STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366195	A. Building B. Wing	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review, and facility policy, the facility failed to promote an environment that maintained each residents' dignity by serving meal trays with disposable spoons and no knives. This affected Resident #4 but had the potential to affect 82 residents who received meals from the kitchen. The facility identified Resident #142 as not receiving meals from the kitchen. The facility census was 83. Findings include: Review of medical record for Resident #4 revealed an admitted [DATE] and diagnoses included acute respiratory failure, end stage renal (kidney) disease, unspecified angina pectoris (chest discomfort), and gastro-esophageal reflux disease (acid reflux) without esophagitis (inflammation of the esophagus). Review of the most recent five day Minimum Data Set assessment dated [DATE] revealed Resident #4 was cognitively intact, required extensive assist of two persons for bed mobility, total dependence of two persons physical assist for transfer, total dependence of one person assist for locomotion, toilet use, and bathing, extensive assist of one person for dressing, independent with set up for eating, limited assistance of one person for personal hygiene, and was always incontinent of bowel and bladder. Review of care plan dated 10/19/22 revealed Resident #4 required assist with activities of daily living related to fatigue with an intervention to encourage resident to participate to the fullest extent possible with each interaction. Review of Resident #4's physician order dated 10/25/22 indicated a renal/controlled carbohydrate diet, regular texture, thin liquids consistency. Interview on 11/28/22 at 2:15 P.M. with Dietary Supervisor (DS) #806 revealed on the 11/11/22, the first day she worked, she had to go get more silverware since the facility did not have enough. Observation on 11/29/22 at 4:54 P.M. revealed Resident #4 did not receive a knife with his meal and had to use a spoon to cut his turkey. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on 11/29/22 at 4:54 P.M. with Licensed Practical nurse (LPN) #902 confirmed Resident #4 did not have a knife and did not offer to get a knife for Resident #4. Observation of the tray line on 12/01/22 from 11:15 A.M. to 12:30 P.M. revealed eight trays received a white plastic spoon, a metal fork and no knife. Dietary #926 at the time of observation confirmed the facility was out of metal spoons and forks and the facility was using plastic spoons but had no plastic knives to use as a replacement. Observation of the test tray on 12/01/22 at 12:35 P.M. revealed one plastic spoon, one metal fork, and no knife were on the meal tray. Interview on 12/2/22 at 9:03 A.M. with Administrator revealed she was aware of the facility running out of silverware and had bought some last week and had more ordered. Review of a list of resident diets revealed Resident #142 received nothing by mouth. Review of email from DS #806 to Owner #976 dated 11/23/22 at 6:08 P.M. confirmed on DS #806's first day of work, the facility did not have spoons or knives to send on the trays for the residents. Review of undated facility policy titled Resident Rights revealed a resident has the right to a homelike environment.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on interview, observation and record review, the facility failed to ensure Resident #56's preferences regarding bathing were honored. This affected one resident (Residents #36) out of three residents reviewed for choices. Findings include: Review of Resident #36's medical record on 12/05/22 2:23 P.M. revealed an admitted [DATE]. Diagnosis included hypertension, type II diabetes mellitus, adult failure to thrive, urinary tract infection (UTI), diarrhea, hyperlipidemia, major depressive disorder, dysphagia, epilepsy, guillian-barre syndrome, and amyotrophic lateral sclerosis (ALS). Review of Resident #36's Minimum Data Set, dated dated dated [DATE] revealed the resident had intact cognition, she needed an extensive assist by two staff members for bed mobility, transfers via hoyer lift, dressing, toileting, personal hygiene and bathing. Review of Resident #36's care plan dated 11/01/22 revealed Resident #36 needed assistance with activities of daily living including showers related to limited mobility, decreased endurance, and strength, adult failure to thrive and weakness. Resident #36 was to receive showers based off her preference. Review of Resident #36's shower preference sheet dated 11/01/22 revealed the resident requested showers four times a week on the evening shift. Review of Resident #36's shower sheets dated 11/03/22 through 12/06/22 revealed the residents preferences were not honored and she had only received bed baths since admission. Interview on 12/01/22 at 12:52 PM with Resident #36 revealed when she was admitted to the facility she told Licensed Practical Nurese (LPN) #966 whom interviewed her about her preferences for showers, she would like to have a shower and not a bed bath. She was unable to get her hair washed with a bed bath and needs to have showers. She stated she has yet to have a shower and only has received bed baths since her admission on 11/01/22. Interview on 12/01/22 at 1:00 P.M. with Licensed Practical Nurse (LPN) #966 revealed she interviewed Resident #36 on admission and filled out her preference sheet stating she wanted showers four times a week on Sunday, Tuesday, Thursday, and Saturday. Interview on 12/01/22 at 1:15 PM with LPN #837 confirmed Resident #36 had only received bed baths since her admission. LPN #837 spoke with Resident #36 and again confirmed her preferences of wanting showers four times a week on Sunday, Tuesday, Thursday, and Saturday on dayshift. LPN #36 confirmed showers were changed to dayshift to ensure they were being completed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Shower Preference dated 10/09/22, revealed the facility was to have the residents choose when they would like to shower and how often to promote cleanliness and provide comfort to the resident.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 46195 Based on observation, interview, and facility policy, the facility failed to ensure the residents had the right to secure and confidential medical records by allowing state tested nursing assistants (STNAs) to use their own personal computers to chart in the electronic medical record (EMR). This had the potential to affect all 83 residents. Findings include: Interview on 12/07/22 at 1:22 P.M. with STNA #917 revealed she had a difficult time finding a facility computer for charting. She stated there were two laptop computers on top of the medication carts along with two desktop computers for the 1100 and 1200 hall for charting. STNA #917 expressed some nurses would not let the STNAs use the laptops, or the nurses would sit in front of the desktop computer while using a laptop, which left the STNAs no computers for charting. STNA #917 stated she would bring in her own computer for easier access to charting. Interview on 12/07/22 at 1:55 P.M. with Director of Nursing (DON) confirmed the STNAs should use the desktop computers at the nursing station, or the laptop computers used for medication administration, if the medication administration was completed, for charting. She was aware the staff were having difficulty charting at times and had asked in the past for computer tablets or computer kiosks. The DON did not know the staff were bringing in their own computers, but she was okay with staff using their own computers for documentation since they don't have remote access to the EMR software program. She was not sure if anyone could screen shot items and then store the screen shots on their personal computer. Observation during facility tour on 12/07/22 from 2:25 P.M. and 2:30 P.M. revealed the 1100 and 1200 hallway nurse's station had two desktop computers and two laptop computers. The 1300 hallway nurse's station had two laptop computers and one desktop computer. The 1400 hallway nurse's station had one desktop computer and one laptop computer. Interview on 12/07/22 at 2:26 P.M. with License Practical Nurse (LPN) #900 revealed she had seen night shift STNAs bring in their own computers to chart. Observation and interview on 12/07/22 at 3:00 P.M. with STNA #803 revealed a grey laptop was observed sitting at the facility's 1400 hall nurse's station. STNA #803 stated it was her own computer, and she brought it into the facility all the time to chart. STNA #803 demonstrated to the surveyor that she went through an internet search site and then typed in the name of the EMR software the facility was using. The password for the EMR software had already been saved to her computer, and the EMR software was then brought up on her computer screen. On the screen was observed to be a resident's name, date of birth, room number, a picture of the resident, and all the areas where the STNAs were to record data. Observation during a facility tour from 2:25 P.M. to 2:30 P.M. on 12/08/22 revealed at each of three nurse's stations was posted undated posted sign with yellow highlighted words stating no personal electronic devices were to be used to log into the EMR software program with no exceptions. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility document titled Information Technology-Confidentiality Form/User Agreement signed by STNA #803 on 03/29/22 revealed the facility would utilize mechanisms to ensure appropriate system access, and employees would agree to provide to the facility any portable device that may contain patient information. Review of facility policy titled Confidentiality of Information, revised March 2014, revealed the facility would safeguard all resident records, whether medical, financial, or social in nature, to protect the confidentiality of the information. Review of facility policy titled Electronic Medical Records, revised March 2014, revealed the facility's medical record system had technical safeguards, which included technical infrastructure, hardware, software, and security capabilities to prevent unauthorized access of electronic protected health information.

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F 0600 Level of Harm - Minimal harm or potential for 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** 42013 Based on observation, interview, record review, and facility policy review, the facility failed to ensure Resident #10 was free from physical and mental abuse. This affected one resident (Resident #10) of three residents reviewed for abuse. Findings include: Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses included hyperlipidemia, type two diabetes mellitus without complications and moderate protein-calorie malnutrition. Review of Resident #10's care plan dated, 08/07/22, included Resident #10 had bladder incontinence related to impaired mobility. Resident #10 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included check Resident #10 for incontinence with rounds and as required for incontinence. Wash, rinse and dry perineum and change clothing as needed after incontinence episodes. Review of Resident #1's Annual Minimum Data Set (MDS) 3.0 assessment dated , 09/26/22, revealed Resident #1 was cognitively intact. Review of the facility Self Reported Incident Form (SRI) dated, 09/30/22 revealed an allegation of physical and emotional, verbal abuse from a staff member towards Resident #10. The SRI stated the Administrator and Director of Nursing (DON) were notified of an incident that occurred on 09/29/22 by the nurse on day shift 09/30/22. State tested Nursing Assistant (STNA) #973 was preparing to give a bed bath to Resident #10 and was called away to assist with the care of another resident while she was gathering supplies. Resident #10 stated STNA #973 left her uncovered in her bed while she assisted with the other resident. STNA #973 stated she did not leave Resident #10 uncovered. STNA #973 stated she and Resident #10 had a playful rapport and would tease each other at times. Resident #10 confirmed this and indicated she did not feel STNA #973 did anything wrong and stated she didn't hurt me. Resident #10 did not express any complaints to the nurse on duty. The facility unsubstantiated the allegations. The facility educated all staff on customer service, resident rights and professionalism on 10/10/22 or 10/11/22. STNA #973 would no longer be used at the facility. Further review of the facility SRI dated, 09/30/22, did not reveal a skin assessment was completed for Resident #10. Further review of the SRI dated, 09/30/22, revealed only one nurse (Licensed Practical Nurse #722) and one STNA (STNA #803) were interviewed regarding allegations of physical, verbal, and emotional abuse directed towards Resident #10 by a staff member. Review of a Witness Statement dated, 09/30/22, written by STNA #803 included after entering Resident #10's room during rounds, Resident #1 (Resident #10's roommate) asked to speak with her. Resident #1 confided to STNA #803 the midnight aide was very rough, verbally abusive and humiliated Resident #10. STNA #803 questioned Resident #10 about her experience with the midnight aide and she told the same story as Resident #1, and almost shed tears. STNA #803 reported the incident to the nurse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Resident Interview with Resident #1 dated, 10/03/22, revealed Resident #1 was asked three questions. The questions were have you ever been treated roughly by staff, have yelled or been rude to you, did you ever feel afraid because of the way you or some other resident was treated. Resident #1 responded no to all the questions. There was no further interview with Resident #1 documented regarding the situation she witnessed involving Resident #10 on 09/29/22. Review of an email from STNA #973 to the Administrator dated, 10/05/22 at 4:26 P.M. included STNA #973 stated when caring for Resident #10 she left her covered in the bed while she gathered supplies. While gathering supplies another STNA asked STNA #973 to assist her with another resident's care. When STNA #973 was finished assisting the other resident she returned to Resident #10's room and gave her a bed bath. STNA #973 stated she sarcastically responded no to Resident #10's question if she was going to put a clean incontinence brief on her. STNA #973 then stated of course she was going to place a clean incontinence brief on Resident #10. STNA #973 stated both of them used the words honey and sweetheart when addressing each other. STNA #973 finished giving Resident #10 a bed bath and left the room. Review of Resident #10's Annual Minimum Data Set (MDS) 3.0 assessment dated , 10/07/22, included Resident #10 was cognitively intact. Review of Resident 10's Quarterly MDS assessment dated [DATE] revealed resident required extensive assistance of one staff member for bed mobility and toilet use, had total dependence on two staff members for transfers, was always incontinent of urine and bowel, and had a stage three pressure ulcer. Review of Resident #1's progress notes dated, 11/23/22, revealed she was admitted to the local hospital for chest pain and was unable to be interviewed. Interview on 11/29/22 at 12:31 P.M. with STNA #803 revealed Resident #10's roommate Resident #1 told her about a situation that happened on night shift. Resident #1 told her the aide was rough with Resident #10 and whipping her around. The aide left Resident #10 exposed and did not close the curtain. Resident #1 stated the aide was not nice with her words. Resident #10 confirmed this happened and was almost in tears regarding the situation. STNA #803 stated she did not know which aide they were talking about. Resident #1 witnessed this incident and was upset this happened to Resident #10 and felt she needed to say something. Interview on 11/29/22 at 12:52 P.M. with the DON revealed she did not remember much about the situation involving Resident #10 other than it happened between 6:00 P.M. and 6:00 A.M. on 09/29/22. Resident #10 alleged that she was left uncovered during a bed bath, the STNA involved said she was doing a bed bath, got called out of room to assist with another resident, and did not remember leaving Resident #10 uncovered. The DON stated she was in the room with Administrator #974 during Resident #10's interview, and Resident #10 kept saying she was OK, she was just left uncovered. The DON stated STNA #973 was suspended immediately pending the investigation, was from a staffing agency and did not currently work at the facility. The DON stated the only STNA interviewed about the situation was STNA #803, and confirmed there were no other aide interviews in the SRI. The DON stated Administrator #974 no longer worked for the facility, and she did not know if he interviewed Resident #1 about the incident she witnessed regarding Resident #10. The DON stated she did not interview Resident #1 and confirmed there was no interview with Resident #1 regarding the incident she witnessed involving Resident #10 included in the investigation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/29/22 at 1:59 P.M. of Resident #10 revealed she was lying in bed. Further observation of her bed revealed there were grab bars on both sides of the bed at the level of her head. Interview on 11/29/22 at 1:59 P.M. with Resident #10 revealed she remembered the situation with STNA #973. Resident #10 stated STNA #973 was really rough with her, her bones were fragile and the aides had to be careful with her. Resident #10 stated she was not a spring chicken and STNA #973 bumped her head on the grab rail on both sides of the bed when she turned her from side to side. Resident #10 stated STNA #973 threw her from side to side very roughly and her head and legs were thrown around. Resident #10 indicated STNA #973 left the room and left her without a cover for about a half hour. Resident #10 stated she did not want STNA #973 to take care of her anymore. Resident #10 stated she had a hurt leg and the aides had to be careful when they turned her from side to side. Resident #10 indicated she wanted to be treated with respect and STNA #973 did not talk to her very nice either. Review of the facility policy titled Abuse, Neglect, and Exploitation of Residents, undated, included it was the responsibility of all staff to identify inappropriate behaviors towards residents, which may include but was not limited to use of derogatory language, rough handling of residents, ignoring residents while providing care. Signs and symptoms which may possibly indicate the presence of abuse included the resident might act withdrawn and unwilling to talk, depressed, ashamed, or overly embarrassed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure a thorough investigation was completed for allegations of physical, emotional and verbal abuse towards Resident #10 by a staff member. This affected one resident (Resident #10) out of three residents reviewed for abuse. The facility census was 83. Findings include: Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses included hyperlipidemia, type two diabetes mellitus without complications and moderate protein-calorie malnutrition. Review of Resident #10's care plan dated, 08/07/22, included Resident #10 had bladder incontinence related to impaired mobility. Resident #10 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included check Resident #10 for incontinence with rounds and as required for incontinence. Wash, rinse and dry perineum and change clothing as needed after incontinence episodes. Review of Resident #1's Annual Minimum Data Set (MDS) 3.0 assessment dated , 09/26/22, revealed Resident #1 was cognitively intact. Review of the facility Self Reported Incident Form (SRI) dated, 09/30/22 revealed an allegation of physical and emotional, verbal abuse from a staff member towards Resident #10. The SRI stated the Administrator and Director of Nursing (DON) were notified of an incident that occurred on 09/29/22 by the nurse on day shift 09/30/22. State tested Nursing Assistant (STNA) #973 was preparing to give a bed bath to Resident #10 and was called away to assist with the care of another resident while she was gathering supplies. Resident #10 stated STNA #973 left her uncovered in her bed while she assisted with the other resident. STNA #973 stated she did not leave Resident #10 uncovered. STNA #973 stated she and Resident #10 had a playful rapport and would tease each other at times. Resident #10 confirmed this and indicated she did not feel STNA #973 did anything wrong and stated she didn't hurt me. Resident #10 did not express any complaints to the nurse on duty. The facility unsubstantiated the allegations. The facility educated all staff on customer service, resident rights and professionalism on 10/10/22 or 10/11/22. STNA #973 would no longer be used at the facility. Further review of the facility SRI dated, 09/30/22, did not reveal a skin assessment was completed for Resident #10. Further review of the SRI dated, 09/30/22, revealed only one nurse (Licensed Practical Nurse #722) and one STNA (STNA #803) were interviewed regarding allegations of physical, verbal, and emotional abuse directed towards Resident #10 by a staff member. Review of a Witness Statement dated, 09/30/22, written by STNA #803 included after entering Resident #10's room during rounds, Resident #1 (Resident #10's roommate) asked to speak with her. Resident #1 confided to STNA #803 the midnight aide was very rough, verbally abusive and humiliated Resident #10. STNA #803 questioned Resident #10 about her experience with the midnight aide and she told the same story as Resident #1, and almost shed tears. STNA #803 reported the incident to the nurse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Resident Interview with Resident #1 dated, 10/03/22, revealed Resident #1 was asked three questions. The questions were have you ever been treated roughly by staff, have yelled or been rude to you, did you ever feel afraid because of the way you or some other resident was treated. Resident #1 responded no to all the questions. There was no further interview with Resident #1 documented regarding the situation she witnessed involving Resident #10 on 09/29/22. Review of an email from STNA #973 to the Administrator dated, 10/05/22 at 4:26 P.M. included STNA #973 stated when caring for Resident #10 she left her covered in the bed while she gathered supplies. While gathering supplies another STNA asked STNA #973 to assist her with another resident's care. When STNA #973 was finished assisting the other resident she returned to Resident #10's room and gave her a bed bath. STNA #973 stated she sarcastically responded no to Resident #10's question if she was going to put a clean incontinence brief on her. STNA #973 then stated of course she was going to place a clean incontinence brief on Resident #10. STNA #973 stated both of them used the words honey and sweetheart when addressing each other. STNA #973 finished giving Resident #10 a bed bath and left the room. Review of Resident #10's Annual Minimum Data Set (MDS) 3.0 assessment dated , 10/07/22, included Resident #10 was cognitively intact. Review of Resident 10's Quarterly MDS assessment dated [DATE] revealed resident required extensive assistance of one staff member for bed mobility and toilet use, had total dependence on two staff members for transfers, was always incontinent of urine and bowel, and had a stage three pressure ulcer. Review of Resident #1's progress notes dated, 11/23/22, revealed she was admitted to the local hospital for chest pain and was unable to be interviewed. Interview on 11/29/22 at 12:31 P.M. with STNA #803 revealed Resident #10's roommate Resident #1 told her about a situation that happened on night shift. Resident #1 told her the aide was rough with Resident #10 and whipping her around. The aide left Resident #10 exposed and did not close the curtain. Resident #1 stated the aide was not nice with her words. Resident #10 confirmed this happened and was almost in tears regarding the situation. STNA #803 stated she did not know which aide they were talking about. Resident #1 witnessed this incident and was upset this happened to Resident #10 and felt she needed to say something. Interview on 11/29/22 at 12:52 P.M. with the DON revealed she did not remember much about the situation involving Resident #10 other than it happened between 6:00 P.M. and 6:00 A.M. on 09/29/22. Resident #10 alleged that she was left uncovered during a bed bath, the STNA involved said she was doing a bed bath, got called out of room to assist with another resident, and did not remember leaving Resident #10 uncovered. The DON stated she was in the room with Administrator #974 during Resident #10's interview, and Resident #10 kept saying she was OK, she was just left uncovered. The DON stated STNA #973 was suspended immediately pending the investigation, was from a staffing agency and did not currently work at the facility. The DON stated the only STNA interviewed about the situation was STNA #803, and confirmed there were no other aide interviews in the SRI. The DON stated Administrator #974 no longer worked for the facility, and she did not know if he interviewed Resident #1 about the incident she witnessed regarding Resident #10. The DON stated she did not interview Resident #1 and confirmed there was no interview with Resident #1 regarding the incident she witnessed involving Resident #10 included in the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/29/22 at 1:59 P.M. of Resident #10 revealed she was lying in bed. Further observation of her bed revealed there were grab bars on both sides of the bed at the level of her head. Interview on 11/29/22 at 1:59 P.M. with Resident #10 revealed she remembered the situation with STNA #973. Resident #10 stated STNA #973 was really rough with her, her bones were fragile and the aides had to be careful with her. Resident #10 stated she was not a spring chicken and STNA #973 bumped her head on the grab rail on both sides of the bed when she turned her from side to side. Resident #10 stated STNA #973 threw her from side to side very roughly and her head and legs were thrown around. Resident #10 indicated STNA #973 left the room and left her without a cover for about a half hour. Resident #10 stated she did not want STNA #973 to take care of her anymore. Resident #10 stated she had a hurt leg and the aides had to be careful when they turned her from side to side. Resident #10 indicated she wanted to be treated with respect and STNA #973 did not talk to her very nice either. Review of the facility policy titled Abuse, Neglect, and Exploitation of Residents, undated, included it was the responsibility of all staff to identify inappropriate behaviors towards residents, which may include but was not limited to use of derogatory language, rough handling of residents, ignoring residents while providing care. Signs and symptoms which may possibly indicate the presence of abuse included the resident might act withdrawn and unwilling to talk, depressed, ashamed, or overly embarrassed. Review of the facility policy titled Abuse Investigations, undated, included to interview any witnesses to the incident. Interview of staff members and volunteers on all shifts who had contact with the resident during the period of the alleged incident. Interview of the resident's roommate, family members and visitors.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, interview, and facility policy, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for a Resident #4 and #36. This affected two residents (Resident #4 and Resident #36) out of 45 residents reviewed for MDS assessment accuracy. Findings include: 1. Record review revealed Resident #4 was admitted to the facility on [DATE] with acute respiratory failure, end stage renal disease, angina pectoris, encounter for aftercare following kidney transplant. Review of Resident #4's physician orders revealed an order dated 10/25/22 for the discontinuation of Nepro 60 milliliters (ml) for 10 hours from 8:00 P.M. to 6 A.M. with a free water flush from 8:00 P.M. to 6:00 P.M., an order dated 10/26/22 for the discontinuation of a 240 ml Nepro bolus after meals if less than 50% of meal eaten and 60 ml free water fluids (FWF) if Nepro bolus was given, an order dated 10/26/22 for the discontinuation of 30 ml/hour free water flush from 9:00 P.M. to 5:00 A.M., an order dated 10/25/22 for the discontinuation of the renal/carbohydrate controlled diet, mechanically altered ground texture, and thin liquids, an order dated 10/25/22 for the start of a renal/carbohydrate controlled diet, regular texture, and thin liquids. Review of Section K for MDS assessment with a reference end date of 11/08/22 revealed MDS #907 signed on 11/11/22 Resident #4 was on a feeding tube and mechanically altered diet within the last seven days. Interview on 12/06/22 at 1:55 P.M. with MDS #907 confirmed the five-day comprehensive MDS assessment dated [DATE] for Resident #4 was incorrectly coded since Resident #4 was not on a feeding tube or a mechanically altered diet during the seven day look back period. Review of facility policy titled Certifying Accuracy of the Resident Assessment, revised December 2009, revealed all personnel who complete any portions of the Material Data Set would certify with their signature the accuracy of that portion of the assessment. 44461 2. Review of Resident #36's medical record revealed an admitted [DATE]. Resident #36's Diagnoses included hypertension, type II diabetes mellitus, adult failure to thrive, urinary tract infection (UTI), diarrhea, hyperlipidemia, major depressive disorder, dysphagia, epilepsy, guillian-barre syndrome, and amyotrophic lateral sclerosis (ALS). Review of Resident #36's Minimum Data Set (MDS) dated [DATE] revealed the resident had intact cognition, she needed an extensive assist by two staff members for bed mobility, transfers via hoyer lift, dressing, toileting, personal hygiene ad bathing. She was independent with eating. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of additional MDS assessments open dated for 02/03/23 revealed sections C, this area assessed the resident cognition and section D, which assessed the residents were already filled out, signed and locked by facility Social Service Designee (SSD) #930 on 11/10/22. Interview on 12/05/22 at 2:00 P.M. with the MDS Coordinator Registered Nurse (RN) #907 and the Director of Nursing (DON) revealed MDS assessments should only be filled out if the resident is in a current MDS look back period. The look back period is seven days before the MDS assessment is due. They both stated they should never be filled out, signed and locked two months ahead of time. Review of facility policy titled, Certifying Accuracy of the Resident Assessment, revised December 2009, revealed all personnel who complete any portions of the Minimum Data Set would certify with their signature the accuracy of that portion of the assessment.

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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** 38094 Based on interview and record review, the facility failed to ensure care plans were comprehensive to address the needs of Residents #24, #83 and #294. This affected three residents (Residents #24, #83 and #294) of three residents reviewed for care plans. Findings include: 1. Resident #24 was admitted [DATE] with diagnoses including metabolic encephalopathy, type II diabetes, morbid obesity due to excess calories, end stage renal disease with anemia (ESRD). Review of Resident #24's physician orders revealed orders for a renal/controlled carbohydrate diet, regular texture with thin liquids. Review of weights for Resident #24 revealed a 16.75 percent (%) (37.3 pounds) increase from 08/27/22 to 11/26/22. Review of care plan of 09/05/22 revealed care areas for anemia related to ESRD and a risk of complications. Interventions included encourage intake of foods high in iron, and vitamin C, review diet and make recommendations as required, and a dietary consult to regulate protein, sodium and potassium. There was no care area for non-compliance with diet. Review of the quarterly Minimum Data Summary (MDS) 3.0 of 10/20/22 revealed resident was cognitively intact, required extensive assist of two for activities of daily living (ADL) and received dialysis. Interview with Renal Dietician (RD) #966 on 12/6/22 at 11:51 A.M. revealed Resident #24 was very noncompliant. She ordered door dash all the time at dialysis. Her fluid gains were excessive. She had an elevated potassium level of 5.8 on 11/18/22. At dialysis, they told Resident #24 that when she orders door dash she should let nursing know so she can receive her phosphate binders. She had been having excessive fluid gains and missing or shortening her treatments. Her noncompliance was her major concern. Interview on 12/06/22 at 12:19 P.M. with the Director of Nursing (DON) verified noncompliance with care and services should have been in Resident #24's care plan. 2. Review of the medical record for Resident #83 revealed the resident was admitted on [DATE] with end stage renal disease, hyperlipidemia, anxiety disorder, hyperlipidemia, anxiety, hypertension, cognitive communication deficit. Review of Resident #82's physician orders revealed orders for a regular diet, regular texture with thin liquids. Physician order dated 09/26/22 revealed the resident received hemodialysis on Mondays, Wednesdays and Friday at an outside dialysis center. (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 Medicare 5-day MDS (3.0) assessment of 10/08/22 revealed the resident was not assessed cognitively, required extensive assist of one for ADLs and received dialysis. Review of the care plan of 10/11/22 revealed no care area for dialysis. It was mentioned briefly in a care area for the resident is resistive to care related to the resident had refused to go to hemodialysis as evidenced by nursing documentation. Interview on 12/06/22 at 12:19 PM with the DON verified a care area for dialysis should be included for anyone on dialysis. 3. Resident #294 was admitted on [DATE], and readmitted [DATE] with end stage renal disease, type II diabetes mellitus with diabetic neuropathy, acute pancreatitis, and moderate protein-calorie malnutrition. The resident received a renal/controlled carbohydrate diet (Renal/CCHO), regular texture, with thin liquids and ensure plus. Review of the quarterly MDS 3.0 assessment of 11/28/22 revealed the resident was moderately cognitively impaired, extensive assist of one, received transfusions, dialysis and a therapeutic diet. Review of care plan of 11/21/22 revealed plans to assist Resident #294 with activities of daily living due to altered cardiovascular status, nutrition problem or potential problem related to diagnoses, history of a stroke, a gastrointestinal bleed and pulmonary edema. Review of Physician progress note of 11/08/2022 revealed Resident #294 stated that she had acute bleeding and she was in the ICU for couple days and then she was on the regular floor. She does not know that anything was done differently and she feels that she still swollen but she also still has low blood because she continues to eats nonedible foods. In fact she loves chewing on tissue. During her stay at the hospital she was maintained on dialysis. Her severe anemia with a hemoglobin of 6.4 on arrival was given a blood transfusion. Review of progress note of 11/30/2022 revealed Resident #294 was observed eating her paper chuck. The nurse told her not to do that. When the aide went back in to check her she was still eating the chuck, and this was after she was eating paper towels. Interview on 12/05/22 at 5:36 P.M. with the DON revealed she was not aware of any behaviors for Resident #294, but verified behaviors should be included in the care plan. Interview on 12/06/22 at 9:14 A.M. with the resident's daughter revealed she made the facility aware of Resident #294's paper eating, due to her iron deficiency, when the resident was first admitted .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #44), who was Spanish speaking and had impaired vision, was provided a functional communication system. This affected one resident (Resident #44) of two residents reviewed for communication difficulty and/or sensory problems. Findings include: Medical Record review revealed Resident #44 had an admitted [DATE] and diagnoses included neuromuscular dysfunction of bladder, unspecified convulsions, unspecified cerebral infarction (stroke), traumatic hemorrhage of cerebrum (acute loss of blood in the brain), altered mental status, and aphasia following cerebral infarction (inability to comprehend of formulate language because of damage to the brain from the stroke). Review of the care plan for Resident #44 dated 09/15/22 revealed a communication problem related to language barrier with a goal of being able to make basic needs known daily using a communication board and a facility provided translator as necessary. Review of physician note for Resident #44 on 10/01/22 revealed the physician had the nurse bring in her phone to help translate the Resident #44's answers to questions. Review of nurses note on 10/06/22 revealed Physician #802 was brought into the room to speak Spanish to him after he had a fall. Review of 11/05/22 nurse progress note revealed Resident #44 was unable to tell them what happened or what he was trying to do after a fall. Review of ophthalmologist note on 11/11/22 revealed Resident #44 complained of very blurry vision and being very photophobic (extreme sensitivity to light). Review of the five-day comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 had minimal difficulty hearing, unclear speech, and moderately impaired vision. Resident #44 understood others and wore corrective lenses. Resident #44 was severely impaired cognitively and required extensive assist of two persons for bed mobility and toilet use, total dependence of one person for bathing, total dependence of two persons for transfer, extensive assistance of one person for dressing, personal hygiene, and supervision of one person assist for eating. Interview on 12/05/22 at 10:35 A.M. with Licensed Practical Nurse (LPN) #961 confirmed Resident #44 did speak Spanish and had a communication board. LPN #961 had never used the communication board since she utilized touched prompts to communicate with Resident #44. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/05/22 at 10:52 A.M. with LPN #962 revealed she was unsure if he understood any English, and facility staff or family would translate when needed. LPN #962 had never used the communication board since she had used observation to determine Resident #44's needs, since Resident #44 would moan for pain and would touch the area where pain was being felt. Interview on 12/05/22 at 12:52 A.M. with State tested Nursing Assistant (STNA) #904 revealed she was the one usually to communicate with Resident #44, since she spoke Spanish. Resident #44 slurred his words when she communicated with him, which would make it difficult for the translation applications on the phone to determine what he was saying. Resident #44 had recent eye surgery, which resulted in extreme sensitivity to the light. As a result, he wore sunglasses all the time or had a blanket over his head. Resident #44 did have a communication board in his room, but he never opened his eyes from the light sensitivity to be able to use it. His family would come in at night and would translate. Observation and interview on 12/05/22 at 3:38 P.M. with STNA #904 and Assistant Director of Nursing (DON) #837 revealed Resident #44 was sleeping in bed with sunglasses covering his eyes. Communication board found in the top drawer of dresser. Communication board observed to have pictures with Spanish words underneath it. Assistant DON #837 acknowledged resident does not open his eyes due to light sensitivity and would not be able to read the communication board. She said the staff could just say the Spanish words under the picture to communicate with Resident #44. Assistant DON #837 acknowledged she could read Spanish, since she took 3 years of Spanish, but she did not know if someone who did not have any Spanish education could read the Spanish words. Interview on 12/05/22 at 4:25 P.M. with family member of Resident #44 confirmed he had impaired vision. Interview on 12/05/22 at 4:52 PM with DON revealed the family told the facility, at the time of admission, Resident #44 was able to understand basic English. The facility made a communication board with Spanish words under the pictures. Resident #44's impaired vision was something new for him. Family of Resident #44 would help translate when they were here in the evening, and the facility used STNA #904, Maintenance Director #810, and Housekeeper #912 to interpret. The DON confirmed the facility did not use the services of a formal translator. Review of ophthalmology note on 12/06/22 revealed the family had not noticed any changes from last visit and Resident #44 was still complaining of light sensitivity. Observation on 12/07/22 at 1:22 P.M. revealed Resident #44 to be sleeping with blanket over head. Communication board observed under a container of wipes and paperwork in the top drawer of the dresser.

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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** 44461 Based on observation, interview, and record review, the facility failed to ensure Resident #36 and Resident #191 received timely incontinence care. This affected two residents (Resident #36 and Resident #191) of three residents reviewed for incontinence. Findings include: 1. Review of Resident #36's medical record on 12/05/22 2:23 P.M. revealed an admitted [DATE]. Resident #36's diagnoses included hypertension, type II diabetes mellitus, adult failure to thrive, urinary tract infection (UTI), diarrhea, hyperlipidemia, major depressive disorder, dysphagia, epilepsy, Guillian-barre syndrome, and amyotrophic lateral sclerosis (ALS). Review of Resident #36's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition, she needed an extensive assist by two staff members for bed mobility, transfers via hoyer lift, dressing, toileting, personal hygiene ad bathing. She was independent with eating. Review of Resident #36's care plan dated 11/01/22 revealed Resident #36 needed assistance with activities of daily living including showers related to limited mobility, decreased endurance, and strength, adult failure to thrive and weakness. Resident #36 had bladder incontinence related to impaired mobility and diuretic use. Review of Resident #36's physician orders dated December 2022 revealed orders for staff to record bowel movements every shift, encourage the resident to turn and reposition frequently with rounds and as needed, and incontinence care every two hours and as needed. Interview on 12/01/22 at 12:52 P.M. with Resident #36 revealed an aide on night shift left the resident completely saturated with urine through her brief, all of her bed linen, and on to the floor. Resident #36 stated she explained what happened to the day turn aide, State tested Nursing Assistant (STNA) #917, when she came in her room for rounds and asked what was on the floor, Resident #36 stated That's me when asked what she meant by this she stated it was her urine on the floor because the night STNA did not change her at all. Interview on 12/01/22 at 1:00 PM with STNA #917 revealed Resident #36's concerns were told to the Registered Nurse (RN) #923, then to Scheduler #824 and then to Licensed Practical Nurse (LPN) #837. STNA #917 confirmed when she came in to do her rounds Resident #36 was saturated with urine through her brief, all of her bed linen, including the chux (incontinence) pad, fitted sheet, and onto the floor, STNA #917 confirmed Resident #36 stated it was her on the floor in regards to the floor being wet with urine. Resident #36 received incontinence care, a bed bath, and linen change. Resident #36 was extremely happy with the care provided by STNA #917. Interview on 12/01/22 at 1:07 PM with LPN #837 revealed she was informed of Resident #36's concerns and brought them up in morning meeting the to the scheduler, she was unsure if any education or questioning was done with the midnight aide STNA #813. (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 12/05/22 at 9:30 AM with the Director of Nursing (DON) revealed no formal education or discussion happened with STNA #813 until 12/01/22 over the phone. The DON stated Scheduler #824 called STNA #813 and left a message with no return call and never did any follow up until 12/01/22. Interview on 12/05/22 12:23 PM with the Scheduler #824 revealed she attempted to contact STNA #813 two times with no return call and then sent a text message with no response received from STNA #813. No other follow up was done until 12/01/22 when surveyor began to ask questions about the situation. 2. Record review for Resident #191 revealed an admitted [DATE] with diagnoses including type II diabetes mellitus, hypertension, osteomyelitis, chronic kidney disease, gastroesophageal reflux, major depressive disorder, and atrial fibrillation. Review of quarterly MDS dated [DATE] revealed the resident had impaired cognition, she needed assistance by one staff member for bed mobility, transfers, dressing, toileting, bathing, and personal hygiene. Review of Resident #191's care plan dated 10/22/22 revealed she was at risk for impaired skin integrity due to incontinence of bowel and bladder. The resident needed assistance with incontinence care every two hours and as needed. Review of Resident #191's physicians orders dated December 2022 revealed orders for incontinence care every two hours and as needed, barrier cream to buttocks after each incontinence episode and as needed, and to encourage and assist resident to turn and reposition every two hours and as needed. Interview on 11/28/22 at 9:08 A.M. with STNA #965 revealed STNA #965 stated he was very busy this morning. He stated he answered Resident #191's call light earlier at 6:30 A.M. and told the resident he would be right back. STNA #965 stated he was busy with other residents and could not get back to her. Observation on 11/28/22 at 9:33 A.M. of incontinence care for Resident #191 revealed her brief was saturated, draw sheet and fitted sheet were wet with urine. Interview on 11/28/22 at 9:39 A.M. with STNA #965 confirmed Resident was saturated, draw sheet and fitted sheet were wet with urine. Interview on 12/07/22 at 11:15 A.M. with Resident #191 revealed she does not get timely incontinence care. Resident stated she laid in urine for two and a half hours waiting on STNA #965 to come back in room to change her on 11/28/22. Interview on 12/08/22 at 10:00 A.M. with Resident #191 revealed they had issues with incontinence care last night, she stated she was soaked most of the night. Review of facility policy titled Perineal Care dated October 2010, revealed facility to provide cleanliness and comfort to the resident, to prevent infections and skin irritation

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on observation, record review, review of facility policy and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention and treatment program to ensure interventions were initiated timely to prevent the development of pressure ulcers and/or to ensure adequate treatments were in place to promote healing. This affected four residents (Resident #9, #10, #20, and #81) of five residents reviewed for pressure ulcers. The facility census was 83. Actual Harm occurred on 12/01/22 when Resident #20, who was severely cognitively impaired, totally dependent on staff for activity of daily living care, was noted to have contractures and had a history of pressure ulcers to the coccyx was assessed to have a Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer to the coccyx without adequate evidence of interventions being in place to prevent the development of or identify the ulcer prior to being found as a Stage III. Actual Harm occurred on 05/25/22 when Resident #10 was assessed to have a Stage III pressure ulcer to the right central left buttock. The facility failed to identify the pressure ulcer prior to it being identified as a Stage III. Findings include: 1. Resident #20 was admitted to the facility on [DATE] with diagnoses including dysphasia following stroke, hemiplegia affecting left, non-dominant side, traumatic brain hemorrhage, malnutrition, kidney transplant status, and type II diabetes. Review of the annual Minimum Data Set (MDS) 3.0 assessment of 09/06/22 revealed the resident was severely cognitively impaired, had continuous inattention, was totally dependent on two staff for activities of daily living, was always incontinent of bowel and bladder, and had an in-house developed Stage III and Stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure ulcer. Review of the care plan of 9/15/22 revealed a care area for actual impairment to skin integrity related to pressure area to sacrum and right lateral ankle. The care plan also noted the resident was at increased risk for further impairment to skin integrity related to impaired cognition, diabetes incontinence, impaired mobility, generalized weakness, hemiparesis from a stroke and a history of skin tears and pressure ulcers. Interventions included wound care to evaluate and treat as needed, assessing, recording and monitoring wound healing, Prevalon boots (boots to offload heels), turning, monitoring diet as ordered and intake, and repositioning frequently with rounds and as needed. Review of Resident #20's progress notes for wound care from 03/03/22 to 12/03/22 revealed a wound to the sacrum was discovered on 02/27/22 and healed on 09/08/22, reopened on 09/15/22 and healed on 10/13/22. (continued on next page)

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Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #20's most recent nutritional assessment, dated 06/13/22 included the need for supplements and monitoring to promote wound healing. There was no further nutritional assessment from a dietician since the reopening of the pressure ulcer on 09/15/22. Observations on 11/28/22 at 10:54 A.M., 1:15 P.M. and 3:54 P.M. revealed Resident #20 laying on his right side with his had tightly clenched around the transfer bar. Interview on 11/28/22 at 2:36 P.M. with the Director of nursing (DON), verified Resident #20's wounds on 02/27/22 and 09/15/22 were facility acquired. Interview on 11/28/22 at 3:02 P.M. with Resident #20's wife revealed she always sees the resident laying in the same position, on his right side. She reported the staff did not reposition the resident often enough. Observation on 12/01/22 at 9:23 A.M. of Resident #20's left sacral area (left sacrum right central buttock) revealed a new open wound approximately two inches by one inch. The wound bed had yellowish colored tissue in the center and was red around the edges. There was a moderate amount of yellowish-green drainage on the dressing. Wound Physician (WP) #802 stated Resident #20 was at high risk for developing pressure ulcers due to his contractures. WP #802 cleansed the wound with 0.125 percent Dakins solution and Licensed Practical Nurse/Unit Manager/Wound Nurse/Infection Preventionist (LPN/UM/WN/IP) #801 applied skin prep, silver alginate and a border dressing to the wound. Review of the wound nurse's note of 12/03/22 revealed wound doctor visit on 12/01/22 discovered a new Stage III pressure ulcer to Resident #20's left central right sacrum measuring 3.0 cm by 2.1 by 0.4. There was no evidence the facility identified the pressure ulcer prior to 12/01/22. Interview on 12/05/22 at 2:49 P.M. with Registered Dietician (RD) #954 revealed he was contracted by the facility and briefly helped in June 2022 and again in November 2022. RD #954 stated he would not necessarily put a note in the resident's records regarding pressure ulcers because he was doing as needed work and was not in facility reviewing weekly wound reports. RD #954 stated he worked remotely and had not been in the facility at all. RD #954 stated he worked approximately six to eight hours a week in June and his main task was completing assessments and care planning. RD #954 stated he would look to see if a resident had a pressure ulcer and make recommendations if he felt it was appropriate. Interview on 12/06/22 at 10:21 A.M. with LPN/UM/WN/IP #801 verified the wound on Resident #20's left sacral area was healed on 09/08/22, was found to re-open as a Stage III on 09/15/22 which had healed. The resident was assessed to have a new Stage III pressure ulcer on 12/01/22. Review of the March 2014 Pressure Ulcer Risk Assessment policy, revealed pressure ulcers usually occur when a resident remained in the same position for increased periods of time causing increased pressure or decreased blood flow. Staff were to perform skin inspections with routine daily care and notify nurses of any changes. Nurses were to conduct weekly skin assessments. 42013 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. Review of Resident #10's medical record revealed an admitted [DATE] with diagnoses including hyperlipidemia, type two diabetes mellitus without complications and moderate protein-calorie malnutrition. Review of Resident #10's physician orders dated, 11/30/21, revealed orders to encourage and assist to turn and reposition frequently with rounds and as needed. Review of Resident #10's Braden Scale assessment dated , 12/22/21, revealed Resident #10 was at moderate risk for developing pressure ulcers and injuries. There were no further Braden Scale assessments documented from 12/22/21 through 05/25/22. Review of Resident #10's medical record did not reveal documentation weekly skin checks were completed from 03/15/22 through 05/25/22. Review of Resident #10's Braden Scale assessment dated , 05/25/22, revealed Resident #10 was at high risk for developing pressure ulcers and injuries. Review of Resident #10's progress notes dated, 05/25/22, included while State tested Nursing Assistant (STNA) was completing a two-hour check and change for Resident #10 an open area was noted to the right buttock. The STNA reported the open area to the nurse and measurements were 3.0 centimeter (cm) by 0.5 cm of the pressure area on mid right buttock. The area had uneven edges, no edema or redness noted. Area cleansed with normal saline solution, collagen with border foam for protection. Resident #10 would be placed on the list to be evaluated per the wound physician. All entities notified. Review of Resident #10's Wound Assessment and Plan dated, 05/26/22, completed by Wound Physician (WP) #802 revealed this was the initial evaluation and Resident #10 had a right central left buttock Stage III pressure ulcer. The measurements were length 6.3 centimeters (cm), width of 7.1 cm, and depth was 0.3 cm. The wound bed composition was 90 percent epthelial and 10 percent granulation. Treatment orders were to cleanse wound with normal saline or sterile water, apply collagen, and cover with bordered foam dressing daily and as needed. Preventative wound recommendations were to use a low air loss mattress (LAL) and a Roho (decrease amount of pressure on sitting area) cushion to chair (related to stage three pressure injury). The assessment further indicated to unload area and side to side turning per facility protocol. Review of Resident #10's physician orders dated, 05/26/22, revealed an order to cleanse pressure area on right buttock with normal saline solution, apply collagen, cover with bordered foam daily and as needed. There were no orders documented for a LAL mattress or Roho cushion to chair. Further review of Resident #10's physician orders from 05/26/22 through 11/30/22 revealed a LAL mattress was not ordered until 10/13/22, and there were no orders documented for a Roho cushion. Review of Resident #10's progress notes from 05/26/22 through 10/13/22 did not reveal documentation of a LAL mattress. Review of Resident #10's dietary progress notes and nutrition assessments from 05/25/22 through 07/21/22 revealed there were no dietary notes or nutritional assessments. Further review of Resident #10's dietary progress notes and nutritional assessments revealed there were no recommendations related to Resident #10's pressure ulcer from 05/25/22 through 07/21/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #10's Wound Assessment and Plan dated, 07/21/22, revealed Resident #10 had a right central left buttock Stage III pressure injury. The length was 3.6 cm, width of 4.0 cm, and the depth was 0.2 cm. The wound bed was 95 percent epthelial tissue and five percent granulation tissue. Review of Resident #10's dietary progress notes dated, 07/21/22, revealed Resident #10's skin was intact and there was no documentation related to Resident #10's right central left buttock Stage III pressure ulcer. There were no further dietary progress notes or nutritional assessments from 07/21/22 through 10/03/22. Preventative wound recommendations documented included to use a LAL mattress and a Roho cushion. Review of Resident #10's care plan dated, 08/07/22 revealed Resident #10 was at increased risk for further impairment to skin integrity related to incontinence, impaired mobility, diabetes mellitus, lymphedema, history of pressure area to left buttock and sacrum. Resident #10 had a left buttock wound that healed on 01/20/22, a sacrum wound that healed 03/10/22 and on 05/25/22 a right central left buttock pressure ulcer was identified. The care plan revealed Resident #10 would be free of complications related to skin integrity through the review date. Interventions included to administer treatments per physician orders; encourage and assist to turn and reposition with rounds and as needed; encourage good nutrition and hydration in order to promote healthier skin; monitor, document location, size, and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration etcetera to physician; pressure redistribution cushion to chair and pressure redistribution mattress to bed. Review of Resident #10's Wound Assessment and Plan dated, 09/29/22, revealed Resident #10 had a right central left buttock Stage III pressure injury (onset date 05/25/22). The measurements were a length of 6.7 cm, width of 6.7 cm, and the depth was 0.2 cm. The wound bed was 97 percent epithelial tissue and three percent granulation. Review of Resident #10's Annual Nutritional assessment dated , 10/03/22, revealed no documentation related to Resident #10's right central left buttock stage three pressure ulcer. The assessment stated Resident #10 had no skin issues and no skin breakdown, therefore nutritional interventions were not reviewed for wound healing. Review of Resident #10's Annual Minimum Data Set (MDS) 3.0 assessment dated , 10/07/22, included Resident #10 was cognitively intact. Review of Resident 10's Quarterly MDS assessment dated [DATE] revealed resident required extensive assistance of one staff member for bed mobility and toilet use, had total dependence on two staff members for transfers, was always incontinent of urine and bowel, and had a stage three pressure ulcer. Review of Resident #10's physician orders dated, 10/13/22, revealed LAL mattress with perimeter overlay to bed at all times, check for placement, function, and comfort every shift. Review of Resident #10's Wound Assessment and Plan dated, 11/17/22, revealed Resident #10's right central left buttock pressure ulcer was healed. The assessment further stated Resident #10's pressure ulcer was at risk for reopening due to limited mobility, moisture, urine, stool. Observation on 11/29/22 at 1:59 P.M. of Resident #10 revealed she was lying in bed on her back with the head of the bed elevated about 45 degrees. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/30/22 at 12:36 P.M. with Licensed Practical Nurse/Unit Manager/Wound Nurse (LPN/UM/WN) #801 confirmed Resident #10's pressure ulcer to her right central left buttock was found on 05/25/22. LPN/UM/WN #801 stated a treatment was initiated on 05/25/22 until Wound Physician (WP) #802 was able to evaluate the wound. Interview on 11/30/22 at 2:48 P.M. with the Director of Nursing (DON) revealed skin checks were to completed weekly, and documented in the residents medical record by the nurses. DON confirmed they were not completed as required for Resident #10. Observation on 12/01/22 at 10:20 A.M. with WP #802 and LPN/UM/WN #801 revealed Resident #10's sacral area and buttock were reddened and no open areas were noted. WP #802 stated the wound was healed to the right central left buttock. Interview on 12/01/22 at 3:00 P.M. with LPN/UM/WN #801 revealed she did not remember if Resident #10 had a Low Air Loss (LAL) mattress before 10/13/22 when the order was placed. LPN/UM/WN #801 stated WP #802 made the decision if a resident needed a LAL mattress. Interview on 12/01/22 at 3:10 P.M. with WP #802 indicated he usually ordered a LAL mattress for a resident with a stage three or four pressure ulcer. WP #802 stated if a resident's pressure ulcer was progressing before it reached a stage three or four then he would go to the next level and order a LAL mattress and roho cushion. Observation on 12/01/22 at 4:46 P. M and on 12/05/22 at 8:52 A.M., 10:05 A.M., and 11:57 A.M. revealed Resident #10 lying in bed and was positioned on her back. There was no observation of staff members repositioning or encouraging her to reposition. Interview on 12/05/22 at 11:55 A.M. with State tested Nursing Assistant (STNA) #970 revealed today was a very busy day, and the staff was working hard to take care of residents. STNA #970 stated she knew Resident #10 was lying in her bed all morning in the same position, and did not get repositioned every two hours as she should on this day. STNA #970 stated what can I say, we are doing our best. Review of Resident #10's electronic record dated, 12/05/22, revealed there was no documentation by STNA staff Resident #10 was turned and repositioned. Interview on 12/05/22 at 2:49 P.M. with Registered Dietician (RD) #954 revealed he was contracted by the facility and briefly helped out in 06/2022 and again in 11/2022. RD #954 stated he would not necessarily put a note in the residents records regarding pressure ulcers because he was doing as needed work, and was not in facility reviewing weekly wound reports. RD #954 stated he worked remotely and had not been in the facility at all. RD #954 stated he worked approximately six to eight hours a week in June and his main task was completing assessments and care planning. RD #954 stated he would look to see if a resident had a pressure ulcer and make recommendations if he felt it was appropriate. RD #954 did not remember if Resident #10 had a pressure ulcer and he did not have his computer to check. Interview on 12/05/22 at 3:23 P.M. with the Administrator revealed RD #958 no longer worked for the facility and was not available to interview. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/07/22 at 3:42 P.M. with RD #956 revealed she was hired by the facility approximately a week ago. RD #956 stated if a resident developed a new pressure ulcer or injury a nutritional assessment should be completed and there should be an assessment in the resident's medical record once a month regarding the pressure ulcer. Review of the facility policy titled Pressure Ulcer Risk Assessment, revised 09/2013, included pressure ulcers were a serious skin condition for the resident. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. A pressure ulcer risk assessment would be completed upon admission, and then weekly times three weeks, with each additional assessment, quarterly, annually and with significant changes. Skin would be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Nurses would conduct skin assessments at least weekly to identify changes. Because a resident at risk can develop a pressure ulcer within two to six hours of the onset of pressure, the at-risk resident needed to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. 3. Review of Resident #9's medical record revealed an admitted [DATE] and diagnoses included osteitis deformans (superficial inflammation of the cortex of the bone) of other bones, severe protein-calorie malnutrition, and obstructive and reflux uropathy. Review of Resident #9's Quarterly Minimum Data Set (MDS) 3.0 assessment dated , 11/25/22, revealed Resident #9 had moderate cognitive impairment. Resident #9 required extensive assistance of two staff members for bed mobility, transfers, and required extensive assistance of one staff member for toilet use. Resident #9 was always incontinent of urine and bowel. Resident #9 did not have a pressure ulcer or injury. Review of Resident #9's care plan 09/19/22 included Resident #9 had the potential for impairment to skin integrity related to impaired mobility, incontinence. Resident #9 had a stage one pressure area to left central right buttock and sacrum. Resident #9 would be free from complications related to skin integrity through the review date. Interventions included to encourage and assist to turn and reposition frequently with rounds and as needed; monitor and document location, size and treatment of skin injury, report abnormalities, failure to heal, maceration etcetera to the physician. Review of Resident #9's medical record from 10/15/22 through 11/17/22 did not reveal weekly skin assessments were completed. Review of Resident #9's Braden Scale For Predicting Pressure Sore Risk dated, 11/09/22, revealed Resident #9 was at moderate risk for developing pressure ulcer, injuries. Review of Resident #9's Wound Assessment and Plan dated, 11/17/22, included Resident #9's left central right sacrum butt wound was healed. The assessment revealed the wound was at risk for reopening due to limited mobility. The assessment further revealed to cleanse the area with saline, use skin prep and overlay a bordered foam dressing on Tuesday, Thursday, Saturday and as needed for one more week. The assessment stated to protect and unload the area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 11/29/22 at 9:09 A.M. of State tested Nursing Assistant (STNA) #803 providing incontinence care for Resident #9 revealed there was no dressing on her sacrum. STNA #803 confirmed there was no dressing over Resident #9's sacral area and stated the nurses did not always replace dressings if they fell off during the night shift. Resident #9 had a large soft brown bowel movement and observation of her sacrum revealed the area was reddened, and an open area was noted. After surveyor intervention Registered Nurse (RN) #800 entered Resident #9's room, and confirmed there was a small open area with no dressing on Resident #9's sacral area. RN #800 cleansed the area with normal saline, applied collagen and a gauze border dressing. Interview on 11/30/22 at 2:48 P.M. with the Director of Nursing revealed skin checks were to completed weekly, and documented in the residents medical record by the nurses. DON confirmed they were not completed as required for Resident #9. Interview on 12/01/22 at 8:10 A.M. with LPN/UM/WN #801 revealed Resident #9's pressure ulcer was healed on 11/17/22 and WP #802 recommended the dressings continue for seven days after the wound was healed for preventative care. LPN/UM/WN #801 stated the dressing change orders were not discontinued after seven days and she would make sure she made the change in Resident #9's medical record to discontinue the dressing change. After surveyor intervention LPN/UM/WN #801 stated she would place Resident #9 on WP #802's schedule today. Observation on 12/01/22 at 9:47 A.M. of Resident #9 with WP #802 and LPN/UM/WN #801 revealed Resident #9 was lying on her back in bed. LPN/UM/WN #801 positioned Resident #9 on her side and removed her incontinence brief revealing it was wet with urine and a small bowel movement. Observation of Resident #9's sacral area revealed it was reddened and she had multiple open areas. The wound bed was pink, and in addition to the open areas Resident #9 had another small circular open area on the sacrum. LPN/UM/WN #801 applied skin prep and border foam to Resident #9's sacrum. LPN/UM/WN #801 stated she would have an STNA change Resident #9's incontinence brief and provide incontinence care for the bowel movement and urine. Review of Resident #9's Wound Assessment and Plan dated, 12/01/22, revealed the wound visit was an initial visit, the wound onset date was 12/01/22 and Resident #9 had a stage two pressure injury to the sacrum, buttock. The wound measurement was length 2.9 cm, width 0.4 cm width, and 0.1 cm depth. The periwound was within normal limits with minimal exudate (a mass of cells and fluid that has seeped out of blood vessels, or an organ, especially in inflammation) and erythema (superficial reddening of the skin) was noted. Treatment orders included to protect area and unload area. Review of Resident #9's physician orders dated, 12/01/22, revealed cleanse sacrum buttock with normal saline, apply skin prep to area, and overlay bordered foam dressing every day shift and as needed. Observation on 12/01/22 at 2:49 P.M., 4:46 P.M., and on 12/05/22 at 8:51 A.M., 10:04 A.M., and 11:54 A.M. revealed Resident #9 was lying on her back. There were no staff present repositioning Resident #9 or encouraging her to change position. Interview on 12/05/22 at 11:55 A.M. with State tested Nursing Assistant (STNA) #970 revealed today was a very busy day, and the staff was working hard to take care of residents. STNA #970 stated she knew Resident #9 was lying in her bed all morning in the same position, and did not get repositioned every two hours as she should. STNA #970 stated what can I say, we are doing our best. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4. Review of Resident #81's medical record revealed an admitted [DATE] and diagnoses included asthma, muscle weakness, and non-[NAME] lymphoma. Resident #81 was discharged to another facility on 12/02/22. Review of Resident #81's physician orders dated, 08/25/22, revealed to complete a Braden Assessment every week for four weeks, every night shift, every Sunday for 21 days. Review of Resident #81's Admission Minimum Data Set (MDS) 3.0 assessment dated , 09/01/22 revealed Resident #81 was cognitively intact and required extensive assistance of two staff for bed mobility and toilet use, and total dependence of two staff for transfers. Resident #81 had a stage two pressure ulcer. Review of Resident #81's Wound Assessment and Plan dated, 09/01/22, included Resident #81 had a stage two pressure ulcer on his coccyx which had a wound onset date of 08/25/22. The wound measurements were a length of 4.3 cm, width of 2.4 cm and a depth of 0.1 cm. Treatment orders included to protect and unload the area. Review of Resident #81's Wound Assessment and plan dated, 09/15/22, included Resident #81's stage two pressure ulcer to his coccyx was healed, but was at risk for reopening due to limited mobility. Treatment orders were to use a bordered foam dressing every Tuesday, Thursday, Saturday and as needed for one week. Treatment orders included to protect and unload area. Review of Resident #81's Braden Scale for Predicting Pressure Sore Risk dated, 09/01/22, and 09/08/22, revealed Resident #81 was at low risk for developing a pressure ulcer. There were no further Braden Scale assessments documented from 09/08/22 through 12/02/22. Review of Resident #81's care plan dated, 09/14/22, included Resident #81 had a stage two pressure ulcer to the coccyx and was at further risk for breakdown due to decreased mobility and incontinence. Resident #81's area to his coccyx would respond to treatment and heal without complication through the review date. The remainder os skin integrity would be maintained through the next review. Interventions included to encourage and assist to turn and reposition during rounds and as needed; observe and document location, size and treatment of skin injury, report abnormalities to the physician. Review of Resident #81's physician orders dated, 09/15/22, revealed to cleanse coccyx with normal saline, apply skin prep, area overlay bordered foam dressing daily and as needed, every day shift every Tuesday, Thursday, and Saturday, and as needed for one week. Review of Resident #81's medical record from 09/22/22 through 11/16/22 did not reveal weekly skin checks were completed. Review of Resident #81's physician orders dated, 11/16/22, revealed weekly skin checks by licensed nurse Thursday night shift, every night shift, every Thursday for skin checks. Interview on 11/30/22 at 2:48 P.M. with the Director of Nursing revealed skin checks were to completed weekly, and documented in the residents medical record by the nurses. DON confirmed they were not completed as required for Resident #81. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/01/22 at 8:10 A.M. with LPN/UM/WN/IP #801 revealed Resident #81's pressure ulcer was healed on 09/15/22 and WP #802 recommended the dressings continue for seven days after the wound was healed for preventative care. LPN/UM/WN #801 stated the dressing change orders were not discontinued after seven days and she would make sure she made the change in Resident #81's medical record to discontinue the dressing change. Observation on 12/01/22 at 10:06 A.M. of Resident #81 revealed he was lying in bed on his back. WP #802 and LPN/UM/WN/IP #801 removed a dressing dated 11/29/22. Observation of Resident #81's coccyx revealed a two inch by approximately one quarter inch dark reddish-purple area which did not blanche, and WP #802 stated pressure caused it. LPN/UM/WN/IP #801 used skin prep and placed a border dressing. After finishing with Resident #81's dressing LPN/UM/WN/IP #801 positioned him on his back. Review of Resident #81's Wound Assessment and Plan dated, 12/01/22, included this was an initial assessment and the wound onset date was 12/01/22. Resident #81 had a stage one pressure injury (intact skin reddened with no blanche) to his coccyx. The wound measurements were a length of 2.8 cm, width of 0. 4 cm, and depth was not applicable. Treatment orders included to protect and unload the area. Observation on 12/01/22 at 12:10 P.M., 2:46 P.M. and 4:47 P.M. revealed Resident #81 was lying on back in bed. Interview on 12/01/22 at 3:11 P.M. with WP #802 indicated if Resident #81 was lying longer than two hours in the same position without offloading it could lead to a pressure injury or ulcer. WP #802 stated he usually ordered a LAL mattress when a pressure ulcer was a stage 3 or 4, or if he saw a progression of the pressure ulcer then he would order a LAL mattress. Review of the facility policy titled Pressure Ulcer Risk Assessment, revised 09/2013, included pressure ulcers were a serious skin condition for the resident. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. A pressure ulcer risk assessment would be completed upon admission, and then weekly times three weeks, with each additional assessment, quarterly, annually and with significant changes. Skin would be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Nurses would conduct skin assessments at least weekly to identify changes. Because a resident at risk can develop a pressure ulcer within two to six hours of the onset of pressure, the at-risk resident needed to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers.

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Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #72's catheter was inserted timely. This affected one resident (Resident #72) out of three residents reviewed for catheter care. Actual Harm occurred on 11/15/22 at 5:37 P.M. when Resident #72 pulled his indwelling catheter out causing redness, irritation and bleeding, and the catheter was not reinserted until Resident #72 experienced abdominal pain and tenderness, was transported to the local Emergency Department on 11/16/22 at 1:57 P. M, a catheter was inserted in the Emergency Department and approximately a liter of urine was returned. Findings include: Review of Resident #72's medical record revealed an admitted [DATE] and diagnoses included obstructive and reflux uropathy, benign prostatic hyperplasia without lower urinary tract symptoms, and mood disorder due to known physiological condition with depressive features. Resident #72 was discharged to the hospital on 11/16/22. Review of Resident #72's care plan dated,11/04/22, revealed Resident #72 had an indwelling catheter related to obstructive uropathy. The care plan indicated Resident #72 would show no signs and symptoms of urinary infection through the review date. Resident #72 would remain free from catheter-related trauma through review date. Interventions included to monitor and document intake and output per facility policy; observe for signs and symptoms of discomfort on urination and frequency; observe, document for pain and discomfort due to catheter; observe, record, report to physician for signs and symptoms of urinary tract infection, including pain, burning, blood-tinged urine, no output; Resident #72 had an indwelling 16 French catheter with a 10 milliliter (ml) balloon. Review of Resident #72's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #72 had severe cognitive impairment. Resident #72 required extensive assistance of two staff members for bed mobility, extensive assistance of one staff member for transfers, and had total dependence on one staff member for toilet use. Resident #72 had an indwelling catheter. Review of Resident #72's progress notes dated, 11/15/22 at 8:12 A.M., written by Medical Director #940 included Resident #72 had issues with his indwelling catheter and pulling it out. Resident #72's indwelling catheter was intact and draining upon examination. Review of Resident #72's nursing progress note, dated 11/15/22 at 5:37 P.M. revealed an unidentified State tested Nursing Assistant (STNA) notified Licensed Practical Nurse (LPN) #971 that Resident #72 pulled out his indwelling catheter. when LPN #971 assessed the situation she noted stool and blood trailing from Resident #72's bed to the bathroom. Resident #72 was confused. LPN #971 called Medical Director (MD) #940 and was given verbal orders to reinsert Resident #72's catheter. LPN #971 attempted to reinsert Resident #72's catheter, and Resident #72 yelled out in pain. LPN #971 administered Tylenol (acetaminophen) and would pass on in report to try again. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #72's nursing progress note written on 11/16/22 at 5:42 A.M. revealed Resident #72's catheter was out. Review of Resident #72's progress notes from 11/15/22 at 5:37 P.M. through 11/16/22 at 12:39 P.M. did not reveal documentation Resident #72's physician was notified the nurses were unable to insert an indwelling catheter. Review of Resident #72's nursing progress note dated, 11/16/2022 at 12:39 P.M revealed Resident #72's abdomen was distended and he was complaining of pain and discomfort. Resident #72 pulled foley catheter out and the nurse was unable to replace due to significant trauma to urethra. Bloody drainage noted. Resident #72 was transported to the local hospital by an Emergency Response ambulance company. Review of Resident #72's Prehospital Care Report Summary dated, 11/16/22, included a call was received from the facility at 12:34 P.M., the ambulance was dispatched at 1:32 P.M. and arrived at the facility at 1:36 P.M. The ambulance arrived with Resident #72 at the local hospital Emergency Department at 1:55 P.M. The Report revealed the dispatch reason was a sick person with a urination problem. The report further revealed Resident #72 had a foley catheter (indwelling catheter), Resident #72 pulled it out and the nurses were unable to reinsert a catheter. Resident #72 had pain on palpation to the abdomen and did not have a catheter in place. The facility wanted Resident #72 sent out to the Emergency Department to see the urology service and have a new catheter inserted. Emergency Medical Services (EMS) arrived at the Emergency Department, Resident #72 was registered and given a bed after about an hour of waiting in line. Review of Resident #72's Emergency Department Encounter dated, 11/16/22 at 1:57 P.M. included Resident #72 presented to the Emergency Department for urinary retention which started 11/15/22. Complaint was constant, moderate severity, nothing made it better or worse. Resident #72 had a chronic indwelling catheter secondary to neurogenic bladder, and pulled it out multiple times and again on 11/15/22. The facility was unable to reinsert an indwelling catheter and reported hematuria when the catheter was pulled out. Resident #72 pointed and localized the pain to his lower abdomen. Resident #72 was unable to provide further history due to his baseline mental status. Resident #72 had an indwelling catheter (coude catheter, designed to maneuver around obstructions or blockages in the urethra) placed in the Emergency Department and approximately one liter of urine was returned. Resident #72's labs show evidence of a urinary tract infection. Resident #72 was hypotensive to 77/47 and urinalysis was consistent with urinary tract infection, demonstrating packed [NAME] Blood Cells (WBC) with many bacteria, large LE (leukocyte esterase, used to determine urinary tract infection) with hematuria. Resident #72 was started on levaquin and doxycycline. Further review of Resident #72's Emergency Department report included a clinical impression of sepsis, due to unspecified organism and urinary tract infection associated with catheterization of urinary tract. Resident #72 was admitted to the intensive care unit and his condition was critical. Review of Resident #72's progress notes dated,11/17/2022 at 9:09 A.M., revealed Resident #72 was admitted to the local hospital with a diagnosis of catheter associated urinary tract infection. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/30/22 at 2:51 P.M. with Registered Nurse (RN) #804 revealed on 11/16/22 she arrived for work and the midnight nurse told her Resident #72 pulled his catheter out on 11/15/22. RN #804 stated the midnight nurse did not try to replace it because Resident #72 had significant trauma to the urethra and she wanted to give him a break. RN #804 indicated the night nurse did not say if she attempted to contact Resident #72's physician to notify her the catheter was unable to be inserted. RN #804 stated she did not call the physician when she first assessed Resident #72 around 7:30 A.M. or 8:00 A.M. RN #804 stated Resident #72's urethra was red and inflamed and there was some urine and blood leakage noted. RN #804 stated she did not try to insert a catheter and thought Resident #72 was okay. RN #804 stated she proceeded to administer medications to the residents she was assigned to, and when she finished the med pass the aides told her Resident #72 was complaining of pain and discomfort in the bladder area. RN #804 stated she could not remember for sure but thought it was around 11:30 A.M. when this occurred. RN #804 stated she did not attempt to insert a catheter and called Resident #72's physician immediately. RN #804 stated she received orders from the physician to send Resident #72 to the Emergency Department. RN #804 revealed Resident #72 pulled out at least four indwelling catheters out since he admitted to the facility. RN #804 stated LPN #971 was working on 11/16/22 and told her Resident #72 pulled his indwelling catheter out on 11/15/22 and she passed the information to the night nurse. Interview on 12/01/22 at 4:37 P.M. with LPN #971 revealed she worked on 11/15/22, and around 5:00 P.M. an unidentified STNA told her Resident #72 pulled his catheter out. LPN #971 stated she entered Resident #72's room to evaluate him and saw blood and stool everywhere, noted trauma to Resident #72's urethra and also blood coming out of Resident #72's urethra. LPN #971 stated she called Medical Director (MD) #940, told her Resident #72 pulled his catheter out and there was trauma to his urethra and blood draining from his urethra. LPN #971 stated she received orders from MD #940 to reinsert Resident #72's catheter. LPN #971 verified Resident #72 yelled out in pain and she was unable to insert the catheter, but did not call MD #940 to notify her she could not reinsert Resident #72's catheter. LPN #971 stated she administered Tylenol (acetaminophen) to Resident #72 and told the next shift nurse Resident #72's catheter was out and needed reinserted. LPN #971 stated 11/15/22 was a very busy and hectic day and she felt overwhelmed with her assignment. LPN #971 stated when she called MD #940 she was told Nurse Practitioner (NP) #972 was on call because MD #940 was going out of town. LPN #971 indicated there were no memos stating Nurse Practitioner #972 was on call for MD #940. LPN #971 stated she did not call NP #972 to notify her Resident #72's catheter was unable to be inserted. LPN #971 stated she worked the next day and the nurse taking care of Resident #72 knew about the situation with his catheter, and knew he was on a blood thinner. LPN #971 stated she had another assignment on 11/16/22 and went on about her business. Interview on 12/07/22 at 9:03 A.M. with the Director of Nursing (DON) revealed she did not know anything about Resident #72 pulling his catheter out, or it was unable to be reinserted until he was sent to the Emergency Department on 11/16/22. The DON stated none of the day shift or night shift nurses contacted her. The DON stated NP #972 told her no nurses notified her Resident #72's catheter was pulled out or they were unable to reinsert it. Interview on 11/30/22 at 6:20 P.M. with MD #940 revealed she was unable to look at her messages from 11/15/22 and 11/16/22 because Resident #72 was discharged from the facility. MD #940 stated she remembered she was called about Resident #72 pulling his catheter out but could not verify the time. MD #940 stated she did not remember any nurse calling her to tell her Resident #72's catheter was unable to be reinserted after she gave the order to insert a catheter. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled Change in Resident's Condition or Status, revised 06/2013, included the facility should promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical, mental condition and or status. The Nurse/Dietitian/Respiratory Therapist would notify the resident's Attending Physician or On-Call Physician when there had been a significant change in the resident's physical/emotional/mental condition. A significant change of condition was a decline or improvement in the resident's status that would not normally resolve itself without intervention by staff.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interviews, record review and facility policy review, the facility failed to timely implement nutritional interventions for residents who experienced weight loss or were at risk of compromised nutrition. This affected four residents (Residents #38, #44, #66, and #80) out of five residents reviewed for nutrition. The facility census was 83. Actual harm occurred on 11/30/22 when Resident #44 was assessed to have a significant weight loss of 40 pounds (22.5 percent) from Resident #44's previous weight on 10/14/22 of 177 pounds and the facility failed to ensure nutritional interventions were implemented to prevent and address the weight loss. Findings include: 1. Medical Record review revealed Resident #44 had an admitted [DATE] and diagnoses included unspecified cerebral infarction (stroke), traumatic hemorrhage of cerebrum (acute loss of blood in the brain), altered mental status, gastro-esophageal reflux disease (GERD) with esophagitis, depression, type two diabetes, and dysphagia following cerebral infarction. Review of Resident #44's admission nutrition assessment dated [DATE], revealed the resident needed assistance with meals. The resident was confused and had no skin issues or known significant weight changes. Resident #44 was consuming 75 percent of meals. Review of Resident #44's nutritional care plan dated 09/14/22 revealed the resident had a nutritional problem or potential nutritional program due to COVID 19, asthma, diabetes mellitus, cerebrovascular accident, GERD, and hypothyroidism. Interventions included intakes of greater than 50 percent (%) for three months, maintain current body weight for three months, monitor weights, intakes, provide adequate nutrition/hydration, and monitor resident and make adjustments to the plan of care as needed. Review of Physician #940's progress note dated 09/27/22 revealed a suspicion that Resident #44 was not consuming much during mealtimes, since his albumin level was low, and the staff were to encourage him during mealtimes. Review of Physician #940's progress note dated 10/03/22 revealed the need to monitor his nutritional intake due to uncontrolled blood sugars. Review of Resident #44's 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was severely impaired and required extensive one person assistance with eating. Review of facility weights revealed Resident #44's weight was stable between 176.2 pounds and 180.8 pounds between 09/14/22 and 10/14/22. Review of medical record revealed Resident #44 was hospitalized from 11/22/22 to 11/25/22 for a urinary tract infection. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of hospital records revealed the nutrition assessment completed on 11/23/22 for Resident #44 indicated Resident #44 had an average meal intake of 25 to 50 %, was at nutritional risk due to noted poor appetite for one to two weeks prior to admission, had a stated weight of 160 pounds, was started on an oral nutritional supplement while in the hospital, and would continue to be monitored. Review of hospital discharge paperwork printed 11/25/22 at 11:14 A.M. revealed Resident 44's latest vitals showed a weight of 152 pounds and 6.4 ounces. Review of admission/readmission evaluation dated 11/25/22 for Resident #44 revealed the most recent weight was 177.0 pounds on 10/14/22. Review of physician orders for Resident #44 indicated an order for a mechanically altered chopped texture, thin texture dated 11/25/22. Review of November 2022 meal intakes for Resident #44 revealed 52 meals with no data recorded; however, of the meals recorded, Resident #44 consumed 0% to 75% of his meals prior to hospital stay and after being readmitted on [DATE], all recorded meals were refused. Resident #44's medical record, including progress notes, showed no evidence of nutritional intervention on the days meals were refused or not recorded. Review of the weight obtained on 11/30/22 for Resident #44 (after surveyor requested it) revealed a weight of 135.8 pounds, and a reweight of 137.0 pounds was obtained on the same day, reflecting a significant weight loss of 40 pounds (22.5 %) from Resident #44's previous weight on 10/14/22 of 177 pounds. Assistant DON #837 verified the weight at the time of observation. Review of nutrition assessment started on 11/30/22 but signed on 12/04/22 revealed meal intakes were poor with refusal to 25% of meals being consumed, was on mirtazapine (Remeron) which might affect appetite stimulation, daily needs were 1550-1860 calories, 62-68 grams of protein, and fluid needs were 1860 milliliters, and ensure three times a day would be recommended secondary to significant weight loss and poor meal intakes. Review of Resident #44's breakfast, lunch, and dinner diet tray cards dated 11/30/22 revealed there was nothing listed in the dislike/do not serve or the special instructions sections. Review of Resident #44's physician orders revealed a nutritional supplement was not added until 12/04/22 to include Ensure three times a day. Interview on 12/01/22 at 4:25 P.M. with family of Resident #44 revealed she was not aware of the weight loss. She confirmed the resident had not been eating, and he needed assistance with eating due to his impaired vision. She stated Resident #44 would refuse meals at times, and she felt the weight loss was from a combination of not receiving the assistance with meals that he needed and from the meal refusals. She voiced his current weight was low for him. Interview on 12/01/22 at 4:38 P.M. with Physician #940 revealed she was unaware of Resident #44's weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/01/22 at 5:58 P.M. with Dietitian #954 revealed Resident #44's weight was all over the place and he had requested an additional weight to ensure the present weight was accurate. He stated Resident #44's meal intakes were all over the board, and he was already on Remeron which could help increase his appetite. Dietitian #954 felt if the weight was still down after the requested reweight was obtained, Resident #44 would need some sort of intervention. He then stated he would no longer be covering the home since a new contracting company was starting. Interview on 12/05/22 at 11:35 A.M. with Director of Nursing (DON) revealed the unit manager was the one who would check the admissions to ensure nothing was missed. The nurse who completed the admission/readmission evaluation dated 11/25/22, came from another facility where the weights for readmits and admits were entered differently. The DON confirmed the unit manager missed that a new weight was not obtained for Resident #44, and there was not a new weight attained upon readmission for Resident #44. Interview on 12/05/22 at 12:52 P.M. with State tested Nursing Assistant (STNA) #904 revealed she was the one who communicated with Resident #44 since they both spoke Spanish. STNA confirmed he had lost weight since she could see it on his body. She stated she told him he was wasting away. She fed him every meal when she worked, and he could hold a drink container or some finger foods if you put them in his hand. She voiced he ate better when he was first admitted , and he has told her he was not hungry. She would often offer him something else if he refused items, but he refused those items. When he was done eating, he would say in Spanish That's it. He has told her he did not like the food. She has told the kitchen his preferences and nothing has been done. He has continued to receive items on his tray, like apple juice, that he did not like. She has let the nurses know that he has not been eating and has been losing weight multiple times. The family did bring in supplements and snacks over the weekend. Someone would need to offer him the snacks since Resident #44 would not ask for the snacks. Interview on 12/05/22 at 10:52 A.M. with Licensed Practical Nurse (LPN) #962 revealed on certain days Resident #44 had a great appetite. If he was in pain, he would not eat. If Resident #44 was comfortable with the aide, he would eat better. LPN #940 completed his admission note in the progress notes. She stated until a new weight was put in the admission screener, the most recent weight was pulled forward in her note. She stated the person who completed the admission screener was responsible for obtaining a readmission weight. Observation on 12/06/22 at 1:35 P.M. revealed Resident #44's tray was observed sitting on the over bed table with the meal of two chicken tenders, one roll, one scoop mashed potatoes, and jello all untouched. The 8-ounce milk carton and the container of ensure plus were both unopened. Interview on 12/06/22 at 1:36 with STNA #980 revealed she did not know why his meal was not touched since she was not his aide that day. At the time of observation and questioning, the unit nurse went into his room and opened the Ensure plus, put a straw in it and held it to his mouth. Resident #44 then took some sips of the supplement but did not want his meal. Interview on 12/06/22 at 1:45 P.M. with STNA #803 revealed she passed out all of the meal trays and STNA #980 was supposed to feed Resident #44. Interview on 12/07/22 at 1:08 P.M. with LPN #960 revealed if a resident refused a meal, the facility should provide something else to eat. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/07/22 at 1:20 with LPN #961 revealed if a resident was not eating well she should tell a supervisor. Review of facility policy titled Resident Nutrition Services, revised November 2009, revealed nursing would evaluate food and fluid intake in residents with, or at risk for significant nutritional problems. Nursing staff would assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. Significant variations from usual eating or intake patterns would be recorded in the resident's medical record. The nurse supervisor and/or unit manager would evaluate the significance of such information and report it. Review of facility policy titled Weight Assessment and Intervention, revised 2008, revealed residents would be weighed on admission, the next day and weekly for two weeks thereafter. If no weight concerns are noted, weights would be measured monthly thereafter. The multidisciplinary team would strive to prevent, monitor, and intervene undesirable weight loss. 2. Review of medical record for Resident #80 revealed an admitted [DATE] and diagnoses included end stage renal (kidney) disease, essential (primary) hypertension (high blood pressure), acute on chronic diastolic (congestive) heart failure, and type 2 diabetes with hyperglycemia (excessive amount of glucose circulating in the blood) Review of care plan dated 07/26/22 revealed Resident #80 had a nutritional problem, or the potential of a nutrition problem, related to hyperkalemia, nausea and vomiting prior to admission, Acute Kidney Injury on chronic kidney disease, oral nutritional supplement, and therapeutic diet with goals of providing adequate nutrition hydration, maintain weights, and intakes greater than 50 %. Interventions included provide diet/supplements per orders and honor food preferences and monitor weights. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 was cognitively intact, was independent with set up only eating, had no significant weight loss, was on a therapeutic diet, and was on dialysis. Review of physician orders for Resident #80 indicated an order for hemodialysis every Tuesday, Thursday, and Saturday dated 08/16/22, an order for a renal/controlled carbohydrate diet, regular texture, thin Liquids consistency dated 08/15/22 with a 100 gram protein added on 11/17/22 and an order for ensure with meals dated 12/04/22. Review of meal intakes for Resident #80 revealed for October 2022 six meal intakes were recorded with consumption varied from 0% to 75%. For November 2022, 27 meals were recorded with consumption between 0-25%. Review of facility weights revealed Resident #80 weighed 207 pounds on 7/25/22, 177.4 pounds on 08/08/22, 162.4 pounds on 08/25/22, 162.2 pounds on 09/01/22, and 163.0 on 10/18/22 which reflected a significant weight loss of 44.6 pounds (21.5 percent) from 7/25/22 to 8/25/22. Review of dietary progress notes for Resident #80 revealed ensure plus daily and ensure clear daily was recommended related to poor appetite on 08/19/22 and there were no other nutritional notes until 10/25/22 when the 44 pound weight loss within three months was noted to be anticipated due to fluid shifts and variable intakes from stomach discomfort. Resident #80 was to continue with current interventions. (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 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/01/22 with Dietitian #954 on 12/01/22 at 5:58 P.M. confirmed Resident #80 had lost a significant weight loss. He felt some of the weight loss could have been anticipated related to fluid shifts however this weight loss was so severe not all of it was anticipated. He confirmed Resident #80 was not assessed in a timely manner for the weight loss. He revealed if the weight loss was anticipated it would be care planned, and he confirmed there was no planned weight loss as a goal in the care plan. Interview on 12/01/22 at 9:40 A.M. with Renal Dietitian #964 confirmed Resident #80 had lost weight. On 7/30/22 Resident #80 left the dialysis center weighing 85.4 kilograms(kg) (187.9 pounds). He missed three treatments on 08/06/22, 08/09/22, and 08/11/22. On 08/13/22, he left the facility weighing 76.9 kg (169.2 pounds). On 08/30/22 he left the facility weighing 71.9 kg (158.2 pounds). His weight had remained stable since 08/30/22. Resident #80's albumin levels have decreased from 3.9 gram (g) per deciliter (dl) on 09/06/22 to 3.8 g/dl on 10/4/22 to 3.5 g/dl on 11/05/22. Renal Dietitian #964 has tried to reach out by email and has called several times with no return response from the facility. The renal doctor was concerned about the decreased albumin levels and ordered Resident #80 to be on a 100 g protein diet. Interview on 12/07/22 at 1:28 PM with Resident #80 confirmed he had lost weight, which he thought was from a combination of improved edema status and from poor meal intakes. He had never been asked his preferences. He was unaware there were alternatives for meals. He stated he either ate the meal or did not. Staff had never offered anything else if he did not eat. He stated he often used his supplements as meal replacements. Interview on 12/07/22 at 2:20 P.M. with LPN #902 confirmed his weight loss back in July and August of this year was a combination of resolved edema and poor meal intakes. Review of facility policy titled Resident Nutrition Services, revised November 2009, revealed nursing would evaluate food and fluid intake in residents with, or at risk for significant nutritional problems. Nursing staff would assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. Significant variations from usual eating or intake patterns would be recorded in the resident's medical record. The nurse supervisor and/or unit manager would evaluate the significance of such information and report it. 3. Review of medical record for Resident #38 revealed an admitted [DATE] and diagnoses included acquired absence of left leg above knee (12/05/22), cerebral infarction (stroke), end stage renal disease, and type two diabetes with diabetic neuropathy. Review of care plan dated 07/06/22 revealed Resident #38 was had a nutritional or potential nutritional problem related to diabetes, end stage renal disease, therapeutic diet, and oral nutritional supplement with interventions which included provide diet/supplements per orders and honor food preferences as able, monitor weights, and adjust the plan of care as needed. Review of five day Modified Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact, was independent with no set up required for eating, was on a therapeutic diet, and had no significant weight changes. Review of progress note dated 11/17/22 revealed Resident #38 had been admitted to the hospital on with diagnoses of osteomyelitis of the left foot. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of admission/readmission evaluation dated 11/26/22 for Resident #38 revealed he had returned from the hospital and had new left above knee amputation. Review of facility weights revealed Resident#38 weighed 200.8 pounds on 11/15/22, 187.0 pounds on 11/28/22, 182.1 pounds on 11/29/22, and 181.7 pounds on 12/01/22 which resulted in a significant weight loss of 6.8 percent (%) from 11/15/22 to 11/28/22. Review of Dietitian #956 weight change note for Resident #38 dated 12/04/22 revealed resident had experienced a significant weight loss and the weight fluctuation was in relation to dialysis. Interview on 12/07/22 at 3:35 P.M. with Dietitian #956 confirmed Resident #38 had a significant weight loss. She felt the weight loss was related to the weight fluctuation since he was on dialysis. She confirmed she did not read the hospital records was unaware Resident #38 had an amputation while in the hospital, which would result in a weight loss. Dietitian #956 stated she would have recalculated his needs and his BMI if she had known he had an amputation. Review of facility policy titled Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol revealed the nursing staff will monitor and document the weight and dietary intake of residents in a format that permits readily available comparisons over time. The physician and/or dietitian will review possible causes of anorexia or weight loss. The staff and physician will identify pertinent interventions based on identified causes. 38094 4. Resident #66 was admitted on [DATE] with diagnoses including history of stroke, Monoclonal gammopathies (conditions in which abnormal proteins are found in the blood), diabetes type II, acute respiratory failure with hypoxia, hyperlipidemia, hypomagnesemia, Vitamin D deficiency, congestive heart failure, edema, hypokalemia, acidosis, chronic kidney disease stage IV and cyst of kidney. Review of Resident #66's physician orders revealed orders for a renal /controlled carbohydrate diet, regular texture with thin liquids. Review of the Medicare 5-day MDS 3.0 assessment revealed the resident was cognitively intact, required extensive assist of two for ADLs, received oxygen therapy and dialysis. A nutritional assessment was completed on 09/29/22 by the former facility dietician revealed the resident was at risk of malnutrition related to his increased needs with hemodialysis. There was no further communication from a dietician at the facility Review of care plan of 10/23/22 for Resident #66 revealed a care area for nutrition related to edema, congestive heart failure and diabetes with interventions including providing diet and supplements per orders and honoring food preferences. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #66 on 11/28/22 at 3:56 P.M. revealed he does not receive the right diet. He normally eats one starch a day, as a diabetic. The facility was giving him two starches at each meal. They gave him a donut with icing for breakfast. He would like to have more protein, instead on the one old egg he sometime got. He would like fish, chicken. Sometimes the facility did not give him any meat for three days. Resident #66 revealed dietician at dialysis agreed with him that he was not eating right. Resident #55 revealed nobody at the facility asked him his preferences but the dietician at dialysis did. Observation and interview with Resident #66 on 11/30/22 at 8:35 A.M. revealed he received a pancake with syrup, coffee and diet lemonade for breakfast. Interview on 11/30/22 09:31 A.M. with Registered Nurse (RN) #804 revealed they made sure Resident #66 received his breakfast, medication and a blood sugar right away because his sugar tended to run low in the morning. She verified all residents usually received a donut or danish for breakfast. Interview on 12/01/22 at 9:20 A.M. Renal Dietitian (RD) #963 revealed she has been unable to reach a dietician or someone in dietary at the facility about Resident #66's diet preferences. The resident voiced to her that he was always hungry and was not getting enough to eat. She had a whole list of his preferences. She reported he has had a 6.9% weight loss from 10/02/22 to 12/01/22.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident's #2, #15, #16, #25, #58 and #81 were administered oxygen per physician orders. This affected six residents (Resident's #2, #15, #16, #25, #58 and #81) out of seven reviewed for oxygen administration. Findings include: 1. Review of Resident #81's medical record revealed an admitted [DATE] and diagnoses included asthma, muscle weakness, and non-[NAME] lymphoma. Review of Resident #81's physician orders dated, 08/29/22, revealed administer oxygen at five liters per minute via nasal cannula, every shift. Review of Resident #81's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #81 was cognitively intact and required extensive assistance of two staff for bed mobility and toilet use, and total dependence of two staff for transfers. Resident #81 used oxygen. Observation on 11/28/22 at 2:23 P.M. of Resident #81 revealed he was lying in bed and had oxygen administered at two liters per minute via nasal cannula. Further observation of Resident #2 revealed there was no date documented on his oxygen tubing when it was changed. After surveyor intervention Registered Nurse (RN) #800 entered Resident #81's room and confirmed Resident #81's oxygen was administered at two liters per minute via nasal cannula, and there was no date on the oxygen tubing documenting when it was changed. RN #800 checked Resident #81's physician orders and stated the orders were to administer the oxygen at five liters per minute via nasal cannula. 2. Review of Resident #2's medical record revealed an admitted [DATE] and diagnoses included cerebral infarction, acute kidney failure, fibromyalgia, and multiple sclerosis. Review of Resident #2's physician orders dated 03/18/22, revealed administer oxygen at five liters per minute via nasal cannula continuously every shift. Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated , 11/19/22, revealed Resident #2 was cognitively intact and was independent for bed mobility, transfers, and toilet use. Resident #2 used oxygen. Review of Resident #2's care plan, dated 09/12/22, included Resident #2 had oxygen therapy related to CHD, history of tobacco use. Resident #2 would have no signs and symptoms of poor oxygen absorption through the review date. Interventions included to give medications as ordered by physician; observe, document side effects and effectiveness. Review of Resident #2's Medication Administration Record (MAR) dated 11/01/22 through 11/28/22 revealed documentation each shift oxygen was administered at five liters per minute via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/28/22 at 9:35 A.M. of Resident #2 revealed she was lying in bed, and was administered oxygen at 3.5 liters per minute via nasal cannula. Registered Nurse (RN) #800 entered Resident #2's room and confirmed the oxygen was administered at 3.5 liters per minute via nasal cannula. After checking Resident #2's physician orders RN #800 stated the oxygen should be set at five liters per minute via nasal cannula. 3. Review of Resident #15's medical record revealed an admitted [DATE] and diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, dementia, type two diabetes mellitus with hyperglycemia, and major depressive disorder. Review of Resident #15's physician orders dated, 09/05/21, revealed oxygen tubing to be changed weekly on Sundays, every night shift, every Sunday, and as needed. Must be dated. Review of Resident #15's physician orders dated, 02/08/22, revealed oxygen administration at eight liters per minute via nasal cannula, continuous every shift. Review of Resident #15's Annual MDS 3.0 assessment dated , 09/04/22, revealed Resident #15 was cognitively intact. Resident #15 required extensive assistance of one staff member for bed mobility and transfers. Resident #15 used oxygen. Observation on 11/28/22 at 10:02 A.M. with Resident #15 revealed she was lying in bed and was administered oxygen at seven liters per minute via nasal cannula and there was no date documented on the oxygen tubing when it was changed. Resident #15 stated her oxygen should be set at eight liters per minute via nasal cannula. After surveyor intervention RN #800 entered Resident #15's room and confirmed the oxygen was administered at seven liters per minute via nasal cannula and there was no date on the oxygen tubing stating when it was changed. RN #800 checked Resident #15's physician orders and confirmed the oxygen should be administered at eight liters per minute via nasal cannula. Review of the facility policy titled Oxygen Administration, revised, 10/2010, included the purpose of the procedure was to provide guidelines for safe oxygen administration. Verify that there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 44461 4. Record review for Resident #16 revealed and admitted d of 02/04/22 and a discharge date of [DATE] by death in facility. Resident #16's diagnoses included stroke, obstructive sleep apnea, emphysema, history of COVID-19, acute respiratory failure, chronic obstructive pulmonary disease (COPD), and history of a pulmonary embolism. Review of Resident #16's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had impaired cognition. Review of Resident #16's physician's orders dated December 2022 revealed orders for oxygen via nasal cannula at two liters/minute as needed. Observation on 12/01/22 at 4:46 P.M. of Resident #16's oxygen revealed she was on three liters/minute via nasal cannula continuously. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/22 at 4:50 P.M. with Licensed Practical Nurse (LPN) #900 confirmed Resident #16 was on three liters/minute of oxygen via nasal cannula which was not following the physician orders of two liters/minute of oxygen via nasal cannula. Review of the undated facility policy titled Oxygen Administration revealed under section titled Preparation bullet point number one stated facility nursing staff was to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 5. Record Review for Resident #25 revealed an admitted [DATE]. Resident #25's diagnoses included cerebral infarction, venous insufficiency, monothematic mitral valve insufficiency, dysarthria, cardiac arrhythmias, morbid obesity, and hypertension. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #25 had intact cognition. Review of Resident #25's care plan dated 11/23/22 revealed there was a care plan in place for oxygen therapy, however the care plan was for one liters/minute via nasal cannula. Review of Resident #25's physicians orders dated December 2022, revealed orders for Resident to be on one liters/minute of oxygen via nasal cannula continuously and may titrate to keep blood oxygen level (SpO2) above 92% every shift. Change oxygen tubing weekly on Sundays and as needed. Oxygen tubing must be kept in bag and dated when changed and oxygen tubing was to be kept in bag at all times (AAT) if not in use. Review of Resident #25's SpO2 documentation from 11/01/22 through 12/01/22 revealed the lowest SpO2 was 94% and the highest was 98% with no documentation of titration of oxygen. Observation on 11/30/22 at 5:20 P.M. of Resident #25's oxygen concentrator revealed she was receiving 7.5 liters/minute of oxygen via nasal cannula. Interview on 11/30/22 at 5:15 P.M. with Resident #25 revealed she stated she was to be on two liters/minute of oxygen via nasal cannula. She stated her oxygen tubing was changed today (11/30/22) but the last time it was change was two weeks ago. Interview on 12/01/22 at 4:55 P.M. with LPN #900 confirmed Resident #25 was on 7.5 liters/minute of oxygen which was not following the physician orders of one liter/minute of oxygen via nasal cannula. She stated they monitor residents SpO2 every shift and she is always in the high 92% and above. There were no attempts made to titrate the residents oxygen levels down. Review of the undated facility policy titled Oxygen Administration revealed under section titled Preparation bullet point number one stated facility nursing staff was to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 6. Record review for Resident #58 revealed an admitted [DATE]. Resident #58's Diagnoses included pneumonia, occlusion and stenosis of bilateral carotid arteries, choric kidney disease, Neutrogena bladder, type II diabetes mellitus, hypertension, dysphagia, aphasia, depression, urinary retention, and anemia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of quarterly MDS dated [DATE] revealed Resident #58 had intact cognition. Review of Resident #58's care plan dated 10/24/22 revealed the resident had a history of pneumonia and is at risk for complications. Interventions included her pneumonia would resolve without complications, nursing staff was to listen to and document on residents breath sounds, head of bed to be elevated for comfort, monitor vital signs including SpO2, notify the physician with any new signs or symptoms of worsening pneumonia, oxygen therapy, change oxygen tubing weekly on Sundays and as needed, tubing must be kept in bag AAT if not in use, change the residents position with rounds to facilitate lung secretion movement and drainage, and resident was to have oxygen via nasal cannula at five liters/minute continuously. Review of physician's orders dated December 2022, revealed oxygen at five liters/minute was discontinued on 05/31/22 and never reordered by the physician. Observation 11/30/22 at 11:30 A.M. revealed Resident #58 had oxygen at five liters/minute via nasal cannula running. Interview with Resident #58 on 11/30/22 at 11:32 A.M. revealed she believed she should only be on two liters/minute of oxygen via nasal cannula. Resident #58 stated she was not short of breath, and she had no respiratory symptoms. Resident #58 stated she does remove her oxygen at times because she feels it is too much and gets irritated with it. Interview on 12/01/22 at 3:45 P.M. with LPN #900 confirmed Resident #58 was on oxygen at five liters/minute via nasal cannula and there was no current physician's order for it. Review of the undated facility policy titled Oxygen Administration revealed under section titled Preparation bullet point number one stated facility nursing staff was to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #2 received her pain medication per physician orders. This affected one resident (Resident #2) out of three residents reviewed for pain management. The facility census was 83. Findings include: Review of Resident #2's medical record revealed an admitted [DATE] and diagnoses included cerebral infarction, acute kidney failure, fibromyalgia, and multiple sclerosis. Review of Resident #2's physician orders dated 05/26/22, revealed oxycodone-acetaminophen tablet 7.5 -325 milligrams (mg), give one tablet by mouth every six hours for pain. Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated , 11/19/22, revealed Resident #2 was cognitively intact and was independent for bed mobility, transfers, and toilet use. Resident #2 used oxygen. Review of Resident #2's Medication Administration Record (MAR) from 11/22/22 at 6:00 P.M. through 11/24/22 at 12:00 P.M. revealed Resident #2 was not administered oxycodone. Review of Resident #2's progress notes from 11/22/22 at 6:00 P.M. through 11/24/22 at 12:00 P.M. revealed on 11/23/22 at 5:15 A.M., 12:46 P.M., and 5:10 P.M. the notes stated awaiting delivery of oxycodone-acetaminophen 7.5 mg-325 mg, give one tablet by mouth every six hours for pain. On 11/23/22 at 11:05 PM. and and 11/24/22 at 5:04 A.M. the progress notes stated medication (oxycodone) not available. Observation on 11/28/22 at 9:35 A.M. of Resident #2 revealed she was lying in bed. Resident #2 stated her medications did not get reordered timely. Resident #2 stated she was sick on Thanksgiving day (11/24/22) because she did not receive her pain medication (oxycodone) for a few days before Thanksgiving. Resident #2 stated she was having withdrawal symptoms because she did not receive the oxycodone. Interview on 12/01/22 at 2:00 P.M. with the DON revealed Resident #2's oxycodone was ordered 11/23/22 and arrived on 11/25/22. The DON was not sure why the oxycodone was not ordered sooner. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/01/22 at 04:32 P.M. with Licensed Practical Nurse (LPN) #971 revealed she worked on 11/23/22 at 6:00 P.M. through 11/24/22 at 6:00 A.M. LPN #971 stated Resident #2 was out of oxycodone (pain medication) for a few days. LPN #971 stated she worked for a staffing agency and she did not order Resident #2's oxycodone, and just documented the medication was not available in Resident #2's medical record. LPN #971 stated she did not have access to the automated medication dispensing system in the facility because she was from a staffing agency. LPN #971 stated she administered Tylenol to Resident #2. LPN #971 stated she did not check with any other nurses in the facility to see if they had access to the automated medication dispensing system. LPN #971 stated she did not call the Director of Nursing (DON) or Resident #2's physician, or the pharmacy to try to get an authorization code for the automated medication dispensing system so she could administer Resident #2 oxycodone. LPN #971 indicated she did not know the DON's phone number to contact her. LPN #971 stated she did not contact anyone regarding Resident #2's oxycodone. Interview on 12/05/22 at 12:57 P.M. with the DON confirmed Resident #2's oxycodone was not administered from 11/22/22 at 6:00 P.M. through 11/24/22 at 12:00 P.M. Interview on 12/05/22 at 1:16 P.M. with the DON revealed the facility did not give all nurses from a staffing agency a username and access to the automated medication dispensing system. The DON stated an agency nurse could get authorization from the pharmacy to remove oxycodone from the automated medication dispensing system. The DON confirmed no oxycodone was removed from the automated medication dispensing system for Resident #2 from 11/22/22 at 6:00 P.M. through 11/24/22 at 12:00 P.M. Review of the facility policy titled Pain Clinical Protocol revised 06/2013, included the physician and staff would identify individuals who had pain or who were at risk for having pain. The physician would order appropriate non-pharmacologic and medication interventions to address the individual's pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review, and facility policy, the facility failed to ensure ongoing communication and collaboration with the dialysis facility for residents who required dialysis. This affected all 14 residents (Resident #8, #24, #35, #38, #53, #57, #62, #66, #67, #74, #79, #80, #83, #294) of 14 residents reviewed for dialysis at the facility. Findings include: 1. Review of medical record for Resident #80 revealed an admitted [DATE] and diagnoses included end stage renal (kidney) disease, essential (primary) hypertension (high blood pressure), acute on chronic diastolic (congestive) heart failure, and type 2 diabetes with hyperglycemia (excessive amount of glucose circulating in the blood) Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 was cognitively impaired, required limited assistance with one-person physical assist for bed mobility, walk in room, walk in corridor, dressing, and toilet use, was independent with set up only eating and personal hygiene, was always continent of bowel and bladder, and was on dialysis. Review of physician orders for Resident #80 indicated an order for hemodialysis every Tuesday, Thursday, and Saturday dated 08/16/22, an order for a renal/controlled carbohydrate diet, regular texture, thin Liquids consistency dated 08/15/22 with a 100 gram protein added on 11/17/22 and an order for ensure with meals dated 12/04/22. Review of care plan dated 08/23/22 revealed Resident #80 had renal insufficiency related to end stage renal disease with interventions which included dietary consult to regulate protein, sodium, and potassium intake, monitor vital signs per order and as needed, and observe and report changes in mental status. Review of meal intakes from 10/01/22 to 11/30/22 for Resident #80 revealed in October 2022 six meal intakes were recorded with meal intakes varied from refusal to 75 percent (%) being consumed and the rest of the meals had no data recorded and in November 2022 27 meal intakes were recorded with refusal to 25% of meals being consumed and the rest of the meals had no data recorded. Review of the communications from the dialysis center to the facility from 10/08/22 to 11/17/22 for Resident #80 revealed three communications. On 10/08/22 a nurse at dialysis wrote a note to make sure Resident #80 was on the proper dose of renvela, on 11/11/22 the dialysis dietitian faxed over Resident #80's 11/08/22 labs which were drawn at dialysis, and on 11/17/22 the dietitian faxed over the nephrologist's order for a 100 g protein diet. Interviews on 11/30/22 at 11:40 A.M. and on 12/01/22 at 5:58 P. M with Dietitian #954 revealed he was not aware of the new order for a 100 g protein diet on 11/17/22, and he had not communicated with anyone from dialysis since he began coverage on 11/12/22. He confirmed the dietitian should communicate with dialysis periodically. Dietitian #953 stated some dialysis centers will send information, but he had not received any. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/22 at 9:40 A.M. with Renal Dietitian #964 revealed Resident #80 had lost weight. On 7/30/22 Resident #80 left the dialysis center weighing 85.4 kilograms(kg) (187.9 pounds). He missed three treatments on 08/06/22, 08/09/22, and 08/11/22. On 08/13/22, he left the facility weighing 76.9 kg (169.2 pounds). On 08/30/22 he left the facility weighing 71.9 kg (158.2 pounds). His weight had remained stable since 08/30/22. Resident #80's albumin levels have decreased from 3.9 gram (g) per deciliter (dl) on 09/06/22 to 3.8 g/dl on 10/4/22 to 3.5 g/dl on 11/05/22. Renal Dietitian #964 has tried to reach out by email and has called several times with no return response from the facility. The renal doctor was concerned about the decreased albumin levels and ordered Resident #80 to be on a 100 g protein diet. Interview on 12/06/22 at 4:45 P.M. with the Director of Nursing (DON) and LPN #837 revealed the document titled Dialysis Hand Off Communication Report was not being filled out by the facility nurses prior to the residents going to dialysis. Interview on 12/07/22 at 9:45 A.M. with Dialysis Manager #951 for Resident #80's dialysis center revealed, according to Dialysis Nurse #952 and Dialysis Technician #953, the facility did not send communication sheets, which listed the pretreatment vitals, with residents. Dialysis Manager #951 stated after every treatment a communication sheet from the dialysis center was sent with the residents, and the dialysis center had recently sent copies of treatment sheets for Resident #80 to the facility on [DATE] after the facility had requested them. Interview on 12/07/22 at 10:34 A.M. with the DON confirmed dialysis residents did not have communication binders until 12/01/22, when she initiated them. Interview on 12/07/22 at 1:28 P.M. with Resident #80 revealed he had lost weight, which he felt was from a combination of improved edema and not eating the facility meals. He voiced a concern about receiving items on his tray, such as potatoes, orange juice and milk, which were not appropriate for a renal diet. Resident #80 stated his dialysis dietitian tried to tell the facility his preferences, and there has been no changes. He revealed he either ate or did not eat since staff members have never offered him something else if he did not eat his meal, and he used his supplements as a meal replacement. Review of undated facility policy titled Dialysis revealed communication with the dialysis center would be maintained using a communication book, which was to be sent every time the resident went for dialysis. The licensed nurse would evaluate observe and/or assess the shunt/fistula for signs/symptoms of bleeding and infection. The access site would be monitored and any bleeding, pain, swelling, or tingling/numbness would be reported to the physician. Post dialysis nurse would monitor BP, pulse, presence/absence of bruit/thrill, monitor for s/s of fluid overload, and would remove pressure dressing from the shunt/fistula site upon return from dialysis as indicated. If resident refused to go to dialysis, the physician would be notified. 2. Review of medical record for Resident #74 revealed an admitted [DATE] and diagnoses included unspecified atrial fibrillation (irregular heartbeats), acute respiratory failure with hypoxia (difficulty breathing due to inadequate oxygen supply), end stage renal (kidney) failure, and dependence on renal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 was moderately impaired cognitively, required extensive of one person assist for dressing and personal hygiene, extensive of two person assist for bed mobility and toilet use, total dependence of one person assist for locomotion and bathing, total dependence with two person assist for transfer, was independent with set up for eating, and was on dialysis. Review of physician orders for Resident #74 indicated an order for hemodialysis every Monday, Tuesday, Wednesday, Thursday, and Friday dated 02/09/22. Review of care plan dated 02/27/22 revealed Resident #74 had renal insufficiency related to end stage renal disease and was on dialysis with interventions which included dietary consult to regulate protein, sodium, and potassium intake, monitor vital signs per order and as needed, and observe and report changes in mental status, and Resident #47 needed dialysis related to end stage renal disease with interventions which included no signs or symptoms of complications from dialysis and obtain vital signs and weight per protocol. Review of progress notes from 08/07/22 to 12/6/22 revealed no documentation between dialysis and the facility regarding Resident #74. Interviews on 11/30/22 at 11:40 A.M. and on 12/01/22 at 5:58 P. M with Dietitian #954 revealed he had not communicated with anyone from dialysis since he began coverage on 11/12/22. He confirmed the dietitian should communicate with dialysis periodically. Dietitian #953 stated some dialysis centers will send information, but he had not received any. Interview on 12/06/22 at 4:45 P.M. with the Director of Nursing (DON) and LPN #837 revealed the document titled Dialysis Hand Off Communication Report was not being filled out by the facility nurses prior to the residents going to dialysis. The dialysis center has a copy of the document and have been filling out their section and sending it back with the resident. Once the facility received the communication report back from dialysis, it was confirmed the facility nurses were not filling out the bottom portion of the form labeled For Nursing Home Use Only-Upon Return to the Facility Following Dialysis, which included the observation of signs or symptoms of infection and if bruit or thrill were present for their fistulas, and the facility nurses were throwing the forms in the locked shred box Interview on 12/07/22 at 10:07 A.M. with Dialysis Nurse #950 revealed the only facility nurse to send communication sheets was LPN #900 and all other facility nurses did not send any communication sheets. Dialysis Nurse #950 stated she would mark an X on the top section where pre dialysis information would be entered, so the information could not be entered later, because the information should have been on the sheet when the resident arrived. She would then fill out the middle section, where dialysis information was recorded, and then she would drop the communication sheet off at the nurse's station after dialysis. The communication sheets were to be filed in the residents' charts. Dialysis Nurse #950 had voiced her concerns to the DON and the Assistant DON #801, and they told her they knew staff had to get better at sending the communication sheet. The DON told her she made binders recently to help with the communication. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility documents titled Dialysis Hand Off Communication Report for Resident #74 from 10/06/22 to 12/05/22 revealed the top section, which consisted of areas to note mental status, allergies, vital signs, current diet/fluid restrictions, resident compliance with diet/fluid restrictions, new medications since last dialysis, medical problems since last dialysis, labs drawn, and condition of assess site prior to leaving dialysis, and if there were any signs or symptoms of infection, which was to be completed by the facility prior to resident going to dialysis was blank with a large x over the section for 13 out of 22 documents. The top section of the documents which were filled in were all completed by LPN #900. The middle section, which consisted of areas to note pre and post dialysis weights, problems during dialysis, post treatment vitals, new lab results, updated or new physician orders, dietitian or social worker recommendations, food/fluid consumed during dialysis, medications given during dialysis, and any additional comments, was always filled out by the dialysis unit. The bottom section, which consisted of areas to note if bruit (vascular murmur) or thrill (vibratory sensation) were present, if there were any signs or symptoms of infection, and any additional comments, which was to be filled out by the facility were all blank. Review of undated facility policy titled Dialysis revealed communication with the dialysis center would be maintained using a communication book, which was to be sent every time the resident went for dialysis. 3. Review of medical record for Resident #294 revealed an admitted [DATE] and diagnoses included end stage renal disease, type two diabetes mellitus, unspecified anemia, and moderate protein calorie malnutrition. Review of five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #294 had moderately impaired cognition, required extensive assist of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene, limited assistance of one person for walk in room, supervision of one-person physical assist for eating, and was on dialysis. Review of physician orders for Resident #294 indicated an order for hemodialysis Tuesday, Thursday, and Saturday dated 11/12/22, and order for a renal carbohydrate diet, regular texture, thin liquids dated 11/10/22, and an order for Ensure plus dated 12/01/22. Review of care plan dated 10/24/22 revealed Resident #294 needed dialysis related to end stage renal disease with interventions which included vital signs pre and post dialysis, obtain vital signs and weights per protocol, and check and change dressing daily at access site, and Resident #294 had a nutritional problem or potential nutritional problem related to having end stage renal disease and needed hemodialysis and type two diabetes with interventions which included provide diet/supplements per orders and monitor resident and make adjustments to the plan of care as needed. Review of the communication between facility and dialysis for Resident #294 revealed there was only one document which was faxed from the dialysis center on 12/03/22. Interviews on 11/30/22 at 11:40 A.M. and on 12/01/22 at 5:58 P.M. with Dietitian #954 revealed he had not communicated with anyone from dialysis since he began coverage on 11/12/22. He confirmed the dietitian should communicate with dialysis periodically. Dietitian #954 stated some dialysis centers will send information, but he had not received any. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/22 at 9:20 A.M. with Renal Dietitian #963 revealed she has had a hard time reaching the dietitian at the facility. She does fax to the facility monthly Resident #294's labs and weights. The last time she called the facility to speak with a dietitian, the facility told her they did not have a dietitian at that time. She had even left a message for the message for the food service manager with no return call. Interview on 12/06/22 at 4:45 P.M. with the Director of Nursing (DON) and LPN #837 confirmed the document titled Dialysis Hand Off Communication Reports were not being filled out by the facility nurses prior to the residents going to dialysis. Interview on 12/07/22 at 10:34 A.M. with the DON confirmed dialysis residents did not have communication binders until 12/01/22, when she initiated them. Review of undated facility policy titled Dialysis revealed communication with the dialysis center would be maintained using a communication book, which was to be sent every time the resident went for dialysis. The licensed nurse would evaluate observe and/or assess the shunt/fistula for signs/symptoms of bleeding and infection. The access site would be monitored and any bleeding, pain, swelling, or tingling/numbness would be reported to the physician. Post dialysis nurse would monitor BP, pulse, presence/absence of bruit/thrill, monitor for s/s of fluid overload, and would remove pressure dressing from the shunt/fistula site upon return from dialysis as indicated. If resident refused to go to dialysis, the physician would be notified. 42013 4. Review of Resident #53's medical record revealed an admitted [DATE] and diagnoses included end stage renal disease, dependence on renal dialysis, and type two diabetes mellitus. Review of Resident #53's care plan dated, 09/30/22, included Resident #53 needed hemodialysis related to ESRD (end stage renal disease) and was at risk for complications. Resident #53 would have immediate intervention should any signs and symptoms of complications from dialysis occur through the review date. Resident #53 would have no signs and symptoms of complications from dialysis through the review date. Interventions included to check and change dressing daily at access site; observe, document, report to the physician as needed any signs and symptoms of infection to access site: redness, swelling, warmth or drainage; observe LUE (left upper extremity) AVF (arteriovenous fistula) for signs and symptoms of bleeding and notify the physician as needed. Review of Resident #53's physician orders dated, 10/19/22, revealed hemodialysis Monday through Friday via LUE AVF (left upper extremity arteriovenous fistula). Review of Resident #53's Quarterly Minimum Data Set (MDS) 3.0 assessment dated , 10/19/22, revealed Resident #53 was cognitively intact. Resident #53 required extensive assistance of two staff members for bed mobility, total dependence of two staff members for transfers, and Resident #53 received dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #53's Dialysis Hand Off Communication Reports from 09/02/22 through 12/05/22 revealed the area on the report to be filled out before dialysis was blank on all the reports with no information documented. Further review of the reports revealed the section titled Nursing Home Use Only, Upon Return To Facility Following Dialysis was blank on all the forms with no information documented for bruit present, thrill present, signs and symptoms of infection and the nurses signature. Review of Resident #53's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 09/02/22 through 12/05/22 did not reveal documentation Resident #53's AVF was checked for bruit, thrill, or signs of bleeding. Interview on 12/06/22 4:45 PM with the Director of Nursing (DON) and Licensed Practical Nurse/Assistant Director of Nursing (LPN/ADON) #837 revealed Dialysis Hand Off Communication Report sheets were not filled out by the facility nurses prior to residents going to dialysis. The sheets were not sent with the residents to dialysis. Dialysis centers have blank copies of this form and have been filling out their portions of the forms and sending it back to the facility with the resident, however facility nurses were throwing the forms in the locked shred box and not filling out the bottom portion of the form labeled For Nursing Home Use Only-Upon Return to the Facility Following Dialysis. Documentation included in this section was observing residents for signs and symptoms of infection, checking residents to see if bruit and thrill were present for their AV fistulas. The DON stated there was space to provide any additional comments and a signature. 38094 5. Resident #24 was admitted [DATE] with diagnoses including metabolic encephalopathy, diabetes type II, heart disease and end stage renal disease with anemia. The resident received off-site dialysis three days a week and was her diet order was a renal/controlled carbohydrate diet with regular texture and thin liquids. Review of the quarterly MDS 3.0 assessment of 10/20/22 revealed the resident was cognitively intact, required extensive assist of two for ADLs, and received dialysis. Review of the care plan of 09/05/22 revealed care areas for anemia related to diabetes and at risk of complications. Interventions included dietary consults to regulate protein, sodium and potassium. Interview with Renal Dietician (RD) #966 on 12/06/22 at 11:51 AM revealed Resident #24 was very noncompliant. She ordered door dash all the time at dialysis. Her fluid gains were excessive. She had an elevated potassium level of 5.8 on 11/18/22. At dialysis, they told Resident #24 that when she ordered door dash she should let nursing know so she can receive her phosphate binders. She had been having excessive fluid gains and missing or shortening her treatments. Her noncompliance was her major concern. RD #966 had been unable to reach a dietician at a facility for the past few months. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/06/22 4:45 PM with the DON and LPN #837 revealed Dialysis Hand Off Communication Report sheets were not being filled out by the facility nurses prior to residents going to dialysis. The sheets are not being sent with the residents to dialysis. Dialysis centers have blank copies of this form and have been filling out their portions of the forms and sending back to the facility with the resident, however facility nurses are throwing the forms in the locked shred box and not filling out the bottom portion of the form labeled For Nursing Home Use Only-Upon Return to the Facility Following Dialysis documentation included in this section is observing residents for signs and symptoms of infection, checking residents to see if bruit and thrill are present for their AV fistulas, there is space to provide any additional comments and a signature. Review of undated Dialysis policy revealed the facility has established standards of care for the dialysis resident which will be maintained by the nurse. Nurse will evaluate, observe and/or assess the shunt/fistula for sign /symptoms of bleeding and infection every shift. This will be recorded on the resident's medical record. Communications with the dialysis centers would be kept in a binder at each nurse station. There were no communication sheets from dialysis for review until they were faxed to the facility on [DATE] after requested. 6. Resident #66 was admitted on [DATE] with diagnoses including history of stroke, Monoclonal gammopathies (conditions in which abnormal proteins are found in the blood), diabetes type II, acute respiratory failure with hypoxia, hyperlipidemia, hypomagnesemia, Vitamin D deficiency, congestive heart failure, edema, hypokalemia, acidosis, chronic kidney disease stage IV and cyst of kidney. The resident received off-site dialysis three days a week and was ordered a Renal /controlled carbohydrate diet, regular texture with thin liquids. Review of the Medicare 5-day MDS 3.0 revealed the resident was cognitively intact, required extensive assist of two for ADLs, received oxygen therapy and dialysis. Review of care plan of 10/23/22 for Resident #66 revealed a care area for nutrition related to edema, congestive heart failure and diabetes with interventions including providing diet and supplements per orders and honoring food preferences. A nutritional assessment was completed on 09/29/22 by the former facility dietician revealed the resident was at risk of malnutrition related to his increased needs with hemodialysis. There was no further communication from a dietician at the facility. Interview with Resident #66 on 11/28/22 at 3:56 P.M. revealed he does not receive the right diet. He normally eats one starch a day, as a diabetic. The facility was giving him two starches at each meal. They gave him a donut with icing for breakfast. He would like to have more protein, instead on the one old egg he sometime got. He would like fish, chicken. Sometimes the facility did not give him any meat for three days. Resident #66 revealed the dietician at dialysis agreed with him that he was not eating right. Nobody at the facility asked him his preferences, but the dietician at dialysis did. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/22 at 9:20 A.M. Renal Dietitian (RD) #963 revealed she has been unable to reach a dietician or someone in dietary at the facility about Resident #66's diet preferences. The resident voiced to her that he was always hungry and was not getting enough to eat. She had a whole list of his preferences. She reported he had has a 6.9 percent weight loss from 10/02/22 to 12/01/22. Interview on 12/06/22 4:45 PM with the DON and LPN #837 revealed Dialysis Hand Off Communication Report sheets were not being filled out by the facility nurses prior to residents going to dialysis. The sheets are not being sent with the residents to dialysis. Dialysis centers have blank copies of this form and have been filling out their portions of the forms and sending back to the facility with the resident, however facility nurses are throwing the forms in the locked shred box and not filling out the bottom portion of the form labeled For Nursing Home Use Only-Upon Return to the Facility Following Dialysis documentation included in this section is observing residents for signs and symptoms of infection, checking residents to see if bruit and thrill are present for their AV fistulas, there is space to provide any additional comments and a signature. There were no communication sheets from dialysis for review until they were faxed to the facility on [DATE] after requested. 7. Review of the medical record for Resident #83 revealed the resident was admitted on [DATE] with end stage renal disease, hyperlipidemia, anxiety disorder, hyperlipidemia, anxiety, hypertension, cognitive communication deficit. The resident received a regular diet, regular texture with thin liquids. Review of the Physician order dated 09/26/22 revealed the resident received hemodialysis on Mondays, Wednesdays and Friday at an outside dialysis center. Review of the Medicare 5-day MDS (3.0) assessment of 10/08/22 revealed the resident was not assessed cognitively, required extensive assist of one for ADLs and received dialysis. Review of the care plan of 10/11/22 revealed no care area for dialysis. It was mentioned briefly in a care area for the resident is resistive to care related to the resident had refused to go to hemodialysis as evidenced by nursing documentation. There were no communication sheets from dialysis until they were faxed to the facility on [DATE] after request. Interview with Renal Dietician (RD) #966 on 12/06/22 at 11:51 A.M. revealed she had a hard time reaching a dietician at the facility. She faxed sheets over and used to communicate with the former dietician but has not talked to any for a few months. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/06/22 4:45 P.M. with the DON and LPN #837 revealed Dialysis Hand Off Communication Report sheets were not being filled out by the facility nurses prior to residents going to dialysis. The sheets are not being sent with the residents to dialysis. Dialysis centers have blank copies of this form and have been filling out their portions of the forms and sending back to the facility with the resident, however facility nurses are throwing the forms in the locked shred box and not filling out the bottom portion of the form labeled For Nursing Home Use Only-Upon Return to the Facility Following Dialysis documentation included in this section is observing residents for signs and symptoms of infection, checking residents to see if bruit and thrill are present for their AV fistulas, there is space to provide any additional comments and a signature. 8. Review of the medical record for Resident #79 revealed the resident was admitted [DATE] with diagnoses including malignant neoplasm of prostate, end stage renal disease, severe protein-calorie malnutrition, hypercalcemia and hyperlipidemia. Review of the Physician order dated 11/09/22 revealed the resident hemodialysis Monday Wednesday and Friday at a community dialysis center. Orders revealed the resident received a renal/Controlled Carbohydrate Diet (Renal/CCHO) diet, Regular texture, Thin Liquids consistency. Review of the 11/14/22 Medicare 5-day MDS 3.0 revealed the resident was severely cognitively impaired, with limited assist of one for ADLs, on dialysis and received a therapeutic diet. Care plan of 11/04/22 revealed care areas for anemia, pain related to cancer, potential for impairment to skin integrity, radiation therapy related to cancer with bone metastasis, renal insufficiency related to end stage disease and risk of complications, hemodialysis and a nutrition problem. There was no binder or communication sheets from dialysis for review regarding Resident #79's care. Interview on 12/01/22 at 9:20 A.M. with Renal Dietitian (RD) #963 revealed the RD was having a hard time reaching the dietitian at the facility. She faxed a monthly report to them, tried calling and emailing the dietitian with no response back from the dietitian. The last time she called the facility, the receptionist told her there was no dietitian at the facility at this time. Interview on 12/06/22 4:45 P.M. with the DON and LPN #837 revealed Dialysis Hand Off Communication Report sheets were not being filled out by the facility nurses prior to residents going to dialysis. The sheets were not being sent with the residents to dialysis. Dialysis centers have blank copies of this form and have been filling out their portions of the forms and sending back to the facility with the resident, however facility nurses are throwing the forms in the locked shred box and not filling out the bottom portion of the form labeled For Nursing Home Use Only-Upon Return to the Facility Following Dialysis documentation included in this section is observing residents for signs and symptoms of infection, checking residents to see if bruit and thrill are present for their AV fistulas, there is space to provide any additional comments and a signature. Interview on 12/06/22 at 05:24 P.M. with LPN #837 verified the facility had no communication sheets from dialysis for Resident #79. 9. Review of medical records for Resident #8, #35, #38, #57, and #67 revealed all residents were receiving dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/06/22 at 4:45 P.M. with the Director of Nursing (DON) and LPN #837 confirmed the document titled Dialysis Hand Off Communication Reports were not being filled out by the facility nurses prior to the residents going to dialysis. Interview on 12/07/22 at 10:34 A.M. with the DON confirmed dialysis residents did not have communication binders until 12/01/22, when she initiated them. Review of undated facility policy titled Dialysis revealed communication with the dialysis center would be maintained using a communication book, which was to be sent every time the resident went for dialysis. The licensed nurse would evaluate observe and/or assess the shunt/fistula for signs/symptoms of bleeding and infection. The access site would be monitored and any bleeding, pain, swelling, or tingling/numbness would be reported to the physician. Post dialysis nurse would monitor BP, pulse, presence/absence of bruit/thrill, monitor for s/s of fluid overload, and would remove pressure dressing from the shunt/fistula site upon return from dialysis as indicated. If resident refused to go to dialysis, the physician would be notified. 44461

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review and review of facility policy, the facility failed to ensure Resident #24's physician was able to be contacted for Resident #24's change in condition. This affected one resident (Resident #24) out of three reviewed for emergency physician services. Findings include: 38094 Resident #24 was admitted [DATE] with diagnoses including metabolic encephalopathy, diabetes type II, heart disease and end stage renal disease with anemia. The resident received off-site dialysis three days a week. Review of Resident #24's physician orders revealed orders for a renal/controlled carbohydrate diet with regular texture and thin liquids. Review of Resident #24's Quarterly MDS 3.0 assessment of 10/20/22 revealed the resident was cognitively intact, required extensive assist of two for activities of daily living, and received dialysis. Review of the care plan of 09/05/22 revealed care areas for anemia related to diabetes and at risk of complications. Interventions included dietary consults to regulate protein, sodium and potassium. Review of progress notes of 12/08/22 at 4:20 A.M. and 4:41 A.M. revealed Resident #24 was responsive only to painful stimuli. Her vitals were within normal limits. Her husband requested she be sent out to the hospital. The nurse reported she was unable to reach anyone at either of the on-call numbers for the resident's physician with no voicemail for the first number and the second number not being in service. Interview on 12/08/22 at 12:50 P.M. with Director of Nursing (DON) revealed she was unsure if the nurse on duty overnight did reach someone from the office of Resident #24's practice. She reported the physician was notified when he entered the facility later on 12/08/22. Review of Physician Services policy of April 2013 revealed the physician participates in resident assessment and care planning, monitoring changes in medical status, providing, consultation or treatment and provides. pertinent timely assessments. Policy of April 2013 for Attending Physician revealed the physician's responsibility includes timely and appropriate medical orders.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on observation, interview, and record review, the facility failed to ensure sufficient staffing to provide timely incontinence care to Resident #191, provide sufficient restorative services to Resident #48, #50, #62 and #191, provide pain medications timely to Resident #2, and timely answer resident call lights. This had the potential to affect all 83 residents residing in the facility. Findings include: 1. Record review for Resident #191 revealed an admitted [DATE] with diagnoses including type II diabetes mellitus, hypertension, osteomyelitis, chronic kidney disease, gastroesophageal reflux, major depressive disorder, and atrial fibrillation. Review of quarterly MDS dated [DATE] revealed the resident had impaired cognition, she needed assistance by one staff member for bed mobility, transfers, dressing, toileting, bathing, and personal hygiene. Review of Resident #191's care plan dated 10/22/22 revealed she was at risk for impaired skin integrity due to incontinence of bowel and bladder. The resident needed assistance with incontinence care every two hours and as needed. Review of Resident #191's physicians orders dated December 2022 revealed orders for incontinence care every two hours and as needed, barrier cream to buttocks after each incontinence episode and as needed, and to encourage and assist resident to turn and reposition every two hours and as needed. Interview on 11/28/22 at 9:08 A.M. with STNA #965 revealed STNA #965 stated he was very busy this morning. He stated he answered Resident #191's call light earlier at 6:30 A.M. and told the resident he would be right back. STNA #965 stated he was busy with other residents and could not get back to her. Observation on 11/28/22 at 9:33 A.M. of incontinence care for Resident #191 revealed her brief was saturated, draw sheet and fitted sheet were wet with urine. Interview on 11/28/22 at 9:39 A.M. with STNA #965 confirmed Resident was saturated, draw sheet and fitted sheet were wet with urine. Interview on 12/07/22 at 11:15 A.M. with Resident #191 revealed she does not get timely incontinence care. Resident stated she laid in urine for two and a half hours waiting on STNA #965 to come back in room to change her on 11/28/22. Interview on 12/08/22 at 10:00 A.M. with Resident #191 revealed they had issues with incontinence care last night, she stated she was soaked most of the night. Review of facility policy titled Perineal Care dated October 2010, revealed facility to provide cleanliness and comfort to the resident, to prevent infections and skin irritation (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Resident #48 was admitted [DATE] with diagnoses including injury to the spinal cord in the cervical region, spinal stenosis: cervical, and quadriplegia from a motor vehicle accident. Review of physician orders revealed orders for bilateral dynamic hand splints at all times while in bed for contractures. A physician order dated 08/30/22 revealed the resident was discharged from occupational therapy (OT) and referred to restorative nursing. An order dated 09/06/22 revealed the resident was discharged from physical therapy (PT) and referred to restorative nursing. Review of the quarterly MDS 3.0 of 11/15/22 revealed the resident was cognitively intact, and required total dependence of two for Activities of Daily Living (ADL). Review of the care plan of 11/17/22 revealed care areas included risk for an alteration in musculoskeletal status related to quadriplegia and hand contractures. Review of the Restorative services log for Resident #48 for November and December 2022 revealed the resident was to receive lower extremity stretching and strengthening at least 15 minutes six to seven days a week. The log indicated the resident received services three days out of thirty and refused services twice during the month. There were two days which indicated Restorative Aide (RA) #816 was pulled to work the floor and two days that RA #816 did not work. There was nothing recorded 11/24/22 through 11/30/22 and the facility could not provide any further information. The log for December 2022 revealed the resident did not receive services on 12/02/22 and 12/06/22 but did receive services on 12/07/22. Interview on 11/28/22 at 10:25 A.M. with Resident #48 revealed he did not always receive restorative services as scheduled. Interview on 11/30/22 at 2:11 P.M. with RA #816 and Licensed Practical Nurse/Unit Manager/Wound Nurse/Infection Preventionist/Restorative Nurse (RLPN) #801 revealed residents are usually scheduled for restorative services three times a week. RA #816 was the only restorative aide, and worked five days a week. When she was pulled to work the floor she could not provide restorative services, except for some of the residents on the hall she was working. RLPN #816 did not so restorative nursing progress notes. Interview on 12/08/22 at 10:09 A.M. with the Administrator and the Director of Nursing (DON) revealed there is another aide who provides restorative services on a part time basis but they could not provide any documentation of her training or restorative services for this resident. Review of the July 2013 policy for Restorative Nursing Care revealed the facility had an active program of restorative nursing which is developed and coordinated .to assist each resident maintain an optimal level of self-care and independence. 3. Resident #50 was admitted on [DATE] with diagnoses ulcerative proctitis (inflammation of the lining of the rectum), diabetes type II, and a history of stroke and severe sepsis. Review of Resident #30's quarterly MDS 3.0 assessment of 10/10/22 revealed the resident was cognitively intact, displayed rejection of care, and was total dependence of two for ADLs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of progress note of 11/11/12 revealed Resident #50 was discharged from PT, effective 11/03/22 and referred to restorative nursing. Review of care plan of 11/27/22 revealed care areas included history of stroke, increased risk of falls and resistance to care. Review of the restorative services log of November 2022 revealed Resident #50 was to receive bilateral lower extremity stretching with (PRAFO boots) his shoes with braces for at least 15 minutes six to seven days a week. The resident refused services on 11/15/22 and 11/22/22. Services were marked as not provided on 11/17/22, 11/19/22, 11/24/22, 11/26/22 and 11/29/22 because RA #816 was pulled to work the floor. Interview on 11/28/22 at 5:10 P.M. with Resident #50 revealed the resident was recently discharged from therapy and was supposed to have his PRAFO boots put on twice a day by restorative but it had not happened. The PRAFO boots were observed sitting on a chair across from the resident's bed. They were observed in the same place, same position on 11/29/22 at 9:15 A.M. and 11/30/22 at 11:15 A.M. Interview on 11/30/22 at 2:11 P.M. with RA #816 and RLPN #801 revealed Resident #50 was picked up for restorative services but had refused twice and verified services were not offered five days due to the RA working the floor. Residents are usually scheduled for restorative services three times a week. RA #816 was the only restorative aide, and worked five days a week. When she was pulled to work the floor she could not provide restorative services, except for some of the residents on the hall she was working. RLPN #816 did not so restorative nursing progress notes. Interview on 12/08/22 at 10:09 A.M. with the Administrator and the Director of Nursing (DON) revealed there is another aide who provides restorative services on a part time basis but they could not provide any documentation of her training or restorative services for this resident. Review of the July 2013 policy for Restorative Nursing Care revealed the facility had an active program of restorative nursing which is developed and coordinated .to assist each resident maintain an optimal level of self-care and independence. 4. Resident #62 was admitted on [DATE] with diagnoses including peripheral vascular disease, hypertension, metabolic encephalopathy, chronic respiratory failure, mild cognitive impairment and COVID-19 (11/13/20). Review of the annual MDS 3.0 of 10/10/22 revealed the resident was alert and oriented, independent for ADLs with setup only required. Review of the care plan of 11/12/22 revealed care areas potential for pressure development and an increased risk of falls. Review of order dated 11/18/22 revealed Resident #62 was discharged from OT services and referred to restorative services. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #62's restorative documentation, revealed there was no log for restorative services for November 2022. Review of the restorative services log of December 2022 revealed Resident #62 was referred for bilateral strengthening, dynamic balance and activities. The resident was scheduled for restorative services on 12/02/22 and 12/07/22 but did not receive then due to RA#816 working the floor. Interview on 11/30/22 at 2:11 P.M. with RA #816 and RLPN #801 revealed residents were usually scheduled for restorative services three times a week. RA #816 was the only restorative aide, and worked five days a week. When she was pulled to work the floor she could not provide restorative services, except for some of the residents on the hall she was working. RLPN #816 did not so restorative nursing progress notes. Interview on 12/08/22 at 9:45 A.M. with Resident #62 revealed the resident had not yet received any restorative services. Review of the July 2013 policy for Restorative Nursing Care revealed the facility had an active program of restorative nursing which is developed and coordinated .to assist each resident maintain an optimal level of self-care and independence. 5. Record review for Resident #191 revealed an admitted [DATE] and diagnoses included type II diabetes mellitus, hypertension, osteomyelitis, choric kidney disease, gastroesophageal reflux, major depressive disorder, and atrial fibrillation. Review of quarterly MDS dated [DATE] revealed the resident had impaired cognition, she needed assistance by one staff member for bed mobility, transfers, dressing, toileting, bathing, and personal hygiene. Review of Resident #191's physicians orders dated December 2022 revealed she was discharged from physical and occupational therapies on 11/23/22 and was referred to the restorative nursing program. Interview on 12/01/22 at 9:32 A.M. with the Therapy Director Physical Therapy Assistant (PTA) #814 revealed Resident #191 was referred to restorative therapy on 11/23/22 when she completed her PT/OT services. As of 12/01/22 the resident had not been seen by Restorative therapy. When asked what PTA #814's expectations were for how soon restorative therapy programs should start she stated with in one week of discharge. PTA #814 was asked to screen the resident to see if there were any declines since the end of Resident #191's PT/OT services. As of 12/01/22 there were not any declines. Interview on 12/01/22 at 12:47 P.M. with the Restorative Nurse LPN #801 revealed the therapy department would bring and hand the referral form to her. The resident who was referred would then be placed on to the restorative schedule for the first of the next month. LPN #801 stated if there was a new referral made they will remove a resident who has been on restorative therapy for a long period of time to make room for the new referral. Interview on 12/01/22 at 12:35 P.M. with Resident #191 revealed she was discharged from therapy on 11/23/22 with a referral to restorative nursing for therapy. The resident stated she was aware she was to be on restorative therapy and knew what it was. She has not started it yet and is unsure when it will start. Resident #191 stated she does not feel she had declined since discharge from therapy. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interviews on 11/30/22 at 2:11 P.M. with LPN #801 and State tested Nursing Assistant (STNA) #816 revealed residents are usually scheduled for three time a week for restorative services. STNA #816 was the only restorative aide. When STNA #816 was pulled to the floor restorative therapy services (RTS) were not completed. STNA #816 stated if she was pulled to the floor she will document an X on the day restorative services were not available and she would mark an R if the resident refused. If there were three or more refusals the resident is cut from restorative services to make room for another resident. There were no restorative notes completed. Interview on 12/06/22 at 2:00 P.M. with LPN #801 revealed if a resident was discharged from therapy for example on 11/02/22 and was referred to restorative services the resident would not be added on the restorative schedule until the first of the following month. Review of restorative therapy documentation from 11/23/22 through 12/08/22 revealed Resident #191 did not start her restorative programs until 12/01/22 even though therapy referred Resident #191 to restorative on 11/23/22. 6. Review of Resident #2's medical record revealed an admitted [DATE] and diagnoses included cerebral infarction, acute kidney failure, fibromyalgia, and multiple sclerosis. Review of Resident #2's physician orders dated 05/26/22, revealed oxycodone-acetaminophen tablet 7.5 -325 milligrams (mg), give one tablet by mouth every six hours for pain. Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated , 11/19/22, revealed Resident #2 was cognitively intact and was independent for bed mobility, transfers, and toilet use. Resident #2 used oxygen. Review of Resident #2's Medication Administration Record (MAR) from 11/22/22 at 6:00 P.M. through 11/24/22 at 12:00 P.M. revealed Resident #2 was not administered oxycodone. Review of Resident #2's progress notes from 11/22/22 at 6:00 P.M. through 11/24/22 at 12:00 P.M. revealed on 11/23/22 at 5:15 A.M., 12:46 P.M., and 5:10 P.M. the notes stated awaiting delivery of oxycodone-acetaminophen 7.5 mg-325 mg, give one tablet by mouth every six hours for pain. On 11/23/22 at 11:05 PM. and and 11/24/22 at 5:04 A.M. the progress notes stated medication (oxycodone) not available. Observation on 11/28/22 at 9:35 A.M. of Resident #2 revealed she was lying in bed. Resident #2 stated her medications did not get reordered timely. Resident #2 stated she was sick on Thanksgiving day (11/24/22) because she did not receive her pain medication (oxycodone) for a few days before Thanksgiving. Resident #2 stated she was having withdrawal symptoms because she did not receive the oxycodone. Resident #2 revealed it always took a long time to have the call light answered. Interview on 12/01/22 at 2:00 P.M. with the DON revealed Resident #2's oxycodone was ordered 11/23/22 and arrived on 11/25/22. The DON was not sure why the oxycodone was not ordered sooner. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/01/22 at 04:32 P.M. with Licensed Practical Nurse (LPN) #971 revealed she worked on 11/23/22 at 6:00 P.M. through 11/24/22 at 6:00 A.M. and they were really short staffed this night. LPN #971 stated Resident #2 was out of oxycodone (pain medication) for a few days. LPN #971 stated she worked for a staffing agency and she did not order Resident #2's oxycodone, and just documented the medication was not available in Resident #2's medical record. LPN #971 stated she did not have access to the automated medication dispensing system in the facility because she was from a staffing agency. LPN #971 stated she administered Tylenol to Resident #2. LPN #971 stated she did not check with any other nurses in the facility to see if they had access to the automated medication dispensing system. LPN #971 stated she did not call the Director of Nursing (DON) or Resident #2's physician, or the pharmacy to try to get an authorization code for the automated medication dispensing system so she could administer Resident #2 oxycodone. LPN #971 indicated she did not know the DON's phone number to contact her. LPN #971 stated she did not contact anyone regarding Resident #2's oxycodone. Interview on 12/05/22 at 12:57 P.M. with the DON confirmed Resident #2's oxycodone was not administered from 11/22/22 at 6:00 P.M. through 11/24/22 at 12:00 P.M. 7. During the annual survey, the following resident concerns were identified related to staffing: a. Interview on 11/28/22 at 9:59 A.M. with Resident #61 revealed on 11/27/22 there was only one STNA available. When thyme put the call light on the staff would turn the light off, and the resident waited almost three hours in a wet brief. b. Interview on 11/28/22 at 10:54 A.M. with Resident #191 revealed the resident waits a long time for call light to be answered. On this morning, the resident revealed she waited an hour for the call light to be answered. c. Interview on 11/28/22 at 1:12 P.M. with Resident #4 revealed the facility was unbelievable understaffed. Resident #4 revealed there was only one STNA on the floor and when they press the call light for needs they have to wait two to three hours for it to be answered. d. Interview on 11/28/22 at 3:02 P.M. with Resident #20's representative revealed the facility was short staff and not taking care of the resident as they should. The representative revealed the resident cannot ask for water and the water jug in the room is always room. The resident cannot call for help so the resident lays there until someone notices he needs changed and is last on the list. Representative revealed management changes frequently and she has found STNA's sleeping in the resident's room. e. Interview on 11/28/22 at 3:15 P.M. with Resident #62 revealed staffing levels were very bad on weekends and nights, staff have an attitude and they do not want to be bothered. f. Interview on 11/28/22 at 3:23 P.M. with Resident #24 revealed there was not enough staff on the weekends or at night to meet his needs and the staff have an attitude. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	g. Interview on 11/29/22 at 1:29 P.M. with Residents #14, #28, #46, #48, #76, and #85, during the Resident Council group meeting, revealed the facility staffing levels were not good. There were lots of call offs, including one night (unsure of date) when seven total nurses and aides called off. The facility used a lot of agency staff, and long term care residents tend to get the agency who are not familiar with their needs. Residents wait a long time for assistance, especially on nights and weekends. The facility does not care if people are supposed to show up at 7:00 P.M., but do not come until 7:30 P.M. Resident #85 reported she has had to stay up till 11:00 P.M. or 12:00 A.M. to get her nighttime meds. Unnamed staff have been overheard asking where other staff are because their names are on the schedule. It was reported that when people don't show up, they just fill the schedule in with names. The facility runs their own staffing agency so they can manipulate the schedule how ever they want.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 46195 Based on interview, observation, and facility policy review, the facility failed to ensure residents were provided well balanced meals and failed to honor the residents' food and beverage preferences. This affected Residents #4,#6, #26, #48, #61, #66, #77, and #80 and had the potential to affect 82 residents who received meals from the kitchen. The facility identified Resident #142 as not receiving meals from the kitchen. The facility census was 83. Findings include: Interview and observation on 11/28/22 at 1:02 P.M. and on 11/30/22 at 12:07 P.M. revealed Resident #4 felt he was getting items on his meal tray that he should not be getting on a renal diet, such as tomato and potato items. He stated he had told the facility staff his preferences; however, there were no preferences listed on his diet card. Resident #4 stated he told the facility staff he did not like the lemon diet iced tea; however, they kept sending the diet iced tea on his tray. Resident #4 stated he had voiced his preferences more than once, and he thought it fell on deaf ears. Observation of Resident #4's dietary card revealed there were no preferences or dislikes listed on the tray card. Interview during kitchen observation on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor (DS) #806 revealed she was responsible for obtaining food and beverage preferences, but she had not obtained any preferences since she started on 11/11/22. The facility did not have planned menus, spread sheets, or an alternate menu. Interview on 11/28/22 at 2:15 P.M. with DS #806 revealed the facility toaster was not working and the facility had been serving Danishes, donuts, muffins instead of toast at breakfast. Interview on 11/28/22 at 5:33 P.M. revealed Resident #48 stated the facility had run out of food items at times. He expressed the facility no longer had menus or alternates, and he never received what he requested. Observation and interview on 11/29/22 at 7:55 A.M. revealed Resident #26 preferred cheerios for breakfast and she could not remember the last time she received cheerios. Observation of her tray card revealed cheerios was written as a preference and her tray did not contain any cheerios. Observation of tray line on 11/29/22 from 11:12 A.M. to 12:06 P.M. revealed the facility ran out of sweet and sour chicken and six residents received a hamburger, rice, and capri vegetables and three residents received a hamburger, mashed potatoes, and capri vegetables. Interview on 11/29/22 at 4:43 P.M. revealed Resident #61 was never asked about food and beverage preferences. She stated she did not like the scrambled eggs since they upset her stomach, but the facility kept sending them to her. She also had been receiving zero percent milk which she did not like. Resident #61 stated she was never asked about food and beverage preferences, and the facility did not send a menu. She felt she had no choices regarding her meals. If she did not like what was served, she would snack on something in her room. (continued on next page)

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	366195	A. Building B. Wing	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/30/22 at 9:00 A.M. with Speech Therapy #909 revealed she had noticed the facility breakfasts were very similar with everyone receiving scrambled eggs and either a donut, danish, muffin, pancake, waffle, or French toast. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 revealed the dietary manager or dietary designee should be obtaining the residents' food and beverage preferences. Interview on 11/30/22 at 11:45 A.M. revealed Resident #66 was never asked about preferences. Interview on 11/30/22 at 11:56 A.M. revealed Resident #77 felt he never got toast at breakfast, which he liked, and was never asked about his preferences. Interview on 12/01/22 at 11:07 A.M. revealed DS #806 stated the kitchen ran out of milk after the previous night's dinner, and there was no milk for breakfast that morning. The facility received a milk delivery after breakfast. Observation of the tray line on 12/01/22 from 11:15 A.M. to 12:30 P.M. revealed the facility ran out of carrots and peas and 24 residents did not receive any vegetables. The facility ran out of spaghetti noodles and 12 residents received mashed potatoes instead, and Residents (#4, #6, and #80) received no starch since the mashed potatoes were not appropriate for a renal diet. Interview on 12/07/22 at 1:28 P.M. revealed Resident #80 felt he was getting items on his meal tray that he should not be getting on a renal diet, such as potato items, orange juice, and milk. Resident #80 voiced he had received potatoes for lunch that day. Resident #80 stated his dialysis dietitian had tried to tell the facility his preferences, and there have been no changes. He was unaware if there were alternates for the meal. He either ate or did not eat the meal, since staff never offered anything else if he did not eat the meal. Resident #80 voiced he often used his supplements as meal replacements. Review of facility policy titled Resident Food Preferences, revised November 2008, revealed upon admission or within 24 hours after admission, a resident's food preferences were to be obtained, and the resident's clinical record, which included the tray card, would document the resident's likes and dislikes and special dietary instructions or limitations. Review of facility policy titled Menus, revised October 2008, revealed menus would be written at least two weeks in advance, dated, and posted in the kitchen at least one week in advance. Menus would be varied and posted in at least two resident areas. Review of facility policy titled Kitchen Weights and Measures, revised April 2007, revealed the food service manager would ensure cooks prepared the appropriate amount of food for the number of servings required.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 46195 Based on observation, interview ,review of dietary schedules, and review of the Facility Wide Assessment, the facility failed to consistently provide adequate number of dietary staff to ensure a clean kitchen and dumpster area. This had the potential to affect all 83 residents who resided in the facility, excluding Residents #142 who did not receive nutrition by mouth. Findings include: Observation of the kitchen and interview on 11/28/22 from 11:00 A.M. to 12:02 P.M. revealed the perimeter of the floor revealed a build up of dirt. Dietary Supervisor (DS) #806 stated the dietary aides were to mop it at night. Observation of the three-compartment sink revealed all three compartments had food debris on the bottom and sides. DS #806 confirmed the three-compartment sink had not been cleaned the previous night. DS #806 stated the tasks were not being completed since the facility did not have enough staff at night. DS #806 revealed the facility had hired some new staff, but they had not started yet. Interview and observation of the dumpster area on 11/20/22 with DS #806 revealed debris on the cement pad where the two blue dumpsters sat. At the time of the observation, DS #806 verified the findings and stated the area was better than what it usually looked like. DS#806 stated the dietary department had been short staffed, and they had not had time to come and clean the area. Review of the Facility Assessment, updated on 07/18/22, revealed the staffing plan specified the facility needed two individuals to fill the dietitian and director and nutrition services positions and five individuals to fill the food and nutrition services positions. Review of Dietary October and November 2022 schedules revealed the facility did not meet the recommended facility daily need of five nutrition services positions on 10/01/22, 10/02/22, 10/13/22, 10/16/22, 10/22/22, and 10/23/22 and on 11/06/22, 11/07/22, 11/08/22, 11/10/22, 11/13/22, and 11/25/22. Interview on 11/30/22 at 10:05 A.M. and on 12/07/22 at 2:45 P.M. with Administrator revealed DS #977 quit without notice on 08/16/22 and DS #978, who worked at a sister facility, filled in from 08/17/22 until Assistant DS #965 started on 10/27/22. The Administrator confirmed DS #978 worked at another facility and was not at the facility more than 20 hours in a week. DS #806 started on 11/08/22 and Assistant DS #965 walked out on 11/21/22. Dietitian #958's last day in the facility was 10/31/22 and Dietitian #954 started 11/12/22. On 11/28/22 a new dietitian contract was signed for dietitian consulting services for the period from 11/28/22 to 12/27/22, and Dietitian #954 would no longer be covering the facility. The Administrator confirmed the facility was not meeting their daily dietary service needs with the current dietary vacancies.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46195 Based on observation, interview, policy review, and record review, the facility failed to ensure a standardized menu was followed and failed to ensure menus were distributed or posted for residents to make food choices. This had the potential to after all 82 residents receiving meals from the facility, specifically affected Residents #2, #4, #61, and #80. The facility identified Resident #142 as not receiving meals from the facility. The census was 83. Findings include: Interview and observation during the kitchen tour on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor (DS) #806 revealed there were no facility menus. DS #806 at the time of observation confirmed the facility does not have planned menus or spread sheets at this time, and the facility staff would go off their knowledge of what scoop size to use. Interview on 11/28/22 at 1:02 P.M. revealed Resident #4 had no idea what the menu was and felt there was a lot of repetition. Interview on 11/28/22 at 2:15 P.M. and on 11/29/22 at 11:26 PM with DS #806 revealed staff members go off memory what each diet was supposed to get regarding food and beverage items. DS #806 stated the facility would send three to four ounces of protein, four ounces of a starch and four ounces of vegetable each meal. No menus were being sent out to the floor, but DS #806 was in the process of working on getting one. Observation of the menu board on 11/28/22 at 6:30 P.M. and subsequent observations throughout the survey of the menu board to the left of facility dining room door revealed there was no menu posted. Interview with Resident #2 on 11/29/22 at 7:50 AM revealed Resident #2 did not get a choice, and if she could not eat it, she would not eat. Observation and interview on 11/29/22 at 12:46 P.M. revealed Resident #4 did not eat his lunch. Resident #4 stated when he got too much of the same food items, he did not want to eat. Interview on 11/30/22 at 9:00 A.M. with Speech Therapy #909 stated there have not been any menus in the facility for a few months, and she had no idea what the residents should be receiving for their meals. Interview on 11/30/22 at 10:22 A.M. with the Administrator confirmed there were no menus or spreadsheets, and the new consulting company was going to provide menus and spreadsheets going forward. Interview on 11/30/22 at 11:17 A.M. revealed Resident #61 confirmed the facility did not send out a menu. He stated he had no choices at the facility, and if he did not like what was served, he would just snack on something in his room. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/07/22 at 1:28 P.M. revealed Resident #80 felt the facility did not involve him in decisions about his diet and his meals consisted of whatever the kitchen sent him. Resident #80 was unaware if there were alternates for the meals, and stated if he didn't like the meal, he would just not eat. Resident #80 stated he would often use his supplements as a meal replacement. Review of resident council minutes notes from November 2021 to November 2022 revealed concerns on 07/22/22 of the menus not being handed out, on 09/26/22 of the menus, on 10/24/22 of the meals not matching the menus, and on 11/21/22 of the food portions being too small. Review of facility policy titled Standardized Recipes, revised April 2007, revealed standardized menus would be developed and used in the preparation of foods, and the food service manager would maintain the recipe file and make it available to the food service staff as necessary. Review of facility policy titled Menus, revised October 2008, revealed menus would be written at least two weeks in advance, dated, and posted in the kitchen at least one week in advance. Menus would be varied and posted in at least two resident areas. Review of the facility policy titled Food Nutrition Program, revised 2007, revealed the facility would have an organized nutrition-related program which included a dietitian who would help assess nutritional needs and risks of all residents in the facility and would help assure the facility provided appropriate meals and other nutritional interventions and a food service manager who would oversee the activities and functions of the kitchen staff, including food storage and preparation, sanitation issues, menu planning and preparation.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46195 Based on observation, interview, and record review, the facility failed to ensure food was served at an appetizing temperature and an acceptable palatability. This had the potential to affect 82 residents who received meals in the facility. The facility identified Resident #142 as receiving no food from the kitchen. The facility census was 83. Findings include: An interview on 11/28/22 at 10:03 A.M. with Resident #61 revealed every time the food was delivered it was cold or lukewarm and the meat was often dry. An interview conducted on 11/28/22 at 1:02 P.M. with Resident #4 revealed the food was the worst, and the food was cold almost every time it was delivered. An interview conducted on 11/28/22 03:24 PM with Resident #24 revealed the food was nasty and cold. An interview conducted on 11/29/22 at 8:35 A.M. with Resident #80 revealed food was cold and not good. An interview conducted on 11/29/22 at 4:41 P.M. with Resident #77 revealed the meals were frequently cold. Review of facility temperature logs from August 2022 through November 2022 revealed no tray line temperatures were recorded for August, September, and October 2022, and five unspecified days of temperatures for breakfast and lunch and 13 unspecified days of dinner temperatures were recorded for November 2022. Interview on 11/28/22 at 2:15 P.M. with Dietary Supervisor #806 confirmed no tray line temperatures were recorded from August to October 2022, and for November 2022, five unspecified days of temperatures for breakfast and lunch and 13 unspecified days of dinner temperatures were recorded. Interview and observation of the tray line on 12/01/22 from 11:15 A.M. to 12:30 P.M. revealed the temperature at the beginning of the tray line was 171.1 degrees Fahrenheit (F) for the Monterey chicken, 168. 4 degrees F for spaghetti noodles, 163.4 degrees F for peas and carrots, 201 degrees F for the mashed potatoes, and 192 degrees F for the ground chicken, and 167.3 degrees F for the hamburger patty. At 12:12 P.M., the facility ran out of the peas and carrots, and 24 residents did not receive a vegetable. At 12:16 P.M., the facility ran out of the spaghetti noodles, and 12 residents received mashed potatoes instead. Dietary Staff #835 at time of observation revealed there was no explanation of why there was not enough food cooked. Observation of the facility plate warmer revealed the right side of the unit was not warm to touch which Dietary #835 confirmed at the time of observation. Tray service began at 11:15 A.M. The surveyor observed the last tray for the trays being completed at 12:28 P.M. At that time, a test tray was requested and placed on the food cart. The cart left the kitchen at 12:28 P. M. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Dietary Supervisor #806 on 12/01/22 at 12:28 P.M. revealed the facility did have metal pellets to help keep the food warm, but they did not have enough lids and bottoms to use them. Dietary Supervisor #806 was updated the right side of the plate warmer was not warm to touch, and the facility ran out of vegetables and spaghetti noodles for lunch. The last tray was passed to the residents from the cart at 12:35 P.M. The test tray was removed at 12:35 P. M and taken to an empty resident room by the surveyor and Dietary Supervisor #806. Dietary Supervisor # 806 checked the temperatures of the food as the surveyor tasted the food for temperature and palatability. The Monterey chicken was 114.0 degrees F and tasted bland and lukewarm. There were no vegetables since the facility ran out of them during the tray line. Mashed potatoes were 124.3 degrees F and bland. The garlic bread roll was warm from being in the oven and was hard on top. The roll was too difficult to bite through due to the hardness of the top of the roll. The banana pudding was 68.7 degrees F and had a good taste but was warm. The eight-ounce container of two percent milk was 58.5 degrees F and tasted warm. The four-ounce container of apple juice was 48.6 degrees F and tasted cool. The coffee was 120.2 degrees, and the cup was warm to touch. Dietary Supervisor #806 at the time of observation confirmed the chicken was not warm enough, the garlic roll was too tough, and milk and banana pudding were too warm.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 46195 Based on observation, interview and record review, the facility failed to prepare food in a form to meet the individual needs of residents. This affected Residents (#9, #10,#20, #27, #35, and #81) who were on a mechanically altered diet and Residents (#9 and #35) who were on nectar thick liquids. The facility census was 83. Findings include: Observation and interview on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor #806 revealed the sweet and sour chicken was made with diced chicken and was being served to both the regular and mechanical soft diets. DS #806 confirmed the sweet and sour was made with diced chicken, and it was appropriate for the mechanical soft ground diets. DS #806 stated the facility would chop up items in the food processor, but she did not feel the food items were getting to the proper food consistency, which was why she would like to see the facility purchase a new commercial combination food processor. Interview on 11/30/22 at 9:00 A.M. with Speech Therapy (ST) #909 revealed a mechanical soft consistency should consist of all meat ground, which included fish, hamburger patties, meatballs, or anything with diced meat. She went on to state she had seen residents at the facility on a mechanically soft ground diet receive intact hamburgers, intact meatballs, and diced chicken, which was not mechanical soft per her standards. When it came to thickened liquids in the facility, the nectar thick juices tended to be thicker than nectar. For breakfast on 11/30/22, ST #909 observed Resident #35's juice to be honey thick instead of physician ordered nectar consistency. She had not had the opportunity to voice her concerns about the diet consistencies to DS #806 since DS #806 was relatively new. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 revealed residents on a mechanical soft ground diet should receive all meats ground which included diced chicken, meatballs, and hamburgers. Review of facility in house census for 11/28/22 revealed Residents (#9 and #35) were receiving nectar thick liquids and Residents (#9, #10, #20, #27, #35, and #81) were receiving a mechanical soft ground meal consistency. Observation of tray line on 12/01/22 from 11:15 A.M. to 12:30 P.M. revealed one of the two thickened orange juices sitting on the beverage cart at this start of the tray line was honey thick instead of nectar thick. Interview on 12/01/22 at 11:26 A.M. with Dietary #926 revealed she was the one who thickened the beverages. She stated she put two scoops of thickener in four ounces of juice to achieve nectar consistency. Review of the undated facility document posted on the wall of the kitchen by the juice gun indicated one leveled off tablespoon was needed to achieve nectar consistency in four ounces of liquid. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/22 at 11:26 A.M. Dietary #926 revealed only one scoop of thickener was needed to achieve nectar consistency in four ounces of juice and confirmed two scoops of thickener in the juice was incorrect for nectar consistency. During the survey, the surveyors did not observe residents coughing or choking during meal consumption. Review of an email from DS #806 and Owner #976 dated 11/23/22 revealed the piece of equipment that was being used by the facility to make mechanical soft ground and puree foods was not making the correct texture and the cost of a new commercial food processor would be $1,338.00. Review of the facility policy titled Food Nutrition Program, revised 2007, revealed the facility would have an organized nutrition-related program which included a food service manager who would oversee the activities and functions of the kitchen staff, including food storage and preparation, sanitation issues, menu planning and preparation.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review, and policy review, the facility failed to obtain or accommodate food and beverage preferences and failed to provide options of similar nutritive value to residents who chose not to eat the food that was initially served or who requested a different meal choice. This affected three (Resident #4, #61 and #80) but had the potential to affect all 82 residents receiving a meal from the kitchen. The facility identified Resident # 143 as not receiving food from the kitchen. The facility census was 83. Findings include: 1. Review of medical record for Resident #80 revealed an admitted [DATE] and diagnoses included end stage renal (kidney) disease, essential (primary) hypertension (high blood pressure), acute on chronic diastolic (congestive) heart failure, and type 2 diabetes with hyperglycemia (excessive amount of glucose circulating in the blood) Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 was cognitively impaired, required limited assistance with one-person physical assist for bed mobility, walk in room, walk in corridor, dressing, and toilet use, was independent with set up only eating and personal hygiene, and was always continent of bowel and bladder. Review of Resident #80's physician orders dated 08/15/22 indicated a Renal/Controlled Carbohydrate Diet (Renal/CCHO) diet, Regular texture, Thin Liquids consistency with 100 g protein a day order added on 11/17/22. Order dated 12/04/22 indicated Ensure (nutritional supplement) with meals secondary to weight loss. Review of Resident #80 meal intakes from 10/01/22 to 11/30/22 revealed refusal to 25 percent of the meals recorded. Review of Resident's #80 care plan dated 07/26/22 revealed a nutritional problem related to nausea and vomiting prior to admission, chronic kidney disease, diabetes, oral nutritional supplement, and therapeutic diet with an intervention to provide diet/supplements per orders and honor food preferences as able. Interview during observation on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor #806 revealed the only alternate was hamburgers. It was her responsibility to obtain the food preferences, but she had not obtained any preferences since she started in November of this year (2022). Observation of the menu board on 11/28/22 at 6:30 P.M. posted at the dining room door and subsequent observations throughout the survey revealed there was no menu or alternate menu posted. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 confirmed the food service manager or dietary designee should be obtaining the food preferences. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/30/22 at 12:05 P.M. with Resident #80 revealed he had never been asked his food and beverage preferences. Interview on 12/01/22 at 9:40 A.M. with Renal Dietitian #964 revealed Resident #80 had lost weight and his albumin levels have decreased from 3.9 grams (g) per deciliter (dl)on 09/06/22 to 3.5 g/dl on 11/08/22. Renal Dietitian #964 had tried to reach out to the facility by emailing and phone calls for the past 3 months with no return email or phone call. Interview on 12/07/22 at 1:28 P.M. with Resident #80 revealed he had lost weight which he felt was from a combination of improved edema and not eating the facility meals. Resident #80 did not feel the facility had involved him in his decisions about his diet since he was never asked about his preferences. Resident #80 stated his renal dietitian tried to tell the facility his preferences, and there has been no changes. Resident #80 stated he was unaware there were alternatives for the meal, and he either eats or does not eat since staff have never offered him anything else if he did not eat. Interview on 12/07/22 at 2:20 P.M. with Licensed Practical Nurse (LPN) #902 confirmed Resident #43 did not eat much which was in part to the food being cold or him not liking it. Review of the facility alternate menu revealed there was no alternate menu. Review of facility policy titled Resident Food Preferences, revised November 2008, revealed upon admission or within 24 hours after admission, a resident's food preferences were to be obtained, and the resident's clinical record, which included the tray card, would document the resident's likes and dislikes and special dietary instructions or limitations. Review of facility policy titled Menus, revised October 2008, revealed menus would be written at least two weeks in advance, dated, and posted in the kitchen at least one week in advance. Menus would be varied and posted in at least two resident areas. 2. Review of medical record for Resident #4 revealed an admitted [DATE] and diagnoses included acute respiratory failure, end stage renal (kidney) disease, unspecified angina pectoris (chest discomfort), and gastro-esophageal reflux disease (acid reflux) without esophagitis (inflammation of the esophagus). Review of the most recent five day Minimum Data Set assessment dated [DATE] revealed Resident #4 was cognitively intact, required extensive assist of two persons for bed mobility, total dependence of two persons physical assist for transfer, total dependence of one person assist for locomotion, toilet use, and bathing, extensive assist of one person for dressing, independent with set up for eating, limited assistance of one person for personal hygiene, and was always incontinent of bowel and bladder. Review of Resident #4's physician order dated 10/25/22 indicated Renal/Controlled Carbohydrate Diet (Renal/CCHO) diet, Regular texture, Thin Liquids consistency. Review of care plan dated 10/14/22 revealed Resident #4 had nutritional problem or potential nutritional problem related to ischemic heart disease, kidney transplant, and end stage renal disease with an intervention to obtain food preferences as able. H (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366195	A. Building B. Wing	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview during observation on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor #806 revealed the only alternate was hamburgers. It was her responsibility to obtain the food preferences, but she had not obtained any preferences since she started in November of this year. Interview on 11/28/22 at 1:02 P.M. with Resident #4 revealed he had been asked his preferences and the facility did not follow them since they are not listed on his dietary card. Observation of the menu board on 11/28/22 at 6:30 P.M. posted at the dining room door and subsequent observations throughout the survey revealed there was no menu or alternate menu posted. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 confirmed the food service manager or dietary designee should be obtaining the food preferences. Interview and observation on 11/30/22 at 12:07 P.M. with Resident #4 revealed he received a diet lemon iced tea on his tray. Resident #4 indicated he had told the facility staff he did not like the diet iced tea, but they continued to send it on his tray. Resident #4 stated he had voiced his preferences more than once, and he felt it fell on deaf ears. Observation of the dietary tray ticket revealed no listed preferences or dislikes. Review of the facility alternate menu revealed there was no alternate menu. Review of facility policy titled Resident Food Preferences, revised November 2008, revealed upon admission or within 24 hours after admission, a resident's food preferences were to be obtained, and the resident's clinical record, which included the tray card, would document the resident's likes and dislikes and special dietary instructions or limitations. Review of facility policy titled Menus, revised October 2008, revealed menus would be written at least two weeks in advance, dated, and posted in the kitchen at least one week in advance. Menus would be varied and posted in at least two resident areas. 3. Review of medical record for Resident #61 revealed an admitted [DATE] and diagnoses included Covid-19 (10/19/22), obesity, type two diabetes mellitus without complications, gastro-esophageal reflux (acid reflux) without esophagitis (inflammation of the esophagus), and moderate protein calorie malnutrition. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #61 was cognitively intact, required extensive assistance with two person assist with bed mobility, dressing, and toilet use, extensive assist with one person assist for eating, and personal hygiene, total dependence of two person assist for bathing, and was always incontinent of bowel and bladder. Review of care plan dated 08/23/22 revealed Resident #61 had nutritional problems or potential problem related to diabetes type two and interventions included Provide diet/supplements per orders and honor food preferences as able Review of the physician progress note on 10/10/22 revealed a dietary consult since Resident #61 complained about the food and how she couldn't eat certain foods. In addition, Resident #61 was worried how the meal items would affect her diabetes. (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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of physician orders for Resident #61 dated 10/11/22 revealed a carbohydrate consistent diet , Regular texture, Thin Liquids consistency. Interviews on 11/29/22 at 4:43 P.M., 11/30/22 at 11:17 A.M., and 11/30/22 at 6:05 P.M. with Resident #61 revealed she was never asked about her preferences. She felt like she had no choices when it came to her meal. If she did not like what was served, she would snack on something in her room. Resident #61 has had family order food in since she felt she was getting inappropriate items for being a diabetic. Interview during observation on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor #806 revealed the only alternate was hamburgers. It was her responsibility to obtain the food preferences, but she had not obtained any preferences since she started in November of this year. Observation of the menu board on 11/28/22 at 6:30 P.M. posted at the dining room door and subsequent observations throughout the survey revealed there was no menu or alternate menu posted. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 confirmed the food service manager or dietary designee should be obtaining the food preferences. Interview with Director of Nursing (DON) on 12/08/22 at 11:05 AM revealed nursing contacted the physician after the dietary consult was ordered and a new order was obtained for carbohydrate consistent diet on 10/11/22. Review of the facility alternate menu revealed there was no alternate menu. Review of facility policy titled Resident Food Preferences, revised November 2008, revealed upon admission or within 24 hours after admission, a resident's food preferences were to be obtained, and the resident's clinical record, which included the tray card, would document the resident's likes and dislikes and special dietary instructions or limitations. Review of facility policy titled Menus, revised October 2008, revealed menus would be written at least two weeks in advance, dated, and posted in the kitchen at least one week in advance. Menus would be varied and posted in at least two resident areas.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review and facility policy review, the facility failed to provide drinks consistent with residents' preferences. This affected three (Residents #4, #61 and #80) but had the potential to affect all 82 residents who received beverages. The facility identified Resident # 142 as not receiving any beverages by mouth. The facility census was 83. Findings include: 1. Review of medical record for Resident #4 revealed an admitted [DATE] and diagnoses included acute respiratory failure, end stage renal (kidney) disease, unspecified angina pectoris (chest discomfort), and gastro-esophageal reflux disease (acid reflux) without esophagitis (inflammation of the esophagus). Review of the most recent five day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact, required extensive assist of two persons for bed mobility, total dependence of two persons physical assist for transfer, total dependence of one person assist for locomotion, toilet use, and bathing, extensive assist of one person for dressing, independent with set up for eating, limited assistance of one person for personal hygiene, and was always incontinent of bowel and bladder. Review of Resident #4's physician order dated 10/25/22 indicated renal/controlled carbohydrate, regular texture, thin liquids consistency. Review of care plan dated 10/14/22 revealed Resident #4 had a nutritional problem or potential nutritional problem related to ischemic heart disease, kidney transplant, and end stage renal disease with an intervention to honor food preferences as able. Interview during observation on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor #806 revealed it was her responsibility to obtain the food preferences, but she had not obtained any preferences since she started on 11/11/12. Interview on 11/28/22 at 1:02 P.M. with Resident #4 revealed he had been asked his preferences and the facility did not follow them since they were not listed on his dietary card. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 confirmed the food service manager or dietary designee should be obtaining the food preferences. Interview and observation on 11/30/22 at 12:07 P.M. with Resident #4 revealed he received a diet lemon iced tea on his tray. Resident #4 indicated he had told the facility staff he did not like the diet iced tea, but they continued to send it on his tray. Resident #4 stated he had voiced his preferences more than once, and he felt it fell on deaf ears. Observation of the dietary tray ticket revealed no listed preferences or dislikes. (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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled Resident Food Preferences, revised November 2008, revealed upon admission or within 24 hours after admission, a resident's food preferences were to be obtained, and the resident's clinical record, which included the tray card, would document the resident's likes and dislikes and special dietary instructions or limitations. 2. Review of medical record for Resident #61 revealed an admitted [DATE] and diagnoses included Covid-19 (10/19/22), obesity, type two diabetes mellitus without complications, gastro-esophageal reflux (acid reflux) without esophagitis (inflammation of the esophagus), and moderate protein calorie malnutrition. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #61 was cognitively intact, required extensive assistance with two person assist for bed mobility, dressing, and toilet use, extensive assist with one person assist for eating, and personal hygiene, total dependence of two person assist for bathing, and was always incontinent of bowel and bladder. Review of care plan dated 08/23/22 revealed Resident #61 had a nutritional problem or potential problem related to diabetes type two and interventions included provide diet/supplements per orders and honor food preferences as able. Review of Physician #979's progress note on 10/10/22 revealed a recommendation for a dietary consult since Resident #61 complained about the food and how she could not eat certain foods. In addition, Resident #61 was worried how the meal items would affect her diabetes. Review of physician orders for Resident #61 dated 10/11/22 revealed a carbohydrate consistent diet, regular texture, thin liquids consistency Interviews on 11/29/22 at 4:43 P.M., 11/30/22 at 11:17 A.M., and 11/30/22 at 6:05 P.M. with Resident #61 revealed she was never asked about her preferences. She felt like she had no choices when it came to her meal. If she did not like what was served, she would snack on something in her room. Resident #61 has had her family order food for her since she felt she was getting inappropriate items for being a diabetic. Observation and interview on 11/30/22 at 11:59 A.M. with Resident #61 revealed one eight-ounce container of zero percent milk was served on the lunch tray. Resident #61 voiced she did not like the zero percent milk. Interview during observation on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor #806 revealed her responsibility was to obtain the residents food and beverage preferences, but she had not obtained any preferences since she started on 11/11/12. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 confirmed the food service manager or dietary designee should be obtaining the food and beverage preferences. Review of facility policy titled Resident Food Preferences, revised November 2008, revealed upon admission or within 24 hours after admission, a resident's food preferences were to be obtained, and the resident's clinical record, which included the tray card, would document the resident's likes and dislikes and special dietary instructions or limitations. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of medical record for Resident #80 revealed an admitted [DATE] and diagnoses included end stage renal (kidney) disease, essential (primary) hypertension (high blood pressure), acute on chronic diastolic (congestive) heart failure, and type 2 diabetes with hyperglycemia (excessive amount of glucose circulating in the blood) Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 was cognitively impaired, required limited assistance with one-person physical assist for bed mobility, walk in room, walk in corridor, dressing, and toilet use, was independent with set up only eating and personal hygiene, and was always continent of bowel and bladder. Review of Resident #80's physician orders dated 08/15/22 indicated a renal/controlled carbohydrate diet, regular texture, thin Liquids consistency with 100 g protein a day order added on 11/17/22. Order dated 12/04/22 indicated ensure with meals secondary to weight loss. Review of Resident #80 meal intakes from 10/01/22 to 11/30/22 revealed refusal to 25 percent of the meals recorded. Review of Resident's #80 care plan dated 07/26/22 revealed a nutritional problem related to nausea and vomiting prior to admission, chronic kidney disease, diabetes, oral nutritional supplement, and therapeutic diet with an intervention to provide diet/supplements per orders and honor food preferences as able. Interview during observation on 11/28/22 from 11:00 A.M. to 12:02 P.M. with Dietary Supervisor #806 revealed her responsibility was to obtain the food and beverage preferences, but she had not obtained any preferences since she started on 11/11/22. Interview on 11/30/22 at 11:40 A.M. with Dietitian #954 confirmed the food service manager or dietary designee should be obtaining the food and beverage preferences. Interview on 11/30/22 at 12:05 P.M. with Resident #80 revealed he had never been asked his food and beverage preferences. Interview on 12/01/22 at 9:40 A.M. with Renal Dietitian #964 revealed Resident #80 had lost weight and his albumin levels have decreased from 3.9 grams (g) per deciliter (dl)on 09/06/22 to 3.5 g/dl on 11/08/22. Renal Dietitian #964 had tried to reach out to the facility by emailing and phone calls for the past 3 months with no return email or phone call. Interview on 12/07/22 at 1:28 P.M. with Resident #80 revealed he had lost weight which he felt was from a combination of improved edema and not eating the facility meals. Resident #80 did not feel the facility had involved him in his decisions about his diet since he was never asked about his preferences. Resident #80 stated he was supposed to limit his milk and avoid orange juice, but he would often receive those drinks on his meal tray. Resident #80 stated his renal dietitian tried to tell the facility his preferences, and there has been no changes. Review of facility policy titled Resident Food Preferences, revised November 2008, revealed upon admission or within 24 hours after admission, a resident's food preferences were to be obtained, and the resident's clinical record, which included the tray card, would document the resident's likes and dislikes and special dietary instructions or limitations.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, policy review, and record review, the facility failed to assure the residents received the appropriate therapeutic diet as prescribed. This affected Resident #80, and had the potential to affect all 74 residents on a therapeutic diet. The facility identified 82 residents as receiving a meal from the kitchen. The facility identified Resident #142 as not receiving a meal from the kitchen. The facility census was 83. Findings include: Review of medical record for Resident #80 revealed an admitted [DATE] and diagnoses included end stage renal (kidney) disease, essential (primary) hypertension (high blood pressure), acute on chronic diastolic (congestive) heart failure, and type 2 diabetes with hyperglycemia (excessive amount of glucose circulating in the blood) Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 was cognitively impaired, required limited assistance with one-person physical assist for bed mobility, walk in room, walk in corridor, dressing, and toilet use, was independent with set up only eating and personal hygiene, was always continent of bowel and bladder, and went to dialysis. Review of Resident #80's physician orders dated 08/15/22 indicated a renal/controlled carbohydrate diet, Regular texture, Thin Liquids consistency with 100 g protein a day order added on 11/17/22. Order dated 12/04/22 indicated Ensure with meals secondary to weight loss. Review of Resident #80's meal intakes from 10/01/22 to 11/30/22 revealed refusal to 25 percent (%) of the meals recorded. Review of Resident #80's September to November 2022 medication administration record revealed refusal to 100 % of the Ensure being consumed and 100% of the Proheal supplements being consumed. Review of Resident's #80's care plan dated 07/26/22 revealed a nutritional problem related to hyperkalemia, nausea and vomiting prior to admission, chronic kidney disease, oral nutritional supplement, and therapeutic diet with an intervention to provide diet/supplements per orders and honor food preferences as able. Interview on 11/28/22 from 11:00 A.M. to 12:02 P.M. and at 2:15 P.M with Dietary Supervisor (DS) #806 revealed the facility does not have planned menus or spread sheets and staff members go off memory what each diet was supposed to get in regard to food and beverage items. Observation and interview on 11/29/22 at 8:10 A.M. of Resident #80's tray revealed his tray card stated no added salt carbohydrate consistent double portions diet. His breakfast tray revealed one scoop of scrambled egg, one muffin and one bowl of applesauce. State tested Nurse Aide (STNA) #811 verified at the time of observation there was only one scoop of egg served. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/22 at 9:40 A.M. with Renal Dietitian #964 revealed Resident #80 had lost weight and his albumin levels had decreased from 3.9 grams (g) per deciliter (dl)on 09/06/22 to 3.5 g/dl on 11/08/22. Renal Dietitian #964 had tried to reach out to the facility by emailing and phone calls for the past three months with no return email or phone call. On 11/17/22, an order was faxed from dialysis to the facility for 100 g protein diet since the renal doctor wanted Resident #80 on this diet due to decreasing albumin levels. Observation of the tray line from 11:15 A.M. to 12:30 P.M. on 12/01/22 revealed the facility ran out of vegetables at 12:12 P.M. with no replacement, ran out of spaghetti noodles at 12:16 P.M. with mashed potatoes being the replacement. Observation of Resident #80's lunch tray on tray line revealed one chicken breast, one roll, and a one snack package of oreos (with his renal restriction he could not eat the starch substitute of mashed potatoes). Dietary #835 confirmed the items on the plate at the time of observation. Interview on 12/01/22 at 5:58 P.M. with Dietitian #954 revealed he had been covering the facility for most of November. He had not had any communication with dialysis. He was unaware of the new order for 100 g protein diet on 11/17/22. Dietitian #954 stated Resident #80 was on Ensure plus, Ensure clear, and Proheal supplementation, and the supplements along with his diet should meet that 100g protein goal if supplements and diet were consumed; however, he could not guarantee resident was meeting the 100 g protein goal without a calorie count. A renal diet consisted of a diet free of oranges, potatoes, and tomato products with milk being limited to four to eight ounces a day. Interview on 12/07/22 at 1:28 P.M. revealed Resident #80 stated he was not receiving the right things on his meal tray since he was supposed to limit his milk intake and avoid potatoes, oranges, orange juice, and tomato products. Resident #80 stated he often received orange juice and milk on his tray and for lunch that day, he received potatoes. His dialysis dietitian tried to tell the facility his preferences and there has been no changes. If he was served something he was not supposed to have, he usually did not consume it. He often uses his supplements as meal replacements. Interview on 11/30/22 at 10:22 A.M. with the Administrator confirmed there were no menus or spreadsheets, and the new consulting company was going to provide menus and spreadsheets going forward. Review of facility policy titled Menus, revised October 2008, revealed menus would be written at least two weeks in advance, dated, and posted in the kitchen at least one week in advance. Menus would be varied and posted in at least two resident areas. Review of the facility policy titled Food Nutrition Program, revised 2007, revealed the facility would have an organized nutrition-related program which included a dietitian who would help assess nutritional needs and risks of all residents in the facility and would help assure the facility provided appropriate meals and other nutritional interventions and a food service manager who would oversee the activities and functions of the kitchen staff, including food storage and preparation, sanitation issues, menu planning and preparation.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation and interviews, the facility failed to provide a substantial snack when there was greater than a 14-hour lapse between the evening meal and breakfast. This had the potential to affect 82 residents who received meals from the kitchen. The facility identified Resident #142 as not receiving meals from the kitchen. Facility census was 83. Findings include: Observation of facility posted mealtimes revealed the start of breakfast service began at 7:15 A.M., lunch service began at 11:15 A.M., and dinner service began at 4:15 P.M., which was a 15-hour lapse between the evening meal and breakfast meal. Observation on 11/28/22 from 6:25 P.M. to 6:28 P.M. of the snack containers delivered by dietary staff to each of the three nurses stations revealed each nursing station received one metal square pan filled with three wrapped peanut butter and jelly sandwiches, three bananas, three snack sizes bags of pretzels, one snack size bag of potato chips, two eight-ounce containers of diet lemonade, two eight-ounce containers of diet iced tea, two snack fig [NAME] packages, and two fruit and grain cereal bars. Interview on 11/28/22 with License Practical Nurse (LPN) #975 at 6:30 P.M. verified the contents of the snack containers and stated this was what the kitchen usually sent for evening snacks. LPN #975 confirmed there were not enough substantial snacks to pass to everyone.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46195 Based on observation, record review and staff interview the facility failed to ensure the kitchen area was maintained in a clean and sanitary manner and food was labeled and dated in a manner to prevent contamination and/or spoilage. This had the potential to affect all 82 residents who received meals from the kitchen. The facility identified Resident # 142 as not receiving meals from the kitchen. The facility census was 83. Findings include: Observation of the kitchen area on 11/28/22 from 8:14 A.M. to 8:45 A.M. revealed the following findings which were verified by Dietary Supervisor (DS) #806: In the walk in cooler was one half bag of shredded cheddar cheese opened and not dated, one gallon storage bag of nine single serve unopened tubes of sour cream with a use by date of 11/08/2, one full bag of pepper jack cubes opened and not dated, one half bag of mild cheddar cheese cubes opened and not dated, one square metal pan of diced ham with a lid not labeled or dated, one large tube of raw hamburger with plastic wrap wrapped around the open end observed sitting directly on the second of the four open wired shelves with a half pan of mashed tator tots directly underneath, two unopened containers of cottage cheese with a best by date of 11/26/22, one full crate of eight ounce diet lemonade containers observed sitting on the cooler floor with another full crate of diet lemonade sitting on top of it, one square metal pan with a lid of chocolate pudding not dated or labeled, one square metal pan with a lid of tropical fruit not dated or labeled, and one rectangular metal pan with a lid of jelly not dated or labeled with a metal spoon stored in it. There was a brown substance observed all over the condenser fans and strings of dust was observed blowing from the condenser fans. In the walk-in freezer was one package of five waffles opened and not dated. The mixer was uncovered and had debris on the base and the underside of the unit. The two worktables by the dietary office had debris and dirt on the underneath shelf. The slicer was observed to have food debris on the blade. The stove top oven was observed to have over 50 food drips down the left-hand side of the stove top oven, debris and grease buildup on the griddle, and approximately 35 food splash marks down the front of the two oven doors. The steam table was observed to have food debris build up around the wells and on the shelf above wells. The convection oven was observed to have a metal tray with foil on it at the bottom of each of the ovens. The trays were full of black debris and were unable to be pulled out to be cleaned per observation from the DS #806. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The plate warmer was observed to have food debris buildup around the metal openings where the plates were stored. A blue trashcan was observed to be not in use and had no lid on it. DS #806 stated she had no idea if there was a lid for that trash can. In the dry storage area, the floor was observed to have potato chip crumbs in the left-hand corner, rolled up dirty rags under shelving to the left-hand side of the door, one packing peanut observed under the can rack, four plastic lids on the right-hand floor, and the floor in general appeared dirty with built up dirt observed around the perimeter of the room. There was one half bag of cheddar cheese sauce opened and not dated, one half bag of country steak gravy mix opened and not dated, one 3/4 full bag of potato chips opened and not dated, one half bag of pancake mix opened and not dated, one large clear plastic container with a blue lid filled with crispy rice cereal not dated or labeled, one large clear plastic container with a blue lid filled with raisin bran cereal not dated or labeled, and one clear plastic bag of 12 dinner rolls opened and not dated. Observation of the dishwasher revealed the floor area under the machine was full of debris and dirt. Observation of the three-compartment sink revealed all three compartments had food debris on the bottom of the compartments and around the sides of the compartments. DS #806 confirmed the three-compartment sink was left from the previous night. DS #806 stated they do not have a sanitizer bucket at this time. They have a green bucket that they will use at times for sanitizer water. The green bucket was observed under the dirty side of the dish machine with a metal squeegee and a dried rolled up rag stored in it. Sanitizer level measured by DS #806 and read 0 parts per million. DS #806 stated the sanitizer was not working. Review of the sanitizer chemical log and dish machine temp log revealed there were no logs completed in October and November of 2022 and the last time it was filled out was in September 2022. DS #806 stated there was not a cleaning schedule, and she was working on developing one. Observation of the kitchen area on 11/28/22 from 11:00 A.M. to 12:02 P.M. revealed the following findings with DS #806 verifying at the time of observation: Observation of the six condiment containers on tray line which held mustard packets, ketchup packet, packaged cookies, salad dressings and tea bags revealed various debris on the bottom of each of the containers. Observation of the floor in the kitchen revealed the perimeter of the floor revealed a buildup of dirt. DS #806 stated the dietary aides were to mop it at night, but it had not been getting done since the facility did not have enough staff during the night to get it done. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility temperature logs from August 2022 through November 2022 revealed no tray line temperatures were recorded from August 1st through October 31st. For November 2022, five unspecified days of temperatures for breakfast and lunch were recorded and 13 unspecified days of dinner temperatures were recorded. Observation of the kitchen and interview on 11/28/22 at 5:05 P.M. with the current Administrator revealed the previous Administrator had been working with the kitchen and his last day was 11/16/22. The Administrator was shown all areas of concern and verified the condition of the kitchen. Observation of the tray line on 11/29/22 from 11:12 A.M. to 12:05 P.M. revealed Dietary #835 was wearing a sweatshirt that had two long draw strings which touched the food or serving side of the 27 plates as Dietary #825 plated up the food. Observation and interview on 11/29/22 at 12:05 P.M. with Dietary #835 revealed there was red debris from the sweet and sour chicken on one of her draw strings which Dietary #835 confirmed at the time of observation. Interview on 11/30/22 at 12:50 P.M. with the Administrator revealed the service provider for the sanitizer was there for an emergency service call, and it was confirmed the sanitizer for the three-compartment sink was not working. New equipment was installed to resolve the issue. Review of the facility policy titled Food Receiving and Storage, revised July 2014, revealed food services would maintain clean storage areas at all times. Dry foods stored in bins would be removed from original packaging, labeled and dated. Refrigerated foods would be stored in a such a way to promote adequate air circulation around food storage containers. Uncooked and raw animal products would be stored separately in drip-proof containers and below fruits, vegetables, and other ready to eat foods. All foods stored in the refrigerator or freezer would be covered, labeled, and dated. Review of facility policy titled Refrigerators and Freezers, revised December 2014, revealed refrigerators and freezers would be kept clean, free of debris, and mopped with a sanitizing solution on a scheduled basis. Review of facility policy titled Sanitization, revised October 2008, revealed all kitchen areas would be kept clean, free from litter and rubbish. All equipment would be maintained in good repair. Sanitizing of environmental surfaces would be performed with a 150-200 parts per million (ppm) solution.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 46195 Based on observation, interview, and facility policy review, the facility did not maintain garbage and refuse properly in an area free of surrounding litter. This had the potential to affect all 83 residents residing in the facility. Findings include: Interview and observation with Maintenance Staff #806 of the dumpster area on 11/30/22 at 8:45 A.M. revealed on the cement pad, where two blue dumpsters sat, were observed to be two clear gloves, four blue gloves, one empty eight ounce container of fruit punch, one fruit and grain bar in the package unopened, one cookie snack bag unopened, one white plastic spoon, one empty eight-ounce container of milk, one candy wrapper, one unopened pepper packet, one empty clear sleeve bag for foam cups, one half of a white Styrofoam plate, two empty clear plastic bags, one straw, one wet napkin, one unopened salt packet, one chocolate frozen supplement lid, a second candy wrapper, one green eight by eleven inch sheet of paper, one empty plastic medicine cup, and one empty pill packet. At the time of the observation, Maintenance Staff #806 verified the findings and stated this was better than what it usually looked like, and then stated, the kitchen had been short staffed and had not had time to clean the area. Review of the facility policy titled Food-Related Garbage and Rubbish Disposal, revised April 2006, revealed outside dumpsters would be kept free of surrounding litter.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on interview, observation and record review, the facility failed to ensure residents received restorative nursing services as recommended by the therapy department. This affected four residents (Resident #48, #50, #62 and #191) of four residents reviewed for restorative nursing services. Findings include: 1. Resident #48 was admitted [DATE] with diagnoses including injury to the spinal cord in the cervical region, spinal stenosis: cervical, and quadriplegia from a motor vehicle accident. Review of physician orders revealed orders for bilateral dynamic hand splints at all times while in bed for contractures. A physician order dated 08/30/22 revealed the resident was discharged from occupational therapy (OT) and referred to restorative nursing. An order dated 09/06/22 revealed the resident was discharged from physical therapy (PT) and referred to restorative nursing. Review of the quarterly MDS 3.0 of 11/15/22 revealed the resident was cognitively intact, and required total dependence of two for Activities of Daily Living (ADL). Review of the care plan of 11/17/22 revealed care areas included risk for an alteration in musculoskeletal status related to quadriplegia and hand contractures. Review of the Restorative services log for Resident #48 for November and December 2022 revealed the resident was to receive lower extremity stretching and strengthening at least 15 minutes six to seven days a week. The log indicated the resident received services three days out of thirty and refused services twice during the month. There were two days which indicated Restorative Aide (RA) #816 was pulled to work the floor and two days that RA #816 did not work. There was nothing recorded 11/24/22 through 11/30/22 and the facility could not provide any further information. The log for December 2022 revealed the resident did not receive services on 12/02/22 and 12/06/22 but did receive services on 12/07/22. Interview on 11/28/22 at 10:25 A.M. with Resident #48 revealed he did not always receive restorative services as scheduled. Interview on 11/30/22 at 2:11 P.M. with RA #816 and Licensed Practical Nurse/Unit Manager/Wound Nurse/Infection Preventionist/Restorative Nurse (RLPN) #801 revealed residents are usually scheduled for restorative services three times a week. RA #816 was the only restorative aide, and worked five days a week. When she was pulled to work the floor she could not provide restorative services, except for some of the residents on the hall she was working. RLPN #816 did not so restorative nursing progress notes. Interview on 12/08/22 at 10:09 A.M. with the Administrator and the Director of Nursing (DON) revealed there is another aide who provides restorative services on a part time basis but they could not provide any documentation of her training or restorative services for this resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2013 policy for Restorative Nursing Care revealed the facility had an active program of restorative nursing which is developed and coordinated .to assist each resident maintain an optimal level of self-care and independence. 2. Resident #50 was admitted on [DATE] with diagnoses ulcerative proctitis (inflammation of the lining of the rectum), diabetes type II, and a history of stroke and severe sepsis. Review of Resident #30's quarterly MDS 3.0 assessment of 10/10/22 revealed the resident was cognitively intact, displayed rejection of care, and was total dependence of two for ADLs. Review of progress note of 11/11/12 revealed Resident #50 was discharged from PT, effective 11/03/22 and referred to restorative nursing. Review of care plan of 11/27/22 revealed care areas included history of stroke, increased risk of falls and resistance to care. Review of the restorative services log of November 2022 revealed Resident #50 was to receive bilateral lower extremity stretching with (PRAFO boots) his shoes with braces for at least 15 minutes six to seven days a week. The resident refused services on 11/15/22 and 11/22/22. Services were marked as not provided on 11/17/22, 11/19/22, 11/24/22, 11/26/22 and 11/29/22 because RA #816 was pulled to work the floor. Interview on 11/28/22 at 5:10 P.M. with Resident #50 revealed the resident was recently discharged from therapy and was supposed to have his PRAFO boots put on twice a day by restorative but it had not happened. The PRAFO boots were observed sitting on a chair across from the resident's bed. They were observed in the same place, same position on 11/29/22 at 9:15 A.M. and 11/30/22 at 11:15 A.M. Interview on 11/30/22 at 2:11 P.M. with RA #816 and RLPN #801 revealed Resident #50 was picked up for restorative services but had refused twice and verified services were not offered five days due to the RA working the floor. Residents are usually scheduled for restorative services three times a week. RA #816 was the only restorative aide, and worked five days a week. When she was pulled to work the floor she could not provide restorative services, except for some of the residents on the hall she was working. RLPN #816 did not so restorative nursing progress notes. Interview on 12/08/22 at 10:09 A.M. with the Administrator and the Director of Nursing (DON) revealed there is another aide who provides restorative services on a part time basis but they could not provide any documentation of her training or restorative services for this resident. Review of the July 2013 policy for Restorative Nursing Care revealed the facility had an active program of restorative nursing which is developed and coordinated .to assist each resident maintain an optimal level of self-care and independence. 3. Resident #62 was admitted on [DATE] with diagnoses including peripheral vascular disease, hypertension, metabolic encephalopathy, chronic respiratory failure, mild cognitive impairment and COVID-19 (11/13/20). Review of the annual MDS 3.0 of 10/10/22 revealed the resident was alert and oriented, independent for ADLs with setup only required. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan of 11/12/22 revealed care areas potential for pressure development and an increased risk of falls. Review of order dated 11/18/22 revealed Resident #62 was discharged from OT services and referred to restorative services. Review of Resident #62's restorative documentation, revealed there was no log for restorative services for November 2022. Review of the restorative services log of December 2022 revealed Resident #62 was referred for bilateral strengthening, dynamic balance and activities. The resident was scheduled for restorative services on 12/02/22 and 12/07/22 but did not receive then due to RA#816 working the floor. Interview on 11/30/22 at 2:11 P.M. with RA #816 and RLPN #801 revealed residents were usually scheduled for restorative services three times a week. RA #816 was the only restorative aide, and worked five days a week. When she was pulled to work the floor she could not provide restorative services, except for some of the residents on the hall she was working. RLPN #816 did not so restorative nursing progress notes. Interview on 12/08/22 at 9:45 A.M. with Resident #62 revealed the resident had not yet received any restorative services. Review of the July 2013 policy for Restorative Nursing Care revealed the facility had an active program of restorative nursing which is developed and coordinated .to assist each resident maintain an optimal level of self-care and independence. 44461 4. Record review for Resident #191 revealed an admitted [DATE] and diagnoses included type II diabetes mellitus, hypertension, osteomyelitis, choric kidney disease, gastroesophageal reflux, major depressive disorder, and atrial fibrillation. Review of quarterly MDS dated [DATE] revealed the resident had impaired cognition, she needed assistance by one staff member for bed mobility, transfers, dressing, toileting, bathing, and personal hygiene. Review of Resident #191's physicians orders dated December 2022 revealed she was discharged from physical and occupational therapies on 11/23/22 and was referred to the restorative nursing program. Interview on 12/01/22 at 9:32 A.M. with the Therapy Director Physical Therapy Assistant (PTA) #814 revealed Resident #191 was referred to restorative therapy on 11/23/22 when she completed her PT/OT services. As of 12/01/22 the resident had not been seen by Restorative therapy. When asked what PTA #814's expectations were for how soon restorative therapy programs should start she stated with in one week of discharge. PTA #814 was asked to screen the resident to see if there were any declines since the end of Resident #191's PT/OT services. As of 12/01/22 there were not any declines. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/22 at 12:47 P.M. with the Restorative Nurse LPN #801 revealed the therapy department would bring and hand the referral form to her. The resident who was referred would then be placed on to the restorative schedule for the first of the next month. LPN #801 stated if there was a new referral made they will remove a resident who has been on restorative therapy for a long period of time to make room for the new referral. Interview on 12/01/22 at 12:35 P.M. with Resident #191 revealed she was discharged from therapy on 11/23/22 with a referral to restorative nursing for therapy. The resident stated she was aware she was to be on restorative therapy and knew what it was. She has not started it yet and is unsure when it will start. Resident #191 stated she does not feel she had declined since discharge from therapy. Interviews on 11/30/22 at 2:11 P.M. with LPN #801 and State tested Nursing Assistant (STNA) #816 revealed residents are usually scheduled for three time a week for restorative services. STNA #816 was the only restorative aide. When STNA #816 was pulled to the floor restorative therapy services (RTS) were not completed. STNA #816 stated if she was pulled to the floor she will document an X on the day restorative services were not available and she would mark an R if the resident refused. If there were three or more refusals the resident is cut from restorative services to make room for another resident. There were no restorative notes completed. Interview on 12/06/22 at 2:00 P.M. with LPN #801 revealed if a resident was discharged from therapy for example on 11/02/22 and was referred to restorative services the resident would not be added on the restorative schedule until the first of the following month. Review of restorative therapy documentation from 11/23/22 through 12/08/22 revealed Resident #191 did not start her restorative programs until 12/01/22 even though therapy referred Resident #191 to restorative on 11/23/22.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38094 Based on interviews, observation and record reviews, the facility failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This affected all residents of the facility. The census was 83. Findings include: During the annual recertification and extended survey completed from 11/28/22 through 12/16/22 the following concerns were identified through observation, record review, facility policy and procedure review and interview: a. The facility failed to promote an environment that maintained dignity and respect, failed to honor Resident #36's choices in bathing, and failed to ensure the safeguard of medical records. See findings at F550, F561, and F583. b. The facility failed to ensure Resident #10 was free from abuse and that all allegations of abuse were thoroughly investigated. See findings at F600 and F610. c. The facility failed to ensure resident minimum data set assessments were accurate for Resident #4 and Resident #36, and comprehensive care plans addressed the needs of Resident #24, #83, and #294. See findings at F641 and F656. d. The facility failed to ensure Resident #44 was provided a functional communication system, and failed to ensure Resident #36 and Resident #191 received timely incontinence care. See findings at F676 and F677. e. The facility failed to ensure pressure ulcer prevention and treatment program to ensure interventions were initiated timely to prevent the development of pressure ulcers and/or to ensure adequate treatments were in place to promote healing. This affected four residents (Resident #9, #10, #20, and #81) of five residents reviewed for pressure ulcers. Actual Harm occurred on 12/01/22 when Resident #20, who was severely cognitively impaired, totally dependent on staff for activity of daily living care, was noted to have contractures and had a history of pressure ulcers to the coccyx was assessed to have a Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer to the coccyx without adequate evidence of interventions being in place to prevent the development of or identify the ulcer prior to being found as a Stage III. Actual Harm occurred on 05/25/22 when Resident #10 was assessed to have a Stage III pressure ulcer to the right central left buttock. The facility failed to identify the pressure ulcer prior to it being identified as a Stage III. See findings at F686. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. The facility failed to ensure Resident #72's catheter was inserted timely. This affected one resident (Resident #72) out of three residents reviewed for catheter care. Actual Harm occurred on 11/15/22 at 5:37 P.M. when Resident #72 pulled his indwelling catheter out causing redness, irritation and bleeding, and the catheter was not reinserted until Resident #72 experienced abdominal pain and tenderness, was transported to the local Emergency Department on 11/16/22 at 1:57 P. M, a catheter was inserted in the Emergency Department and approximately a liter of urine was returned. See Findings at F690. g. The facility failed to timely implement nutritional interventions for residents who experienced weight loss or were at risk of compromised nutrition. This affected four residents (Residents #38, #44, #66, and #80) out of five residents reviewed for nutrition. Actual harm occurred on 11/30/22 when Resident #44 was assessed to have a significant weight loss of 40 pounds (22.5 percent) from Resident #44's previous weight on 10/14/22 of 177 pounds and the facility failed to ensure nutritional interventions were implemented to prevent and address the weight loss. See Findings at F692. h. The facility failed to ensure Resident's #2, #15, #16, #25, #58 and #81 were administered oxygen per physician orders, failed to ensure Resident #2 received her pain medication per physician orders, and failed to ensure 14 residents (Resident #8, #24, #35, #38, #53, #57, #62, #66, #67, #74, #79, #80, #83, #294) on dialysis received ongoing communication and collaboration with the dialysis facility for residents who required dialysis. See findings at F695, F697, and F698. i. The facility failed to ensure sufficient staffing to provide timely incontinence care to Resident #191, provide sufficient restorative services to Resident #48, #50, #62 and #191, provide pain medications timely to Resident #2, and timely answer resident call lights. See Findings at F725. j. The facility failed to provided well balanced meals, failed to honor the residents' food and beverage preferences, failed to consistently provide adequate number of dietary staff to ensure a clean kitchen and dumpster area, failed to ensure menus were distributed or posted for residents to make food choices, failed to ensure food was served at an appetizing temperature and an acceptable palatability in a form to meet the residents need, failed to provide food substitutions, failed to assure the residents received the appropriate therapeutic diet as prescribed, failed to assure residents received sufficient snacks, and failed to ensure the kitchen area was maintained in a clean and sanitary manner, affecting all 82 residents who received meals from the kitchen. See findings at F800, F802, F803, F804, F805, F806, F807, F808, F809, F812, and F814. k. The facility failed to ensure restorative services recommended by therapy were offered to Resident #48, #50, #62 and #191. See findings at F825. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	I. The facility failed to ensure Resident's #29 and #30 were placed on contact isolation related to urine culture results, failed to ensure Resident #29's antibiotics were ordered timely, failed to ensure Resident #2's oxygen tubing was changed as ordered, failed to ensure appropriate hand hygiene during medication administration, failed to ensure Resident #22's catheter was maintained in a sanitary manner to prevent infection, and failed to ensure appropriate personal protective equipment (PPE) was used when care was provided for a resident on contact precautions (Resident #33) to potentially prevent the spread of Clostridium Difficile infections, with the potential to affect all 83 residents residing in the facility. See findings at F880 Interview on 11/28/22 at 9:41 A.M revealed the Acting Administrator (AA) reported she had been acting as the interim administrator for four days, as the last administrator resigned the week before survey entrance. Interview on 12/08/22 at 4:37 P.M. with the Acting Administrator (AA) and Director of Nursing revealed quality assurance committee had recently worked on alarm response time and skin checks. The AA reported when she was the administrator of the building a few years ago, she had a binder for survey which she kept updated with policies, census, and other information. When she stepped in as acting administrator, at the end of November 2022, she found the binder and nothing had been updated since she left.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on interviews, observation and record reviews, the facility failed to ensure to ensure the medical director coordinated medical care and helped to implement and evaluate resident care policies that reflect current professional standards of practice. This affected all residents of the facility. The census was 83. Findings include: 1. Resident #24 was admitted [DATE] with diagnoses including metabolic encephalopathy, diabetes type II, heart disease and end stage renal disease with anemia. The resident received off-site dialysis three days a week. Review of Resident #24's physician orders revealed orders for a renal/controlled carbohydrate diet with regular texture and thin liquids. Review of Resident #24's Quarterly MDS 3.0 assessment of 10/20/22 revealed the resident was cognitively intact, required extensive assist of two for activities of daily living, and received dialysis. Review of the care plan of 09/05/22 revealed care areas for anemia related to diabetes and at risk of complications. Interventions included dietary consults to regulate protein, sodium and potassium. Review of progress notes of 12/08/22 at 4:20 A.M. and 4:41 A.M. revealed Resident #24 was responsive only to painful stimuli. Her vitals were within normal limits. Her husband requested she be sent out to the hospital. The nurse reported she was unable to reach anyone at either of the on-call numbers for the resident's physician with no voicemail for the first number and the second number not being in service. Interview on 12/08/22 at 12:50 P.M. with Director of Nursing (DON) revealed she was unsure if the nurse on duty overnight did reach someone from the office of Resident #24's practice. She reported the physician was notified when he entered the facility later on 12/08/22. Review of Physician Services policy of April 2013 revealed the physician participates in resident assessment and care planning, monitoring changes in medical status, providing, consultation or treatment and provides. pertinent timely assessments. Policy of April 2013 for Attending Physician revealed the physician's responsibility includes timely and appropriate medical orders. 2. Review of Resident #29's medical record revealed an admitted [DATE], a re-entry date of 10/03/22 and diagnoses included pulmonary embolism without acute cor pulmonale, heart failure, major depressive disorder and dementia. (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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #29's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 was cognitively intact and did not have an indwelling catheter and was always incontinent of urine and bowel. Review of Resident #29's lab report for urinalysis and culture and sensitivity revealed Resident #29's urine was collected on 11/15/22 and reported to the facility on [DATE]. The lab results included Resident #29 had Escherichia Coli and the colony count was greater than 100,000 CFU (colony forming unit) per milliliter (ml) and Resident #29 had Methicillin Resistant Staphylococcus Aureus (MRSA) and the colony count was greater than 100,000 CFU per ml. Further review of the lab report revealed Medical Director (MD) #940 reviewed the results on 11/21/22 at 6:13 A.M. Review of Resident #29's physician orders from 11/18/22 through 11/21/22 did not reveal orders for antibiotics to treat Resident #29's urinary tract infection reported on 11/18/22. Review of Resident #29's physician orders dated, 11/21/22 (three days after culture and sensitivity results were reported), revealed Bactrim DS (double strength) tablet 800-160 mg (sulfamethoxazole-trimethoprim), give one tablet by mouth two times a day for UTI (urinary tract infection) for seven days. Further Review of Resident #29's lab report for urinalysis and culture and sensitivity, reported to the facility on [DATE] revealed although the report was reviewed by Medical Director (MD) #940 on 11/21/22 there were no orders to place Resident #29 on Contact Precautions. Review of Resident #29's physician orders from 11/18/22 through 11/30/22 did not reveal Resident #29 was placed on Contact Precautions related to MRSA. Review of Resident #29's care plan dated, 10/03/22 through 11/30/22, did not reveal a care plan for Contact Precautions related to Methicillin Resistant Staphylococcus Aureus found in Resident #29's urinalysis and culture and sensitivity report for urine collected on 11/15/22. Observation on 11/28/22 at 4:30 P.M. of Resident #29 revealed she was lying in bed. There was no observation of a Contact Precaution Sign on the door to her room, or near the door to her room. Further observation did not reveal PPE supplies near the entrance to Resident #29's room. Interview on 11/30/22 at 10:00 A.M. with the DON and Licensed Practical Nurse/Unit Manager/Wound Nurse/Infection Preventionist (LPN/UM/WN/IP) #801 revealed Resident #29 was not on Contact Precautions for Methicillin-resistant Staphylococcus aureus (MRSA). The DON and LPN/UM/WN/IP #801 stated they were not aware Resident #29's urine culture reported she had MRSA infection. LPN/UM/WN/IP #801 stated it must have been missed when the results were reviewed. The DON and LPN/UM/WN/IP #801 stated the urine culture results reported 11/18/22 were reviewed by Medical Director (MD) on 11/21/22. The DON stated Resident #29 had a roommate (Resident #1) from 10/18/22 through 11/23/22 when Resident #1 was transported to the local hospital Emergency Department for complaints of chest pain. The DON confirmed Resident #29's antibiotics were not started until 11/21/22. Interview on 11/30/22 at 6:20 P.M. with Medical Director (MD) #940 stated she agreed Resident #29 should have been on Contact Precautions if MRSA was found in her urine. (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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions, revised, 01/2012, included in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions were necessary would be evaluated on a case by case basis. Examples of infections requiring Contact Precautions included infections with multi-drug resistant organisms (determined on a case by case basis). Place the resident in a private room if possible. If a private room was not available, the Infection Preventionist would assess various risks associated with other resident placement options. Upon entering the Contact Precautions room wear a disposable gown and gloves. Remove the gloves before leaving the room and perform hand hygiene. After removing the gown, do not allow clothing to contact potentially contacted environmental surfaces. 3. Review of the facility Quality Assurance (QA) meeting attendance sheets from April 2021 through October 2022 revealed the Medical Director attended two meetings. Interview with the DON on 12/08/22 at 4:15 P.M. confirmed the Medical Director was present by phone for two of the QA meetings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on observation, interview, and record review, the facility failed to ensure accurate and complete medical records related to dialysis treatment for 14 residents (Resident #8, #24, #35, #38, #53, #57, #62, #66, #67, #74, #79, #80, #83, #294) and oxygen tube changes for Resident #2, and failed to ensure resident medical records were maintained in a confidential and secure manner. This had the potential to affect all residents. The census was 83. Findings include: 1. Review of all 14 residents (Resident #8, #24, #35, #38, #53, #57, #62, #66, #67, #74, #79, #80, #83, #294) of 14 resident medical records of those who receive dialysis in the facility, revealed the medical record did not contain dialysis communication regarding each resident's medical care and status before and after receiving dialysis treatment. Interview on 12/06/22 at 4:45 P.M. with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #837 revealed the document titled Dialysis Hand Off Communication Report was not being filled out by the facility nurses prior to the residents going to dialysis. Review of undated facility policy titled Dialysis revealed communication with the dialysis center would be maintained using a communication book, which was to be sent every time the resident went for dialysis. The licensed nurse would evaluate observe and/or assess the shunt/fistula for signs/symptoms of bleeding and infection. The access site would be monitored and any bleeding, pain, swelling, or tingling/numbness would be reported to the physician. Post dialysis nurse would monitor BP, pulse, presence/absence of bruit/thrill, monitor for s/s of fluid overload, and would remove pressure dressing from the shunt/fistula site upon return from dialysis as indicated. If resident refused to go to dialysis, the physician would be notified. 42013 2. Review of Resident #2's medical record revealed an admitted [DATE] and diagnoses included cerebral infarction, acute kidney failure, fibromyalgia, and multiple sclerosis. Review of Resident #2's physician orders dated, 03/20/22, revealed oxygen tubing to be changed weekly on Sunday and as needed, every night shift, every Sunday. Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated , 11/19/22, revealed Resident #2 was cognitively intact and was independent for bed mobility, transfers, and toilet use. Resident #2 used oxygen. Review of Resident #2's Treatment Administration Record (TAR) dated, 09/04/22, 09/11/22, 09/18/22, 09/25/22, 10/02/22, 10/09/22, 10/16/22, 10/23/22, 10/30/22, 11/06/22, 11/13/22, 11/20/22, 11/27/22 revealed documentation Resident #2's oxygen tubing was changed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 11/28/22 at 9:35 A.M. of Resident #2 revealed she was lying in bed, and was administered oxygen at 3.5 liters per minute via nasal cannula. Further observation revealed Resident #2's oxygen tubing was dated 09/04/22. Resident #2 stated her oxygen tubing had not been changed since 09/04/22. After surveyor intervention Registered Nurse (RN) #800 entered Resident #2's room and confirmed the oxygen tubing was dated 09/04/22. RN #800 stated the oxygen tubing needed changed and she would get new tubing immediately. Interview on 11/28/22 at 10:30 A.M. with the Director of Nursing (DON) confirmed Resident #2's TAR had documentation Resident #2's oxygen tubing was changed but the tubing she was using was dated 09/04/22. 46195 3. Interview on 12/07/22 at 1:22 P.M. with STNA #917 revealed she had a difficult time finding a facility computer for charting. She stated there were two laptop computers on top of the medication carts along with two desktop computers for the 1100 and 1200 hall for charting. STNA #917 expressed some nurses would not let the STNAs use the laptops, or the nurses would sit in front of the desktop computer while using a laptop, which left the STNAs no computers for charting. STNA #917 stated she would bring in her own computer for easier access to charting. Interview on 12/07/22 at 1:55 P.M. with Director of Nursing (DON) confirmed the STNAs should use the desktop computers at the nursing station, or the laptop computers used for medication administration, if the medication administration was completed, for charting. She was aware the staff were having difficulty charting at times and had asked in the past for computer tablets or computer kiosks. The DON did not know the staff were bringing in their own computers, but she was okay with staff using their own computers for documentation since they did not have remote access to the EMR software program. She was not sure if anyone could screen shot items and then store the screen shots on their personal computer. Observation during facility tour on 12/07/22 from 2:25 P.M and 2:30 P.M. revealed the 1100 and 1200 hallway nurse's station had two desktop computers and two laptop computers. The 1300 hallway nurse's station had two laptop computers and one desktop computer. The 1400 hallway nurse's station had one desktop computer and one laptop computer. Interview on 12/07/22 at 2:26 P.M. with License Practical Nurse (LPN) #900 revealed she had seen night shift STNAs bring in their own computers to chart. Observation and interview on 12/07/22 at 3:00 P.M. with STNA #803 revealed a grey laptop was observed sitting at the facility's 1400 hall nurse's station. STNA #803 stated it was her own computer, and she brought it into the facility all the time to chart. STNA #803 demonstrated to the surveyor that she went through an internet search site and then typed in the name of the EMR software the facility was using. The password for the EMR software had already been saved to her computer, and the EMR software was then brought up on her computer screen. On the screen was observed to be a resident's name, date of birth, room number, a picture of the resident, and all the areas where the STNAs were to record data. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation during a facility tour on 12/08/22 from 2:25 P.M. to 2:30 P.M. revealed at each of three nurse's stations was posted an undated sign with yellow highlighted words stating no personal electronic devices were to be used to log into the EMR software program with no exceptions. Review of facility document titled Information Technology-Confidentiality Form/User Agreement signed by STNA #803 on 03/29/22 revealed the facility would utilize mechanisms to ensure appropriate system access, and employees would agree to provide to the facility any portable device that may contain patient information. Review of facility policy titled Confidentiality of Information, revised March 2014, revealed the facility would safeguard all resident records, whether medical, financial, or social in nature, to protect the confidentiality of the information. Review of facility policy titled Electronic Medical Records, revised March 2014, revealed the facility's medical record system had technical safeguards, which included technical infrastructure, hardware, software, and security capabilities to prevent unauthorized access of electronic protected health information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident's #29 and #30 were placed on contact isolation related to urine culture results, failed to ensure Resident #29's antibiotics were ordered timely, failed to ensure Resident #2's oxygen tubing was changed as ordered, failed to ensure appropriate hand hygiene during medication administration, failed to ensure Resident #22's catheter was maintained in a sanitary manner to prevent infection, and failed to ensure appropriate personal protective equipment (PPE) was used when care was provided for a resident on contact precautions (Resident #33) to potentially prevent the spread of Clostridium Difficile infections. This had the potential to affect all 83 residents residing in the facility. Findings include: 1. Review of Resident #29's medical record revealed an admitted [DATE], a re-entry date of 10/03/22 and diagnoses included pulmonary embolism without acute cor pulmonale, heart failure, major depressive disorder and dementia. Review of Resident #29's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 was cognitively intact and did not have an indwelling catheter and was always incontinent of urine and bowel. Review of Resident #29's lab report for urinalysis and culture and sensitivity revealed Resident #29's urine was collected on 11/15/22 and reported to the facility on [DATE]. The lab results included Resident #29 had Escherichia Coli and the colony count was greater than 100,000 CFU (colony forming unit) per milliliter (ml) and Resident #29 had Methicillin Resistant Staphylococcus Aureus (MRSA) and the colony count was greater than 100,000 CFU per ml. Further review of the lab report revealed Medical Director (MD) #940 reviewed the results on 11/21/22 at 6:13 A.M. Review of Resident #29's physician orders from 11/18/22 through 11/21/22 did not reveal orders for antibiotics to treat Resident #29's urinary tract infection reported on 11/18/22. Review of Resident #29's physician orders dated, 11/21/22 (three days after culture and sensitivity results were reported), revealed Bactrim DS (double strength) tablet 800-160 mg (sulfamethoxazole-trimethoprim), give one tablet by mouth two times a day for UTI (urinary tract infection) for seven days. Further Review of Resident #29's lab report for urinalysis and culture and sensitivity, reported to the facility on [DATE] revealed although the report was reviewed by Medical Director (MD) #940 on 11/21/22 there were no orders to place Resident #29 on Contact Precautions. Review of Resident #29's physician orders from 11/18/22 through 11/30/22 did not reveal Resident #29 was placed on Contact Precautions related to MRSA. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #29's care plan dated, 10/03/22 through 11/30/22, did not reveal a care plan for Contact Precautions related to Methicillin Resistant Staphylococcus Aureus found in Resident #29's urinalysis and culture and sensitivity report for urine collected on 11/15/22. Observation on 11/28/22 at 4:30 P.M. of Resident #29 revealed she was lying in bed. There was no observation of a Contact Precaution Sign on the door to her room, or near the door to her room. Further observation did not reveal PPE supplies near the entrance to Resident #29's room. Interview on 11/30/22 at 10:00 A.M. with the DON and Licensed Practical Nurse/Unit Manager/Wound Nurse/Infection Preventionist (LPN/UM/WN/IP) #801 revealed Resident #29 was not on Contact Precautions for Methicillin-resistant Staphylococcus aureus (MRSA). The DON and LPN/UM/WN/IP #801 stated they were not aware Resident #29's urine culture reported she had MRSA infection. LPN/UM/WN/IP #801 stated it must have been missed when the results were reviewed. The DON and LPN/UM/WN/IP #801 stated the urine culture results reported 11/18/22 were reviewed by Medical Director (MD) on 11/21/22. The DON stated Resident #29 had a roommate (Resident #1) from 10/18/22 through 11/23/22 when Resident #1 was transported to the local hospital Emergency Department for complaints of chest pain. The DON confirmed Resident #29's antibiotics were not started until 11/21/22. Interview on 11/30/22 at 6:20 P.M. with Medical Director (MD) #940 stated she agreed Resident #29 should have been on Contact Precautions if MRSA was found in her urine. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions, revised, 01/2012, included in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions were necessary would be evaluated on a case by case basis. Examples of infections requiring Contact Precautions included infections with multi-drug resistant organisms (determined on a case by case basis). Place the resident in a private room if possible. If a private room was not available, the Infection Preventionist would assess various risks associated with other resident placement options. Upon entering the Contact Precautions room wear a disposable gown and gloves. Remove the gloves before leaving the room and perform hand hygiene. After removing the gown, do not allow clothing to contact potentially contacted environmental surfaces. 2. Review of Resident #30's medical record revealed an admitted [DATE] and diagnoses included interstitial pulmonary disease, type two diabetes mellitus with hyperglycemia, chronic kidney disease, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, dementia, schizophrenia. Review of Resident #30's physician orders dated, 10/13/22, revealed urinalysis with culture and sensitivity. Review of Resident #30's progress notes dated, 10/17/22, revealed urine for urinalysis and culture and sensitivity was obtained via straight catheter and sent to lab for testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #30's Lab Results Report for the urinalysis and culture and sensitivity revealed the urine was collected on 10/17/22 and reported on 10/20/22. The report revealed Resident #30 had E. Coli-ESBL (escherichia coli- extended-spectrum beta-lactamases) greater than 100,000 CFU per ml. Resistance to cephalosporins, penicillins and aztreonam is due to ESBL's. Beta lactam combination drugs like ticarcillin clavulanate, amoxicillin clavulanate, ampicillin sulbactam and piperacillin tazobactam have been found to have reduced activity due to ESBL's. The literature strongly suggests that Carbapenems should be used to treat ESBL infections. Contact isolation was indicated. Review of Resident #30's Quarterly MDS 3.0 assessment dated , 10/18/22, revealed Resident #30 had moderate cognitive impairment. Resident #30 required extensive assistance of two staff members for bed mobility, had total dependence of two staff members for transfers, and total dependence of one staff member for toilet use. Resident #30 was occasionally incontinent of urine and always incontinent of bowel. Observation on 11/28/22 at 4:00 P.M. of Resident #30's room revealed she was not in her room due to admission to the local hospital on 11/16/22. There was no observation of a Contact Precaution Sign on the door to her room, or near the door to her room. Further observation did not reveal PPE supplies near the entrance to Resident #30's room. Interview on 11/30/22 at 10:00 A.M. with the DON and Licensed Practical Nurse/Unit Manager/Wound Nurse/Infection Preventionist (LPN/UM/WN/IP) #801 revealed Resident #30 was not on Contact Precautions for E. Coli-ESBL. The DON and LPN/UM/WN/IP #801 stated they were not aware Resident #30's urine culture reported she had E. Coli-ESBL infection on 10/20/22. LPN/UM/WN/IP #801 stated it must have been missed when the results were reviewed. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions, revised, 01/2012, included in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions were necessary would be evaluated on a case by case basis. Examples of infections requiring Contact Precautions included infections with multi-drug resistant organisms (determined on a case by case basis). Place the resident in a private room if possible. If a private room was not available, the Infection Preventionist would assess various risks associated with other resident placement options. Upon entering the Contact Precautions room wear a disposable gown and gloves. Remove the gloves before leaving the room and perform hand hygiene. After removing the gown, do not allow clothing to contact potentially contacted environmental surfaces. 3. Review of Resident #2's medical record revealed an admitted [DATE] and diagnoses included cerebral infarction, acute kidney failure, fibromyalgia, and multiple sclerosis. Review of Resident #2's physician orders dated, 03/18/22, revealed administer oxygen at five liters per minute via nasal cannula continuously every shift. Review of Resident #2's physician orders dated, 03/20/22, revealed oxygen tubing to be changed weekly on Sunday and as needed, every night shift, every Sunday. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated , 11/19/22, revealed Resident #2 was cognitively intact and was independent for bed mobility, transfers, and toilet use. Resident #2 used oxygen. Review of Resident #2's Treatment Administration Record (TAR) dated, 09/04/22, 09/11/22, 09/18/22, 09/25/22, 10/02/22, 10/09/22, 10/16/22, 10/23/22, 10/30/22, 11/06/22, 11/13/22, 11/20/22, 11/27/22 revealed documentation Resident #2's oxygen tubing was changed. Observation on 11/28/22 at 9:35 A.M. of Resident #2 revealed she was lying in bed, and was administered oxygen at 3.5 liters per minute via nasal cannula. Further observation revealed Resident #2's oxygen tubing was dated 09/04/22. Resident #2 stated her oxygen tubing had not been changed since 09/04/22. After surveyor intervention Registered Nurse (RN) #800 entered Resident #2's room and confirmed the oxygen tubing was dated 09/04/22. RN #800 stated the oxygen tubing needed changed and she would get new tubing immediately. Interview on 11/28/22 at 10:30 A.M. with the Director of Nursing (DON) confirmed Resident #2's TAR had documentation Resident #2's oxygen tubing was changed but the tubing she was using was dated 09/04/22. 44461 4. Record review for Resident #84 revealed an admitted [DATE] diagnosis included pneumonia, hypertension, gastroesophogeal reflux disease (GERD), history of COVID-19, dysphagia, normal pressure hydrocephalus, muscle weakness, and cognitive communication deficit. Review of Resident #84 Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #84 has sever cognitive impairment. Resident #84 needed extensive assist by two staff members for bed mobility, he needed physical assistance by one staff member for transfers, dressing, toileting, personal hygiene, bathing and was independent with eating. Review of Resident #84's Physicians orders dated December 2022 revealed all medications were given as prescribed. There were no omissions or missing medications. Observation of medicatoin administration on 11/30/22 at 6:37 A.M. of Registered Nurse (RN) #804 revealed she sanitized hands, then proceeded to pop all medications one by one out of the bingo cards into her bare hands before putting the medications into a medication cup, medications were then crushed and placed in pudding. RN #804 touched the medication cart, medication drawers, the computer, the mouse, and then opened all capsules with bare hands. At no time did she repeat hand hygiene. RN #804 was observed touching the computer key pad, the mouse, the medication cart drawers, multiple bottles within the cart, at no time during the observation did RN #804 repeat hand hygiene by either using alcohol based hand rub (ABHR). Interview on 11/30/22 7:20 A.M. with RN #804 confirmed she did not follow appropriate infection control practices, by washing hands or by using ABHR and confirmed all actions seen during observation were incorrect including placing medication directly in to unclean hand and not directly into a medication administration cup. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366195	A. Building B. Wing	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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	Review of medication administration policy dated December 2012 revealed at bullet point 22 Staff shall follow established facility infection control procedures (i.e. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable. 5. Record review for Resident #22 revealed an admitted d of 10/27/22 with diagnoses included infection and inflammatory reaction due to indwelling urethral catheter, acidosis, disease of the pancreas, weakness, type II diabetes mellitus, acute kidney failure, diarrhea, chronic kidney disease stage III, hypothyroidism, neuromuscular dysfunction of bladder, COVID-19, hyperkalemia, wedge compression fracture of L5, hypertension, and hydronephrosis. Review of Resident #22's Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition, she needed extensive assist by two staff members for bed mobility, transfers, toileting, and she was a one person physical assist for dressing, personal hygiene, and bathing. She was independent with eating. Review of Resident #22's physicians orders dated December 2022, revealed orders for irrigation of foley catheter with 30-60 milliliters (ml), catheter care every shift and as needed, the Foley catheter drainage bag was to be emptied every shift and as needed. Foley catheter bag was to be changed monthly on the 27th and as needed, every night shift starting on the 27th of every month and as needed. Resident #22 was ordered size 16 french foley with a 10 milliliter balloon to hold sterile water. Observation on 11/30/22 at 11:35 A.M. of Resident #22's catheter bag revealed it was on the floor next to her bed. Although there was a privacy bag on her bed frame for her foley catheter, it was not in use. Observation on 12/01/22 at 3:15 P.M. of Resident #22's catheter bag revealed it was on the floor next to her bed. Interview on 12/01/22 at 3:17 P.M. with LPN #902 confirmed urinary catheter bag should not be on the floor due to infection control purposes. LPN #902 stated it should be kept in the privacy bag on the residents' bed, wheelchair, or walker. Observation on 12/08/22 at 8:00 A.M. of Resident #22's catheter bag revealed the catheter tubing and drainage bag were draped over Resident #22's forearm. Interview on 12/08/22 at 8:05 A.M. with Resident #22 revealed she confirmed she frequently will carry her foley catheter tubing and drainage bag draped over her forearm. Resident #22 revealed she just does not care what other people think of her and she will do what she wants to. Interview on 12/08/22 at 11:30 A.M. with LPN #902 revealed she verified the catheter was not in a privacy bag and draped over the residents arm. Interview on 12/08/22 at 11:35 A.M. with Resident #22 revealed she places the catheter bag over her arm when walking with walker, she uses the privacy bag when in the wheelchair, and when in bed the catheter bag is placed on the floor. (continued on next page)

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	366195	A. Building B. Wing	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled Catheter Care, Urinary dated September 2014, revealed under section titled Infection Control number two, letter B. stated Be sure the catheter tubing and drainage bag are kept off the floor. 6. Record Review for Resident #33 revealed an initial admitted [DATE] with a recurrent hospital stay on 11/25/22 and returned to the facility on [DATE]. Resident #33's diagnoses included, C-Diff (a fecal infection), end stage renal disease, hypertension, hyperlipidemia, osteoporosis, vitamin B deficiency, peripheral vascular disease, aortic valve stenosis, dependent on renal dialysis, atrial fibrillation, type II diabetes mellitus, congestive heart failure, major depressive disorder, and spinal stenosis. Review of Resident #33's Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #33 had a severe cognitive impairment. Resident #33 needed extensive assist by two staff members for bed mobility, transfers, toileting, personal hygiene. Resident #33 needed extensive physical assist for dressing and eating. She was totally dependent on staff for bathing/showering. Review of Resident #33's physician orders dated December 2022, revealed Resident #33 had orders for probiotic acidophilus capsules (Lactobacillus) give one capsule by mouth one time a day for supplement, Vancomycin HCl capsule 250 mg, Give capsule by mouth four times a day for C-diff, and was on Contact Isolation every shift for C-diff for 10 Days. Observation on 12/01/22 at 8:21 A.M. revealed STNA #811 entered Resident #33's room who was in contact isolation due to a C-Diff infection. STNA #811 did not have on appropriate personal protective equipment (PPE) including gown and gloves. STNA #811 did have on a surgical mask and goggles which were required due to current COVID-19 guidelines. STNA #811 did not perform hand hygiene when entering the residents room. Review of contact isolation signage on Resident #33's door revealed all staff entering residents' room should have on appropriate PPE including a gown, gloves, mask, and goggles. Upon exiting the residents' room all staff were to perform appropriate hand hygiene with soap and water. Observation on 12/01/22 at 8:24 A.M. revealed STNA #811 exited Resident #33's room who was in contact isolation due to C-Diff infection. STNA #811 did not have on appropriate PPE while in residents' room and did not perform hand hygiene after caring for the resident and before exiting the room. Interview with STNA #811 on 12/01/22 at 8:25 A.M. revealed it was the second time in three years she had been on the 1300 hall and did not know if Resident #33 was in isolation or not. She confirmed the signage on the door stating resident was in contact isolation and the isolation PPE supplies directly outside of the residents room. STNA #811 confirmed she did not complete hand hygiene when entering or exiting the residents room, she then began to put on PPE including a gown and gloves to assist the resident.