STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366175	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at the Meadows	11760 Pellston Court Cincinnati, OH 45240

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure resident call lights were in reach and footrests were placed on wheelchair per resident's preference. This affected two (#10 and #60) of 17 residents sampled. The census was 63. Findings include: 1. Review of the medical record for Resident #10 revealed an admitted [DATE] with a diagnosis of paraplegia. Review of the Minimum Data Set (MDS) assessment, dated 05/16/22, revealed Resident #10 was mildly cognitively impaired and required extensive assistance of one to two staff with activities of daily living (ADLs). Review of the care plan dated 05/16/22 revealed Resident #10 had an ADL self-care performance deficit related to activity intolerance, disease process paralysis due to gunshot wound, hemiplegia, impaired balance, limited mobility, limited range of motion, musculoskeletal impairment, pain, shortness of breath. Interventions included staff to assist resident with mobility and adaptive devices. Review of the care plan dated 05/16/22 revealed Resident #10 had impaired physical mobility related to decreased range of motion, neuromuscular impairment, pain/discomfort, partial paralysis (hemiplegia), right sided neglect. Interventions included call light in reach. Observation on 008/03/22 at 4:00 P.M. revealed Resident #10 was up in his wheelchair and his call light was not in reach and his footrests were not on his wheelchair. Interview on 08/03/22 at 4:00 P.M. with Resident #10 confirmed the aides had gotten him up in his chair using the Hoyer lift. The staff had left his call light attached to wall and he was unable to reach it. Resident #10 confirmed he thought they were coming back to put his footrests on his wheelchair so he could wheel himself out to the smoking area. Resident confirmed it was not safe for him to propel himself in the wheelchair with footrests in place because his legs were paralyzed. (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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/03/22 at 4:03 P.M. with Licensed Practical Nurse (LPN) #300 confirmed Resident #10's call light was out of reach and his footrests were not on his wheelchair. LPN #300 further confirmed Resident #10 was able to use his call light and it should be left within his reach. LPN #300 further confirmed resident's footrests need to be on his wheelchair for safety. 2. Review of medical record for Resident #60 revealed an admitted d of 12/13/19 with a diagnosis of schizoaffective disorder. Review of the MDS for Resident #60 dated 07/08/22 revealed resident was cognitively impaired and required extensive assistance with ADLs. Observation on 08/15/22 at 8:24 A.M. revealed Resident #60 was sitting up in his wheelchair next to his bed and his call light was hanging on the wall out of the resident's reach. Interview on 08/15/22 at 8:24 A.M. with Resident #60 confirmed his aide got him up in his wheelchair but didn't give him his call light and he wasn't able to reach it. Interview on 08/15/22 at 8:25 A.M. with State tested Nursing Assistant (STNA) #235 confirmed she had assisted Resident #60 into his wheelchair and did not place his call light within reach before leaving the room. Review of the facility policy titled Answering the Call Light, dated March 2021, revealed when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. This deficiency substantiates Complaint Number OH00133445.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, observation, resident interview, staff interview and review of facility policy, the facility failed to ensure residents had a safe, clean, and sanitary environment. This affected one (#8) resident out of 17 sampled for room environment and 13 residents (#8, #10, #12, #24, #27, #29, #35, #39, #40, #44, #56, and #317) who the facility identified who smoked and one resident. The facility census was 63. Findings include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE] with a diagnosis of paraplegia. Observation on 08/02/22 at 9:56 A.M. of Resident #8's room revealed the resident was resting in bed and there was a large puddle of emesis on the floor adjacent to his bed. Interview on 08/02/22 at 9:56 A.M. with Resident #8 confirmed there was a large puddle of emesis on the floor in his room. Resident #8 confirmed he was sick to his stomach the night before and he threw up. Resident #8 confirmed staff had offered him breakfast which he refused but no one had offered to clean up the vomit. Interview on 08/02/22 at 10:05 A.M. with Licensed Practical Nurse (LPN) #340 confirmed the night nurse had told her in report that Resident #8 had complained of stomach pain last night and she had offered him a Zofran, but he refused. LPN #340 confirmed she had not been in resident's room yet to assess him and had not noticed the vomit on the floor until called to the room by the surveyor. Interview on 08/02/22 at 10:12 A.M. with State tested Nursing Assistant (STNA) #410 confirmed she had offered resident a breakfast tray sometime earlier in the morning, but he refused. STNA #410 confirmed she did not notice the vomit on the floor when she entered resident's room earlier in the shift. 2. During observations on 08/01/22 at 1:13 P.M. revealed 11 Residents (#40, #44, #24, #56, #58, #317, #29, #12, #39, #27, and #35) smoking on the outside patio. Further observations revealed numerous cigarette butts which littered the area and numerous cigarette butts in the trashcan. Interview with Activities Staff #540 on 08/01/22 at 1:18 P.M. revealed she was tasked with monitoring the smokers. Activities Staff #540 verified the numerous cigarette butts littering the smoking area. Review of undated facility policy titled Smoking revealed the facility would allow residents to the ability to smoke while maintaining facility safety.

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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** 39703 Based on record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure residents received proper nail care. This affected three (Resident #7, #25, #42) of four residents sampled for activities of daily living (ADLs.) The facility census was 63. Findings include: 1. Review of the medical record for Resident #7 revealed an admitted [DATE] with a diagnosis of myopathy. Review of the Minimum Data Set (MDS) assessment, dated 08/03/22, revealed Resident #7 was cognitively impaired and required extensive assistance of one staff with ADLs. Review of the care plan for Resident #7, dated 08/02/22, revealed an ADL self-care deficit. Interventions included assist with ADLs and keep nails short and clean. Review of the care plan for Resident #7, dated 08/02/22, revealed the resident had the potential for impaired skin integrity and was at risk for skin tears. Interventions included staff should assist with hygiene and general skin care. Observation on 08/01/22 at 3:31 P.M. of Resident #7 revealed the resident's toenails were long, jagged and needed to be trimmed. The toenail extended past the toe approximately one fourth of an inch. Interview on 08/01/22 at 3:31 P.M. with Resident #7 confirmed the toenails were long and had not been trimmed recently. Interview on 08/01/22 at 3:32 P.M. with Licensed Practical Nurse (LPN) #575 confirmed Resident #7's toenails were long and jagged and needed to be trimmed. 2. Review of the medical record for Resident #25 revealed and admitted [DATE] with a diagnosis of cerebral infarction. Review of the MDS assessment, dated 07/27/22, revealed resident was cognitively impaired and required extensive assistance of one to two staff with ADLs. Review of the care plan for Resident #25, dated 04/09/21, revealed resident had an ADL self-care performance deficit. Interventions included staff to assist resident in keeping fingernails short and clean. Observation on 08/01/22 at 1:03 P.M. of Resident #25 revealed the resident's fingernails were long and had debris underneath them. The fingernail extended approximately one quarter inch beyond the end of the fingers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/01/22 at 1:03 P.M. with Resident #25 confirmed his fingernails were too long and needed to be trimmed. Interview on 08/01/22 at 1:04 P.M. with State tested Nursing Assistant (STNA) #280 confirmed Resident #25's nails were long and had debris under them. STNA #280 confirmed the resident's fingernails needed to be trimmed and cleaned. 3. Review of the medical record for Resident #42 revealed an admitted [DATE] with a diagnosis of diabetes mellitus (DM). Review of MDS assessment, dated 07/17/22, revealed resident was cognitively intact and required extensive assistance of one staff with ADLs. Review of the care plan for Resident #42, dated 07/14/22, revealed an ADL self-care performance deficit. Interventions included staff should assist resident with ADLs and should ensure resident's fingernails are kept short and clean. Observation on 08/01/22 at 1:12 P.M. of Resident #42 revealed the resident's fingernails were long and had debris underneath them. The fingernail extended approximately one quarter inch beyond the end of the fingers. Interview on 08/01/22 at 1:12 P.M. with Resident #42 confirmed his fingernails were too long and needed to be trimmed. Interview on 08/01/22 at 1:13 P.M. STNA #220 confirmed Resident #42's nails were too long and had debris under them. STNA #220 confirmed resident's fingernails needed to be trimmed and cleaned but since he was a diabetic only the nurse could do that. Review of the facility policy titled Care of Fingernails and Toenails, dated February 2018, revealed nail care included daily cleaning and regular trimming and proper nail care could aid in the prevention of skin problems around the nail bed. This deficiency substantiates Complaint Number OH00133445 and Complaint Number OH00133627.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed to monitor resident bowel functioning. This resulted in actual harm for Resident #45 when the resident went multiple days with no bowel movements and was subsequently treated at the hospital for severe fecal impaction. The facility also failed to ensure compression stockings were in place as ordered. This affected one resident (#45) out of three reviewed for bowel monitoring and one (#60) of five facility-identified residents with orders for compression stockings. The facility census was 63. Findings include: 1. Review of the medical record for Resident #45 revealed and admitted [DATE] with a diagnosis of traumatic brain injury (TBI.) Review of the Minimum Data Set (MDS) assessment, dated 07/07/22, revealed Resident #45 was cognitively impaired and required extensive assistance of one to two staff with activities of daily living (ADLs), including toilet use. Resident #45 was incontinent of bowel. Review of physician orders dated 12/20/21 revealed senna tablets daily for treatment of constipation and Miralax as needed for constipation. Review of the February 2022 Medication Administration Record (MAR) for Resident #45 revealed resident received senna daily but did not receive any doses of Miralax. Review of the care plan for Resident #45, updated 05/23/22, revealed the resident had an alteration in bowel elimination; constipation related to immobility, pain medication use, and psychotropic medication use. Interventions included: administer laxatives per physician orders, assist with toileting as needed, record all stools, report irregularities to charge nurse, encourage fluid intake as appropriate, note signs and symptoms of constipation, monitor stool frequency, and follow bowel regimen protocol as needed, encourage the resident to voice the need to have bowel movements, report to charge nurse any complaints of abdominal discomfort or difficulty having a bowel movement. Review of the nurse progress note dated 02/22/22 revealed the resident was found with her gastrostomy tube (g-tube) dislodged and the resident was unable to verbalize how long the tube had been out. Resident #45 was sent to the hospital via 911 due to g-tube dislodgement. Review of hospital records for Resident #45, dated 02/22/22, revealed the resident presented in the emergency room with a chief complaint of dislodged g-tube. Resident's abdomen was distended and rigid. The resident was noted with moderately severe constipation and severe fecal impaction causing partial obstruction of the colon. General surgery was consulted and recommended Resident #45 receive soapsuds enemas every four hours and Miralax every six hours per g-tube. Review of nurse progress note for Resident #45 dated 02/23/22 revealed the facility received a report that resident was being admitted to the hospital for a diagnosis of urinary tract infection (UTI.). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of bowel record for Resident #45 for February 2022 revealed there were no bowel movements recorded for 02/01/22, 02/02/22, 02/03/22, 02/04/22, 02/05/22, 02/06/22, 02/07/22, 02/08/22, 02/09/22, 02/10/22, 02/12/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/19/22, 02/20/22, 02/20/22, 02/21/22, 02/22/22. Review of bowel record revealed the resident was incontinent of a small amount of formed stool times one on the each of the following days: 02/11/22, 02/13/22, 02/18/22. Review of nurse progress note dated 02/2622 revealed Resident #45 was readmitted to the facility with no new orders. Interview on 08/02/22 at 3:59 P.M. with State tested Nursing Assistant (STNA) #410 confirmed Resident #45's bowel record for February 2022 revealed the resident did not have bowel movements on the following dates: 02/01/22, 02/02/22, 02/03/22, 02/04/22, 02/05/22, 02/06/22, 02/07/22, 02/08/22, 02/09/22, 02/10/22, 02/12/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/19/22, 02/20/22, 02/20/22, 02/21/22, 02/22/22. STNA #410 confirmed Resident #45's bowel record for February 2022 indicated resident was incontinent of a small amount of formed stool times one on the following dates: 02/11/22, 02/13/22, 02/18/22. STNA #410 confirmed staff should inform the nurse if a resident goes three days or longer without a bowel movement (BM.) Interview on 08/03/22 at 8:14 A.M. with Licensed Practical Nurse (LPN) #285 confirmed if an aide says a resident has gone two to three days without a BM the nurse should assess the resident, check for as needed constipation medications, and call the physician if no results from the as needed medications. Interview on 08/03/22 at 9:16 A.M. with STNA #255 confirmed the computerized charting system gives the aide an alert if a resident has gone too long without a BM. STNA #255 confirmed she would notify the nurse if resident went more than two days without a BM or if they showed signs of abdominal pain. Interview on 08/03/22 at 12:44 P.M., Regional Director of Clinical Operations (RDCO) #580 confirmed the facility's bowel protocol per the medical director was if resident had no BM in three days the nurse should administer Miralax or senna and if still no BM, notify the physician. Interview on 08/04/22 at 1:55 P.M. with the Director of Nursing (DON) confirmed Resident #45 was sent to the hospital for a dislodged g-tube on 02/22/22 and at the hospital they discovered the resident had a severe fecal impaction. The DON further confirmed the bowel record for Resident #45 for February 2022 showed the resident went multiple days without a BM and had only three small BMs recorded for the month of February 2022 prior to the resident's hospitalization . 2. Review of the medical record for Resident #60 revealed an admitted d of 12/13/19. Diagnosis included schizoaffective disorder, bipolar, dementia with behavioral issues, falls, anxiety, repeated falls, and muscle weakness. Review of physician orders dated 05/24/22 revealed Resident #60 was ordered to have ted hose to bilateral lower legs. Review of July and August 2022 treatment administration record (TAR) revealed no documented evidence of resident having ted hose in place. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observations on 08/01/22 at 3:00 P. M revealed Resident #60 was lying in bed with no ted hose in place. Interview with Stated tested Nurse's Aide (STNA) #220 at this time verified the resident had no ted hose in place. STNA #220 stated she had never seen Resident #60 wear TED hose. Interview 08/01/22 at 3:05 P.M. with Registered Nurse (RN) #565 verified Resident #60 was ordered ted hose and verified the resident had no ted hose in place. Observations on 08/02/22 from 6:30 A.M. to 12:30 P.M. reveled Resident #60 was seated in his wheelchair without ted hose in place. Interview on 08/02/22 at 12:36 P.M. with LPN #285 verified Resident #45 had no ted hose in place. LPN #285 was observed to look through resident's personal items and stated she could not find any ted hose. Interview on 08/02/22 at 1:05 P.M. with LPN #285 verified Resident#60 was ordered ted hose but the facility had nothing in place to record and monitor to ensure resident had ted hose placed and removed. LPN #285 stated she updated the physician orders and added ted hose to the TAR so application could be recorded. This deficiency substantiates Complaint Number OH00133859.

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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 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** 39703 Based on record review, staff interview, and review of the facility policy, the facility failed to assess and monitor a pressure ulcer for one (#10) resident. The facility identified four residents with pressure ulcers. The census was 63. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with a diagnosis of paraplegia. Review of the Minimum Data Set (MDS) assessment, dated 05/16/22, revealed resident was mildly cognitively impaired and required extensive assistance of one to two staff with activities of daily living (ADLs). Resident was coded as negative for the presence of pressure ulcers and was at risk for the development of pressure ulcers. Review of the pressure ulcer risk assessment for Resident #10 dated 05/12/22 revealed the resident was at low risk for the development of pressure ulcers. Review of the care plan for Resident #10 dated 05/16/22 revealed a potential for impairment of skin integrity and at risk for skin tears, poor tissue integrity, potential for infection related to altered nutritional state, disease process, immobility, impaired tactile sense, neurological impairment. Interventions included assist with hygiene and general skin care, keep skin clean and dry, apply protective cream after each incontinent episode, turn and reposition per protocol, elevate heels from bed surface while in bed utilizing pillows, and monitor skin risk assessment quarterly. Review of weekly skin checks per licensed nurse for Resident #10 dated 06/02/22, 06/09/22, 06/12/22 revealed resident's skin was intact. Review of the nurse progress note by Licensed Practical Nurse (LPN) #390, dated 06/15/22, revealed Resident #10 had an open area to his sacrum which was identified by the resident's family member. The physician was notified and an order was given to cleanse area with normal saline, pat dry, apply collagen to the wound bed and cover with dry clean dressing once daily and as needed. Review of the medical record for Resident #10 from 06/15/22 to 06/28/22 revealed it did not include an assessment or measurements of the open area to resident's sacrum first identified on 06/15/22. Review of the wound physician visit note dated 06/29/22 revealed Resident #10 had a stage IV pressure ulcer to his sacrum, first noted on 06/15/22, which measured 1.3 centimeters (cm) in length by 0.6 cm in width by 0.4 cm in depth. Composition of the wound was 90 percent (%) granulation tissue and 10% slough. Interview on 08/03/22 at 1:50 P.M. with LPN #390 confirmed Resident #10's representative took a picture of the wound on resident's sacrum and showed it to her. LPN #390 confirmed the facility did not conduct a measurement or assessment of the resident's wound until 06/29/22. (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 undated facility policy titled Pressure Ulcer/Injury Risk Assessment revealed if a new skin alteration is noted the nurse should initiate a (pressure or non-pressure) form related to the type of alteration in skin to document details of the alteration. This deficiency substantiates Complaint Number OH00133445.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40472 Based on observations, staff interviews, medical records review, and review of facility policy, the facility failed to ensure residents environment was free of accident hazards for two (#56 and #60) residents reviewed for falls. Additionally the facility failed to complete quarterly smoking assessments and utilize identified protective aprons while smoking for four (#44, #56, #27 and #29) of 13 residents identified by the facility who smoked. Lastly the facility failed to ensure hazardous chemicals and items were secured on a secured unit. This had the potential to affect all 21 Residents (#61, #62, #17, #364, #21, #40, #37, #32, #363, #55, #09, #59, #43, #35, #14, #52, #02, #04, #28, #54, and #01) who resided in the secured unit who the facility identified as being cognitively impaired and independently mobile. The facility census was 63. Findings include: 1. Review of medical record for Resident # 56 revealed an admitted [DATE]. Diagnoses included cerebral infarction with hemiplegia, lack of coordination, schizophrenia, muscle weakness, difficult in walking, dysphagia, convulsions/epilepsy, and vascular dementia. Review of the most recently completed Minimum Data Set (MDS) assessment, dated 07/04/22, revealed Resident #56 was cognitively intact. Review of the fall risk assessment for Resident #56, dated 06/15/22, revealed the resident was unable to independently come to a standing position. Review of physician orders dated 09/22/16 revealed Resident #56 was ordered Dycem to the wheelchair at all times. Review of physician orders dated 11/19/21 revealed an order for anti-tippers to the wheelchair. Review of the care plan revealed Resident #56 was at risk for falls, had poor balance, weakness, wandered daily and resident had poor safety awareness. Interventions included anti-tippers to wheelchair and Dycem (anti-slip) mat to wheelchair. Observation on 08/01/22 at 9:08 A.M. revealed Resident #56 sitting in a wheelchair inside his room. The wheelchair had no anti-tippers affixed to wheelchair. Observation on 08/01/22 from 10:00 A.M. through 2:50 P.M. revealed Resident #56 was situated in a wheelchair without anti-tippers in place. Observation and interview on 08/01/22 at 3:00 P.M. with State tested Nurse's Aide (STNA) #220 verified Resident #56's wheelchair had no anti-tippers in place and there was no Dycem mat in place. STNA #220 stated she was not aware resident was ordered anti-tippers or a Dycem mat for the wheelchair. Interview on 08/01/22 at 3:10 P.M. with Licensed Practical Nurse (LPN) #385 verified Resident #56 was ordered to have anti-tippers affixed to the wheelchair and a Dycem mat due to fall precautions. (continued on next page)

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	366175	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at the Meadows	11760 Pellston Court Cincinnati, OH 45240

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, review of most recent smoking quarterly assessment, dated 08/18/21, revealed Resident #56 had a dexterity problem and required supervision during smoking. Review of the care plan revealed Resident #56 had potential for injury related to smoking cigarettes. Interventions included resident would have a smoking assessment quarterly for safety and with any significant change, provide supervision during smoking, and staff would remind resident to wear an apron. Observation on 08/01/22 at 1:13 P.M. of residents smoking revealed Resident #56 slouched in his wheelchair smoking with cigarette ashes falling on his clothes and no smoking apron in place. Interview with the DON on 08/04/22 at 4:00 P.M. revealed Resident #56 should have had a smoking apron in place. DON stated she would update the physician orders for Resident #56. The DON also verified the last smoking assessment for Resident #56 was on 08/18/21. The DON stated residents should have a smoking assessment quarterly and as needed for significant changes. 2. Review of medical record for Resident #60 revealed an admitted d of 12/13/19. Diagnoses included schizoaffective disorder, bipolar, dementia with behavioral issues, falls, anxiety, and weakness. Review of physician orders dated 07/14/21 for Resident #60 revealed the resident was ordered to have anti-tippers on wheelchair. Review of the most recently completed MDS assessment dated [DATE] revealed Resident #60 had severely impaired cognition, had no behaviors, did not reject care, was two-person physical assist and was dependent or required extension supervision with activities of daily livings (ADLs). During observations on 08/02/22 at 7:30 A.M. revealed Resident #60 was seated in his wheelchair inside his room eating breakfast. Further observations revealed resident's wheelchair revealed no anti-tippers affixed to resident's wheelchair. Continued observation of room revealed a set of anti-tippers lying on the floor of resident's bathroom. During interview on 08/02/22 at 8:40 A.M. with LPN # 285 revealed she assisted getting Resident #60 out of bed and into his wheelchair before breakfast. LPN #285 verified resident was ordered anti tippers and they were not affixed to his wheelchair. During observation and interview on 08/02/22 at 9:04 A.M. with Director of Nursing (DON) verified Resident #60 was ordered to have anti tippers affixed to his wheelchair and verified anti-tippers were not in place. DON verified the anti-tippers were lying in the bathroom floor. DON stated she would call maintenance to get the anti-tippers affixed to chair. DON stated her expectations were if residents had anti tippers ordered for their wheelchairs, they should be in place. Review of care plan for Resident #60 indicated resident had potential for injuries/falls related to balance deficit, cognitive impairment, history of falls, weakness. Intervention included anti tippers to rear of wheelchair to prevent tipping backwards. 3. Review of the medical records for Resident #44, revealed an admitted [DATE]. Diagnoses included epilepsy muscle weakness, anxiety, bipolar, osteoporosis, dysphagia, and cachexia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of most recent smoking assessment, dated 08/25/21, revealed Resident #44 required supervision during smoking. Review of the most recently completed Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 was cognitively intact. Review of care plan for Resident #44 revealed resident was a smoker, required supervision due to poor decision making and judgement for safety of others and have potential for injury related to smoking. Interventions included the resident would wear a smoking apron at all times and facility would ensure resident smoked safely with quarterly smoking assessments. During observation on 08/01/22 at 1:13 P.M. of residents smoking revealed Resident #44 was actively smoking without an apron. Interview with Activities Staff #540 on 08/02/22 at 9:50 A.M. revealed she was tasked with monitoring the smokers. Activities Staff #540 verified she was not aware if any residents were required to wear a smoking apron and verified they were not in use when residents smoked. Interview on 08/04/22 at 4:00 P.M. with the Director of Nursing (DON) verified Resident #44 was smoking without an apron on and did not have quarterly assessments completed. The DON stated all residents who smoked should have a smoking assessment quarterly and as needed for significant changes due to smoking safely. 4. Review of medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included anxiety, Alzheimer's Disease, dementia, chronic pain, and shortness of breath. Review of most recent smoking quarterly assessment, dated 08/23/21, revealed Resident #27 required supervision during smoking. Review of the most recently completed MDS assessment dated [DATE] revealed Resident #27 had moderately impaired cognition. Review of care plan for Resident #27 revealed resident had potential for injury related to smoking, was non-compliant with facilities smoking policy, at risk for harm/injury due to non-compliance and refusal to follow facility policies. Interventions revealed facility would complete smoking assessments quarterly for safety, resident would wear a smoking apron, and resident would be educated and reminded of facility policy to wear a smoking apron and provide supervision during smoking. Observation on 08/01/22 at 1:13 P.M. of residents smoking revealed Resident #27 was actively smoking with no smoking apron in place. Interview on 08/04/22 at 4:00 P.M. with the DON verified Resident #27 was smoking without an apron on and did not have quarterly smoking assessments completed. 5. Review of medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included muscle weakness, shortness of breath, major depressive disorder, and repeated falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of most recent smoking quarterly assessment, dated 12/01/21, for Resident #29 revealed required supervision during smoking. Review of the most recently completed MDS assessment dated [DATE] revealed Resident #29 was cognitively intact. Review of care plan for Resident #29 revealed resident was a smoker and required supervision due to poor decision making and judgement, and for safety of self and others, had a potential for injury related smoking cigarettes interventions included resident would be supervised during smoking, have quarterly smoking assessment and resident to wear a smoking apron at all times. During observation on 08/01/22 at 1:13 P.M. of residents smoking revealed Resident #29 was actively smoking with no apron in place Interview on 08/04/22 at 4:00 P.M. with the DON verified Resident #29 was smoking without an apron on and did not have quarterly smoking assessments completed. Review of undated facility policy titled Smoking revealed the facility would allow residents to the ability to smoke while maintaining facility safety. Policy indicated facility would do quarterly smoking assessments for Resident safety. 6. Review of medical record for Resident #62 revealed an admitted [DATE]. Diagnosis included, but not limited to, cerebral infarction, schizoaffective disorder, and dementia with behaviors. Review of MDS dated [DATE] revealed Resident #62 had severely impaired cognition, had no behaviors, was one-person physical assist and required extensive assistance with ADLs. During observations on 08/01/22 at 8:55 A.M. in Resident #62's room revealed an unsecured, reddish, liquid inside a gallon container sitting on resident's bathroom shelf marked floor cleaner. Interview on 08/01/22 at 9:01 A.M. with Licensed Practical Nurse (LPN) #340 indicated the gallon container of reddish liquid was a multi-purpose cleaner brought in by Resident #62 daughter to clean the floor. LPN # #340 stated the chemicals should have been secured in the secured unit. 7. Review of medical record for Resident #62 revealed an admitted [DATE]. Diagnosis included, but not limited to, cerebral infarction, schizoaffective disorder, and dementia with behaviors. Review of MDS dated [DATE] revealed Resident #62 had severely impaired cognition, had no behaviors, was one-person physical assist and required extensive assistance with ADLs. Observations of Resident #62's room on 08/01/22 at 8:55 A.M. revealed an unsecured, reddish, liquid inside a gallon container sitting on the resident's bathroom shelf marked floor cleaner. Interview on 08/01/22 at 9:01 A.M. with Licensed Practical Nurse (LPN) #340 revealed the gallon container of reddish liquid was a multi-purpose cleaner brought in by Resident #62's daughter to clean the floor. LPN # #340 stated the chemicals should have been secured in the secured unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/03/22 at 9:32 A.M. on the women's secured unit revealed a room being used for storage with the door unlocked and slightly open. The room contained aero linen disinfectant and deodorizer, Orange Glo wood cleaner, HDX glass cleaner, and Husky disinfectant spray, all had caution labels. There was also a pair of scissors. Interview on 08/03/22 at 9:33 A.M. with LPN Unit Manager #390 confirmed the door to the room was unlocked with no staff present. LPN Unit Manager #390 reported housekeeping staff had just been in the room and must have left the door unlocked. LPN Unit Manager #390 also confirmed the presence of the unsecured scissors and the cleaning products with precautionary labels Observation on 08/03/22 at 10:14 A.M. of a door labeled janitor's closet on the women's secured unit near the common area revealed the door was unlocked. The closet contained disinfectant spray, bleach, and toilet bowl cleaner with precautionary labels. Interview on 08/03/22 at 10:14 A.M. with State tested Nursing Assistant (STNA) #255 confirmed the door was unlocked at the time of the observation. Interview on 08/03/22 at 10:16 A.M. with Housekeeping Staff #500 verified the janitor's closet contained various cleaning products, including disinfectant spray, bleach, and toilet bowl cleaner marked with the word danger on the front of the bottle. The facility identified 21 Residents (#61, #62, #17, #364, #21, #40, #37, #32, #363, #55, #09, #59, #43, #35, #14, #52, #02, #04, #28, #54, and #01) who resided in the secured unit who were cognitively impaired and independently mobile. This deficiency substantiates Master Complaint Number OH00134900.