/01/22 at 8:43 A.M. with RN #470 confirmed Resident #59 had duplicate orders for nitrofurantoin because Macrobid was the same medication as nitrofurantoin. RN #470 confirmed Macrobid was the trade name and nitrofurantoin were the generic name. Interview on 11/01/22 at 12:17 P.M. with the Director of Nursing (DON) confirmed Resident #59 had duplicate orders for the antibiotic Macrobid/nitrofurantoin and the prescriber should be consulted for clarification. Interview on 11/01/22 at 12:25 P.M. with Nurse Practitioner (NP) #480 confirmed Resident #59 had been prescribed duplicate medications because of her existing order for Macrobid once daily for prophylaxis and the new order dated 10/28/22 for twice daily nitrofurantoin. NP #480 further confirmed it was not her intent to order duplicate antibiotic therapy. Review of the facility policy titled Administering Medications dated December 2012 revealed if a dosage of a medication is believed to be inappropriate or excessive for a resident, the nurse should contact the resident's attending physician to discuss the concerns. This deficiency represents non-compliance investigated under Complaint Number OH00136916.

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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** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure residents were free from unnecessary psychotropic medication when staff failed to administer as needed antipsychotic's only when needed to treat a medical symptoms and the facility failed to attempt non-pharmacological interventions prior to administration of an as needed injectable anti-psychotic medication. This affected one (#83) of three residents reviewed for medications. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE] with a diagnosis of undifferentiated paranoid schizophrenia. Review of the Minimum Data Set (MDS) for Resident #83 dated 09/21/22 revealed the resident was severely cognitively impaired. Activities of daily living (ADL's) were not assessed. Review of the care plan for Resident #83 dated 09/15/22 revealed it did not include a care plan for the use of anti-psychotic medications nor did it include a care plan for behavioral symptoms. Review of the admission physician orders for Resident #83 revealed an order dated 09/15/22 for resident to receive the antipsychotic Geodon per intramuscular injection once daily as needed for psychotic behaviors. Review of the nurse progress note for Resident #83 dated 09/16/22 timed at 2:17 A.M. revealed resident received an as-needed IM injection of Geodon. The note did not include documentation of behavioral symptoms which would warrant the use of an injectable antipsychotic medication nor did the note include documentation regarding non-pharmacological interventions attempted prior to administration of the medication. Interview on 11/01/22 at 12:17 P.M. with the Director of Nursing (DON) confirmed Resident #83 received Geodon via IM injection on 09/16/22. DON confirmed the resident's record did not include documentation of behavioral symptoms which would warrant the use of an injectable antipsychotic medication nor did the note include documentation regarding non-pharmacological interventions attempted prior to administration of the medication. Review of the facility policy titled Behavioral Assessment, Intervention and Monitoring dated March 2019 revealed non-pharmacologic approaches would be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. When medications were prescribed for behavioral symptoms, documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to the use of antipsychotic medication, potential risks and benefits of medications as discussed with the resident and/or family. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00137009.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, review of laboratory test results, staff interview, and review of the facility policy, the facility failed to obtain urinalysis and culture and sensitivity testing as ordered by the provider. This affected one (#59) of three residents reviewed for infections. The census was 82. Findings include: Review of the medical record for Resident #59 revealed an admitted [DATE] with a diagnosis of dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) for Resident #59 dated 10/03/22 revealed resident was cognitively intact. Activities of daily living (ADL's) were not assessed. Review of October 2022 monthly physician orders for Resident #59 revealed an order dated 09/13/22 for resident to receive Macrobid (also known as nitrofurantoin) 100 milligrams (mg) by mouth once daily for prevention of urinary tract infection (UTI). Review of urinalysis for Resident #59 dated 10/05/22 revealed urine was turbid and positive for protein, leukocytes and a moderate amount of bacteria. Review of physician orders for Resident #59 revealed an order dated 10/28/22 to obtain a urine specimen stat (immediately) and send to the lab for urinalysis and culture and sensitivity and for resident to receive nitrofurantoin 100 mg twice daily for UTI symptoms. Review of the nurse practitioner (NP) progress note for Resident #59 dated 10/28/22 revealed Resident #59 had an abnormal urinalysis on 10/05/22 which indicated presence of a UTI but a culture and sensitivity was not completed by the lab at that time. Review of NP note revealed an order for nitrofurantoin twice daily for five days and for the facility to obtain a stat urine specimen and send to the lab for urinalysis and culture and sensitivity. Review of the medical record for Resident #59 revealed it did not include results of urinalysis or culture and sensitivity ordered on 10/28/22. Interview on 11/01/22 at 12:17 P.M. with the Director of Nursing (DON) confirmed the facility had not obtained a urine specimen for Resident #59 as ordered by the NP on 10/28/22. Review of the facility policy titled Antibiotic Stewardship dated December 2016 revealed when a culture and sensitivity (C&S) is ordered lab results and the current clinical situation should be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. This deficiency represents non-compliance investigated under Complaint Number OH00136916.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39703 Based on review of facility documents, staff interview, and review of the facility policy, the facility failed to conduct ongoing surveillance of infections. This had the potential to affect all 82 residents residing in the facility. The census was 82. Findings include: Review of antibiotic list for the facility dated 10/01/22 to 10/30/22 revealed there were several residents in the facility with orders for antibiotic medications for infections such as urinary tract infection (UTI), yeast infection, and skin infection. Surveyor requested infection log for the facility from August through October 2022 on 10/31/22 at 11:19 A.M. Interview on 11/01/22 at 12:17 P.M. with the Director of Nursing (DON) confirmed she was new to her role and could not find the facility infection logs requested for August through October 2022. DON confirmed she knew there were residents with infections, and she provided a list of residents currently on antibiotic medications. DON confirmed the facility should conduct ongoing infection surveillance and there should be a chronological line-listing of infections listing residents' name and type of infection, date of onset and treatment so that the facility could watch for trends and concerns regarding infections. DON confirmed she was unable to locate infection logs for the facility for August through October 2022. Interview on 11/01/22 with the Administrator confirmed the facility should maintain an infection log but they were unable to locate the infection log for August through September 2022. Review of the facility policy titled Monitoring Compliance with Infection Control dated September 2017 revealed the facility Infection Preventionist (IP) should provide reports to the Quality Assurance Performance Improvement (QAPI) Committee of the facility's infection surveillance data. The Committee should review and act upon, as necessary, surveillance and monitoring records. This deficiency represents non-compliance investigated under Complaint Number OH00136916.