STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365047	A. Building B. Wing	07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Community Village Healthcare Ctr	1800 Riverside Drive Columbus, OH 43212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, review of the beneficiary notices, staff interview, review of the State Operations Manual, and policy review, the facility failed to ensure residents were provided appropriate beneficiary notices when Medicare part A services were reduced or discontinued and the residents remained in the facility. This affected two residents (#24 and #30) out of three residents reviewed for beneficiary notices. The facility census was 34. Findings Include: 1. Review of the medical record for Resident #24 revealed an admitted on 01/10/23. Diagnoses included type II diabetes, Parkinson's, dementia, muscle weakness, and a history of falling. Review of Resident #24's census revealed the resident had a Medicare part A payer source from 01/10/23 until 03/13/23. Effective 03/13/23, Resident #24 changed to a private pay payer source and remained in the facility. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24 had impaired cognition and scored a ten out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #24 required extensive assistance from one to two staff to complete Activities of Daily Living (ADLs). Review of the Notice of Medicare Non-Coverage for Resident #24 revealed the residents' skilled services would end on 03/12/23. The notice was signed and dated 03/08/23. Review of the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review for Resident #24 revealed the resident had a Medicare part A skilled services episode with a start date on 01/10/23 and the last covered day of part A services was 03/12/23. The facility initiated the discharge from Medicare part A services when benefit days were not exhausted. Resident #24 did not receive an Advanced Beneficiary Notice (ABN) and remained in the facility. Review of the discharge summaries for physical and occupational therapies dated 03/10/23 revealed Resident #24 was discharged from therapies due to reaching the highest practical level. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/20/23 at 12:36 P.M., with the Rehabilitation Manager (RM) #74 confirmed Resident #24 was discharged from skilled services in March due to reaching maximum rehabilitation potential. Resident #24 had not exhausted all of his benefits when he was discharged from the services. RM #74 confirmed Resident #24 remained in the facility. 2. Review of the closed medical record for Resident #30 revealed an initial admitted on 04/12/23, a readmitted on 05/08/23, and a discharge date on 07/04/23. Diagnoses included osteomyelitis of the left shoulder, type II diabetes, arthritis in the left shoulder, fibromyalgia, difficulty in walking, muscle weakness, and chronic pain. Review of the Medicare Five Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 had intact cognition and scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #30 was independent to requiring supervision from staff to complete Activities of Daily Living (ADLs). Resident #30 received daily antibiotic medication. Resident #30 received intravenous (IV) medications. Resident #30 received occupational therapy and physical therapy with a start date on 05/09/23. Review of the census for Resident #30 revealed the resident had a Medicare part A payer source throughout her stay at the facility. Review of the physician orders dated June 2023 revealed Resident #30 had the following order: Cefazolin Sodium Injection Solution Reconstituted two grams (gm) with instructions to inject two gram via IV three times daily for infection until 06/29/23. Resident #30 had a peripherally inserted central catheter (PICC) line in place until 07/04/23 that was flushed once daily. Resident #30 had the following discharge order: may discharge to home with physical therapy, occupational therapy, home health aide, and nursing services on 07/04/23. Review of the discharge summaries for physical therapy and occupational therapy dated 06/30/23 revealed Resident #30 was discharged from physical therapy due to highest practical level being achieved on 06/30/23. Resident #30 was discharged from occupational therapy due to all goals were met on 06/30/23. Review of the Notice of Medicare Non-Coverage (NOMNC) for Resident #30 revealed the notice was signed and dated on 06/30/23 (the same day skilled therapies ended). Resident #30 was not provided with an Advanced Beneficiary Notice (ABN) notice and remained in the facility until 07/04/23. Interview on 07/20/23 at 12:55 P.M., with Rehabilitation Manager (RM) #74 confirmed Resident #30's IV antibiotics were discontinued effective 06/29/23 and the resident's physical and occupational therapies were discontinued on 06/30/23. RM #74 confirmed Resident #30 remained in the facility until 07/04/23. RM #74 stated Resident #30 remained a skilled resident until discharge on [DATE] due to having a PICC line in place that needed flushed once daily. RM #74 confirmed Resident #30 received a NOMNC on 06/30/23, the same day skilled therapies ended and did not receive a SNF ABN. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the State Operations Manual, Appendix PP, revised 02/03/23, revealed, the NOMNC is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. Furthermore, the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) must be given to a beneficiary for the following triggering event: in the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it reduces items or services to the beneficiary. In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or services. Review of the policy titled Notice of Medicare Provider Non-Coverage Policy, updated 04/2018 revealed the policy stated, A Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) will be issued to beneficiaries no later than two days before the termination or reduction of Medicare covered services and prior to the initiation of non-covered Medicare service.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on medical record review, staff interview, review of the self reported incidents, and policy review, the facility failed to ensure resident abuse, neglect and misappropriation allegations were thoroughly investigated. This affected four residents (#138, #142, #141, and #143) of six residents reviewed for abuse. The facility census was 34. Findings include: 1. Record review revealed Resident #143 admitted to the facility on [DATE] with diagnoses including aftercare following joint replacement surgery, stress fracture right ankle, alcohol abuse with alcohol-induced anxiety disorder, depression, atrial fibrillation, type 1 diabetes, and conductive bilateral hearing loss. Review of a self-reported incident (SRI) for an allegation of misappropriation revealed Resident #143 reported she had an iPad charger when she admitted to the facility but was no longer able to locate it. Resident #143's room was searched, as were surrounding rooms and the laundry room. The facility interviewed staff which lead to no reports of the missing iPad charger being seen. The facility stated the allegation of misappropriation was unsubstantiated after also interviewing six other residents with no concerns of missing property. Review of General Incident Investigation Packet revealed Resident #143 was agitated at the time of the incident. Investigation report also stated Resident #143 was alert and oriented when the incident occurred. Due to the allegation of misappropriation the facility staff received re-education on missing personal property, abuse, and completing a personal inventory sheet. The policy for Care of Resident Personal Items stated staff should attempt to place the resident's name on all items if possible. Then, the resident's personal items should be logged on the Inventory of Personal Effects sheet. Review of Resident #143's chart revealed no Inventory of Personal Effects sheet. Interview on 07/18/23 at 3:14 P.M. with Director of Nursing (DON) #10 revealed the facility did not replace Resident #143's iPad charger because her son had replaced it before they had a chance to. Facility did not reimburse resident's son for the new iPad charger. DON #10 also confirmed the facility did not complete an Inventory of Personal Effects sheet upon Resident #143's admission or after the allegation of misappropriate occurred and she became aware of the missing inventory form. Interview on 07/18/23 at 4:23 P.M. with Resident #143 revealed since her iPad charger had gone missing there has been no effort from the facility to reimburse her for the new one her family purchased. Resident #143 stated since the incident occurred, she had lost a blouse and reported it to therapy and housekeeping. Resident #143 stated the home supervisor came into her room to search for the missing blouse but it was never found and was not replaced. 44070 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for the Resident #138 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included epileptic seizures, respiratory failure with hypoxia, embolism, hemiplegia, metabolic encephalopathy and vascular disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #138 was cognitively intact with a BIMS of 15 and required extensive assistance of two staff members for transfers and mobility. Review of the plan of care dated 06/22/23 revealed Resident #138 had an activity of daily living (adl) self-care deficit with interventions of provide assistance with bathing including a sponge bath when a full bath was not tolerated, resident requires oral inspection, and to allow sufficient time for dressing. Review of the progress notes dated 03/27/23 revealed a progress note stating residents daughter spoke with staff about concerns including lack of care her mom received over the weekend and since admission. Family stated Resident #138 had not received a bath, have linens changed, oral care and changed clothes since admission. Progress note also stated these concerns were investigated and determined resident had worked with therapy and received a bath for admission and had linens changed after concern was reported. Review of the self-reported incident investigation number 233422 dated 03/27/23 revealed Resident #138's family reported concerns related to bathing, changing clothes, oral hygiene, and changing linens (ie: crumbs found in bed). The investigation summary stated the facility completed a record review and reported adls were provided. The investigation report included no evidence of the chart review or the reported findings. The investigation contained no evidence of staff interviews and resident interviews, resident skin assessments. The report documented staff were educated, but no evidence of education sign in sheets were provided. Interview on 07/19/23 at 4:55 P.M., with DON and Administrator acknowledged facilities lack of self-reported incident investigations and confirmed missing elements included staff and resident interviews and signed statements, skin and body assessments, interviews of other witnesses, evidence of chart reviews, education and review of the supporting evidence and documentation. 3. Review of the medical record for the Resident #141 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included fracture of left femur, kidney disease, and atrial fibrillation. Review of the Minimum Data Set (MDS) assessment dated ,d+[DATE] revealed Resident #141 was cognitively intact with a BIMS of 15 and required extensive assist of one to two staff for mobility and transfers. Review of the plan of care dated 05/17/23 revealed Resident #141 had a self care deficits. Review of the progress notes revealed no information related to neglect allegations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the self-reported incident investigation number 235323 dated 05/22/23 revealed Resident #141's family reported concerns of resident being afraid at night and reported a long call light wait time of 50 minutes. The investigation summary stated the facility spoke with the resident and she did not like the dark but was not fearful of staff and facility provided a night light for resident use. The investigation summary also reported a call light audit was completed and found a 50 minute call light was confirmed to have occurred on 05/20/23. The investigation report included no evidence of staff interviews and resident interviews, and resident skin assessments. The report staff was educated, but no evidence of education sign in sheets was provided. The report documented call light were audited but provided no evidence of the audits or findings. Interview on 07/19/23 at 4:55 P.M. with DON and Administrator acknowledged facilities lack of self-reported incident investigation and confirmed missing elements included staff and resident interviews and signed statements, skin and body assessments, interviews of other witnesses, education and review of the supporting evidence and documentation. 4. Review of the medical record for the Resident #142 revealed an admitted [DATE] and discharge 05/03/23. Diagnoses included osteomyelitis of right food and ankle, orthopedic joint implant, seizures, migraines, anxiety and weakness. Review of the Minimum Data Set (MDS) assessment dated ,d+[DATE] revealed Resident #142 was cognitively intact with a BIMS of 15 and required limited one person assist. Review of the plan of care dated 06/19/23 revealed Resident #142 had an activity of living self care self deficit requiring assist of two staff for activities of daily living. Review of the progress notes revealed no information related to neglect allegations. Review of the self-reported incident investigation number 235407 dated 05/25/23 revealed Resident #142 reported concerns of neglect of care. Concerns included showers, hydration, medications and treatments as ordered, oral care and accurate meals. The investigation summary stated the facility completed a chart review that disproved the concerns but provided no evidence of this information. The shower schedule was not marked off as completed or refused but as not applicable. For hydration, the Dietitic reported resident was provided with 60-72 ounces of fluids and required a minimum of 75 ounces. The investigation summary reported a record review was completed but provided no evidence or documentation from the record review to show evidence of the resident's claims/concerns being reviewed and discounted. The investigation report included no evidence of staff interviews and resident interviews, and resident skin assessments. The report stated staff was educated, but provided evidence of less than half of the staff completing any education sign in sheets. Interview on 07/19/23 at 4:55 P.M. with DON and Administrator acknowledged facilities lack of self reported incident investigations and provided understanding of missing elements including staff and resident interviews and signed statements, skin and body assessments, interviews of other witnesses, chart reviews, education and assessment and review of the supporting evidence and documentation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Abuse, Mistreatment, Neglect, Injuries of Unknown Source, dated 10/2016. The policy revealed the investigation would be completed within five working days. This shall include interview with the involved resident, the accused, and all witness. Witnesses generally included anyone who was involved or who heard of the incident, came in close contact with the involved resident including other residents, family, and staff working. If no direct witnesses were indicated, interviews should be expanded to cover employees working on the unit for shifts around when the incident occurred. The interviews shall be documented and the interviewee shall review and sign the statement. Obtain medical records including hospital records if indicated. The investigation and all evidence should be reviewed and maintained for the investigation.

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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** 47985 Based on medical record review, staff interview, and policy review, the facility failed to develop comprehensive care plans for resident specific care needs. This affected three residents (#13, #08, and #20) out of thirteen residents reviewed for comprehensive care plans. The facility census was 34. Findings include: 1. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnosis included fracture of the right acetabulum sequela, difficulty walking, moderate protein-calorie malnutrition, and adult failure to thrive. Review of Resident #13's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating an intact cognition for daily decision making abilities. Resident #13 required extensive assistance from one staff member for bed mobility and transfers. No impairments noted to residents bilateral upper or lower extremities. Resident #13 is noted to be frequently incontinent of bowel and bladder function. Resident #13 noted to have one stage one pressure ulcer which was present upon admission. Pressure wound interventions include turning and repositioning program, nutrition and hydration intervention and pressure ulcer injury care. Review of the plan of care dated 06/22/23 revealed Resident #13 had a stage one pressure ulcer to the coccyx. Interventions included applying barrier cream to the coccyx every shift and administer treatments as ordered along with weekly treatment documentation including measurement of each area of skin breakdown width, length, depth, type of tissue and exudate. Review of Resident #13's skin/pressure assessment dated [DATE] revealed resident had a stage three (a pressure wound with full thickness skin loss) pressure ulcer to the coccyx which was noted to be present upon admission. Measurements included 1.7 centimeter (cm) by 2.6 cm by 0.9 cm. Moderate amount of serous exudate noted and wound noted to be deteriorating. Review of Resident #13's physician orders revealed an order dated 06/27/23 for daily wound care for pressure to the coccyx. Order included to clean the wound with wound cleanser, apply Medihoney (a medical honey used to hasten the healing or wounds through its anti-inflammatory effects) and Calcium Alginate (used to keep the wound site moist enough for proper healing) to the wound bed, cover with a foam dressing daily and as needed. Interview on 07/20/23 at 1:20 P.M. with the Director of Nursing (DON) confirmed Resident #13's care plan related to pressure wounds and injures was not accurate and did not appropriately reflect the residents current pressure wound condition. 2. Record review revealed Resident #20 admitted to the facility on [DATE] with diagnoses including meningitis, acute diastolic congestive heart failure, hypertensive heart disease with heart failure, chronic respiratory failure, gastro-esophageal reflux disorder, obstructive sleep apnea, hypothyroidism, hyperlipidemia, unspecified dementia without behavioral disturbance, and osteoarthritis. (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 Resident #20's orders revealed an order for oxygen two liters via nasal cannula continuous and an order to apply continuous positive airway pressure (CPAP) machine every evening at bedtime. Review of Resident #20's respiratory care plan revealed the resident has oxygen therapy. Resident #20's care plan stated she receives oxygen via nasal cannula at two liters as needed. There were no indications Resident #20 wears a CPAP at bedtime. Interview on 07/17/23 at 11:46 A.M. with Resident #20 revealed staff have forgotten to apply her CPAP at bedtime which makes her weak. Interview on 07/20/23 with Director of Nursing (DON) #10 revealed 2:30 P.M. confirmed Resident #20 has an order for oxygen at two liters via nasal cannula continuously and the care plan states Resident #20 has oxygen at liters via nasal cannula as needed. DON #10 also confirmed Resident #20 has an order for her CPAP to be applied every evening at bedtime but there is no care plan to indicate she has a CPAP. 44070 3. Review of the medical record for the Resident #08 revealed an admitted [DATE]. Diagnoses included wedge fracture of lumbar vertebra, heart failure, chronic kidney disease, and fibromyalgia. Review of physician orders for 05/27/23 revealed oxygen tubing to be changed weekly on Saturday. Resident also had orders dated 05/27/23 for oxygen at two liters via nasal cannula to be provided. Review of the plan of care dated 07/03/23 revealed Resident #08 did not have a care plan for oxygen. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #08 was cognitively intact with a BIMS of 13 and required extensive assistance of two staff members for mobility and transfers. Observation on 07/17/23 at 12:03 P.M. revealed Resident #08's door did not have a Oxygen in use no smoking sign. STNA #23 confirmed Resident #08 did not have a no smoking sign, oxygen in use on the door. Interview on 07/19/23 at 3:06 P.M., with the Director of Nursing (DON) revealed oxygen was not care planned for Resident #08. The facility was unable to find a policy for resident care plans.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 The following deficiency represents an incident of past non-compliance that was subsequently corrected prior to this survey. Based on medical record review, staff interview, review of the fall investigation and witness statements, review of the hospital records, and review of the manufacturer recommendations for use, the facility failed to ensure a resident was safely transferred by a mechanical lift. This resulted in Actual Harm on 03/28/23 when Resident #07 was transferred from the bed to the wheelchair with the mechanical lift when the straps to the lift pad tore and Resident #07 dropped to the floor approximately two to three feet. Resident #07 complained of coccyx and buttock pain. Subsequently, Resident #07 was sent to the local hospital where he was diagnosed with a sacral fracture. This affected one resident (#07) of one resident reviewed for accident hazards. The facility census was 34. Findings include: Review of the medical record for Resident #07 revealed an admitted [DATE]. Diagnoses included osteomyelitis, chronic obstructive pulmonary disease, and a fracture of the sacrum 03/28/23. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #07 had mild cognitive impairment, required extensive assistance of two persons for bed mobility, and total dependence of two persons for transfer. Review of the progress note dated 03/28/23 at 11:00 A.M., revealed Resident #07 was being transferred from the bed to the wheelchair by the mechanical lift when the straps of the lift pad tore and the resident dropped two to three feet to the floor. Resident #07 complained of coccyx and buttocks pain at a 10 out of 10 on the scale of one to 10 with 10 being the worst pain. Resident #07 was transferred to the local hospital for evaluation. Review of the care plan dated 03/28/23 revealed to check Resident #07's lift pad prior to each use. Review of the hospital notes dated 03/28/23 revealed Resident #07 had a closed fracture of the sacrum status post a fall from a mechanical lift. Review of the fall investigation revealed Resident #07 required the use of an EZ Way Smart lift to transfer from the bed to the wheelchair. The straps on the mesh lift pad tore due to the resident being a large sized man. Registered Nurse (RN) #83 was called to the resident's room and found Resident #07 on the bars of the mechanical lift while also still on the lift pad. State tested Nurse Aides (STNA) #84 and #43 were witnesses and who also transferred Resident #07. Review of the witness statement of RN #83 dated 03/28/23 revealed when she entered the room two STNAs #84 and #43 were in the room. Resident #07 had fallen from the lift due to the straps of the mechanical lift tore. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the witness statement of STNA #84 dated 03/28/23 revealed STNAs #84 and #43 transferred Resident #07 with the mechanical lift and the lift pad broke in half and Resident #07 dropped to the floor. Review of the witness statement of STNA #43 dated 03/28/23 revealed STNAs #43 and #84 were transferring Resident #07 from the bed to the wheelchair when the mechanical lift pad broke in two different parts causing Resident #07 to drop to the floor. Interview on 07/20/23 at 1:34 P.M., with the Director of Nursing (DON) revealed she was not the DON at the time of the fall. The DON was able to produce the investigation for the fall where it documented the mechanical lift pad tore while using it and the corrective action taken. Interview on 07/20/23 at 1:54 P.M., with Medical Records Coordinator #49 revealed she now inspects the pads every week after the slings/lift pads were washed and completed the audit for the pads. Verified the facility used the regular basic sling and the deluxe sling at the facility from the EZ Way Inc. website. Medical Records Coordinator #49 said the audits were put in place after Resident #07 had the fall from the mechanical lift back in March 2023. Attempted interviews with RN #83 and State tested Nursing Aide #84 during the survey period. Both staff no longer worked at the facility at the time of the survey. Attempted interview with STNA #43 during the survey period and no return call was received. Review of the manufacturer's washable slings and harnesses important notice revised date 05/18/20 revealedthe following: This product is designed and manufactured to the highest possible performance specifications. It is constructed of high quality, durable, 100 percent synthetic fabrics. It has been individually inspected before shipping to ensure the safety of the product. However, water washing temperature, detergents and disinfectants, patient incontinence, frequency of use, types, and weights of patients, etc., all have an impact on the life expectancy of each product. Because of these factors, the continued integrity of the product is not guaranteed. The institution or private user must therefore examine the product to ensure its integrity before each use. EZ Way offers a 6-month warranty on slings and harnesses and recommends replacement after one year or if the sling or harness shows any sign of damage or wear. All slings and harnesses can bear a 1,000-pound weight load but must only be used to hold the amount of weight dictated by the lift or stand capacity. Accordingly, the PURCHASER hereby accepts full responsibility for checking the condition of all slings and harnesses before each use on a patient or client. As a result of the incident, the facility took the following actions to correct the deficient practice as of 03/29/23: On 03/28/23, Medical Records Coordinator #49 audited mechanical lift pads and removed five additional lift pads from use. On 03/28/23, the Interdisciplinary Team (IDT) comprehensive review was completed by the Administrator, the former DON #100, and Occupational Therapist (OT) #74 to put a plan in place to inspect all lift pads prior to use and remove from service if they were worn or frayed. New canvass lift pads were purchased. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/28/23 and 03/29/23, Staff Development Coordinator RN #29 provided all direct care staff education on the mechanical lift pads, the lifts, and inspection of the pad prior to each use. On 03/28/23, the DON/designee updated the care plan of Resident #07 to include inspection of the lift pad prior to use. On 03/28/23, the DON/designee audited all residents who required a mechanical lift and updated the care plan with interventions to inspect the lift pad prior to each use. On 03/28/23, Medical Records Coordinator #49 began audits to ensure the lift pads were in good repair after washing, and prior to use. Five lift pads were removed from service. Audits continued weekly and on 04/04/23 one additional lift pad was removed. Audits were presented and completed weekly and continue as of the annual survey. On 04/18/23, 10 additional new mechanical lift pads were put in service. .

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F 0692 Level of Harm - Minimal harm or potential for 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** 41271 Based on medical record review, staff interview, and policy review, the facility failed to ensure residents fluid intake was adequate to meet their nutritional needs. This affected one resident (#13) out of two residents reviewed for nutritional support. The facility census was 34. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnosis included fracture of the right acetabulum sequela, difficulty walking, moderate protein-calorie malnutrition, and adult failure to thrive. Review of Resident #13's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating an intact cognition for daily decision making abilities. Resident #13 required extensive assistance from one staff member for bed mobility and transfers. No impairments noted to residents bilateral upper or lower extremities. Resident #13 was frequently incontinent of bowel and bladder function. Resident #13 had one stage one pressure ulcer which was present upon admission. Pressure wound interventions include turning and repositioning program, nutrition and hydration intervention and pressure ulcer injury care. Review of the care plan dated 06/16/23 and revised 06/29/23 revealed Resident #13 had a nutritional problem or potential nutritional problem related to advanced geriatric age, right hip fracture, heart disease, congestive heart failure (CHF), anxiety, history of transient ischemic attach (TIA), abdominal aortic aneurysm, needing a mechanically altered diet, poor appetite, significant weigh loss, and varied intake. Interventions included to administer medication as ordered, honor food preferences as able, monitor, record, and report to physician any symptoms or signs of malnutrition, obtain and monitor lab values, and monitor and document intakes. Review of Resident #13's admission Skilled Nursing Facility (SNF) Nutritional assessment dated [DATE] revealed the resident was ordered a regular diet, mechanical soft texture, with nectar thin liquids. The residents current weight was 127 pounds and was 73 inches tall. Estimated needs with ideal body weight of 172 pounds due to underweight status. Daily recommended fluid intake was between 1955 ml to 2346 ml daily. Review of Resident #13's physician diet order revealed a order for a regular diet with mechanical soft texture food and thin consistency fluids ordered 06/28/23. Also noted an order dated 06/22/23 for Enlive (a nutritional support drink), give eight ounces with each meal for nutritional support and to promote weight gain. Review of Resident #13's fluid intake and nutritional supplement intake dated from 06/21/23 through 07/19/23 revealed the total daily intake was less than the required 1955 to 2346 ml required for the resident to maintain adequate fluid intake. Review of Resident #13's progress notes from 06/21/23 through 07/19/23 revealed no evidence of communication to the physician regarding the residents poor fluid intake. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/20/23 at 2:30 P.M., with the Director of Nursing (DON) confirmed Resident #13's fluid intake along with supplement intake was under the recommended amount and fluid intake was something the nursing staff should be monitoring to ensure each resident received and consumed their needed daily intake. If a resident was not getting the required fluids, then the physician would be contacted for recommendations and interventions. Review of the policy titled Evaluation of Hydration Needs, dated 01/2016 revealed 4) An interdisciplinary care plan shall be developed utilizing the clinical conditions and risk factors identified, taking into consideration the amount of fluid that the resident requires. The care plan shall be maintained to be a current reflection of status for each resident. 5) The interdisciplinary team shall work together to determine the resident's response to nutrition interventions. Revised nutrition interventions shall be implemented as needed to facilitate adequate hydration and health.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure residents oxygen tubing and humidifiers were labeled and dated. This affected three residents (#08, #20 and #148) out of three residents reviewed for respiratory services. The facility identified eight residents (#04, #06, #08, #11, #14, #20, #21, and #148) who were receiving oxygen. The facility census was 34. Findings include 1. Review of the medical record for the Resident #08 revealed an admitted [DATE]. Diagnoses included wedge fracture of lumbar vertebra, heart failure, chronic kidney disease, and fibromyalgia. Review of the physician orders dated 05/27/23 revealed Resident #08 had oxygen via nasal cannula at two liters per minute and to change oxygen tubing weekly on Saturday. Review of the plan of care dated 07/03/23 revealed Resident #08's oxygen was not care planned. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #08 was cognitively intact and required extensive assistance of two staff members for mobility and transfers. Observation on 07/17/23 at 12:03 P.M. revealed Resident #08's oxygen tubing and humidifier was undated. Observation and interview on 07/18/23 at 10:31 A.M., with the Unit Manager #24 verified the oxygen for Resident #08 had no date or labeling on the humidifier or oxygen tubing. 2. Review of the medical record for the Resident #148 revealed an admitted [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease, Pneumothorax, fib fracture, weakness and malnutrition. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #148's assessment had not been finalized. Review of the physician orders dated 07/15/23 revealed Resident #148 had oxygen via nasal cannula at a rate of two to four liters per minute. On 07/16/23 an order to change oxygen tubing weekly on Sunday. Review of the plan of care dated 07/17/23 revealed Resident #148 had no evidence of oxygen being care planned with follow-up or interventions. Observation on 07/17/23 at 10:45 A.M. revealed Resident #148's oxygen tubing and humidifier was not dated or labeled. Observation and interview on 07/18/23 at 10:31 A.M., with the Unit Manager #24 revealed the oxygen for Resident #148 had her oxygen tubing and humidifier dated of 07/17/23 but not labeled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47985 3. Review of the medical record revealed Resident #20 admitted to the facility on [DATE]. Diagnoses included meningitis, acute diastolic congestive heart failure, chronic respiratory failure, obstructive sleep apnea, and osteoarthritis. Review of Resident #20's physician orders dated May 2023 revealed an order for continuous oxygen at two liters per minute via a nasal cannula and to change the tubing every Sunday on evening shift. Observation on 07/17/23 at 11:46 A.M. revealed Resident #20 sitting in a wheelchair in her room while visiting with her daughter. Resident #20 was wearing oxygen via nasal cannula. The oxygen tubing was undated. Observation on 07/18/23 at 9:35 A.M. revealed Resident #20's oxygen tubing was undated. Interview on 07/18/23 at 9:35 A.M., with State tested Nursing Assistant (STNA) #23 confirmed Resident #20's oxygen tubing was undated. Interview with the Director of Nursing (DON) confirmed Resident #20 has an order for oxygen at two liters continuously via nasal cannula and the oxygen tubing should be changed every Sunday on evening shift. Review of a policy titled Oxygen Administration via Nasal Cannula-Nurse dated 06/2014 revealed oxygen orders must state the liter flow, duration of use, and specific wearing criteria such as parameters for use. The policy revealed once order is obtained and equipment is ready for use, explain the procedure the the resident, ensure the concentrator is administered as order, and label the oxygen tubing with the resident's name, date, and liter flow. Document the date and time services were rendered in the medical chart.

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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** 41271 Based on medical record review, resident and staff interview, and policy review, the facility failed to ensure the physician was updated on residents uncontrolled pain. This affected one resident (#13) out of three residents reviewed for pain management. The facility census was 34. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnosis included fracture of the right acetabulum sequela, difficulty walking, moderate protein-calorie malnutrition, chronic pain and adult failure to thrive. Review of Resident #13's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating an intact cognition for daily decision making abilities. Resident #13 required extensive assistance from one staff member for bed mobility and transfers. No impairments noted to residents bilateral upper or lower extremities. Resident #13 was frequently incontinent of bowel and bladder function. Review of the nursing note dated 06/13/23 at 1:32 P.M. created by a Licensed Practical Nurse (LPN) revealed Resident #13 complained of general pain at a score of 6 out of 10 on the numeric pain scale with 10 being the worse pain experienced. Resident #13 reported that the pain occurs multiple times a day. Review of the plan of care dated 06/14/23 revealed Resident #13 had the potential for acute pain or chronic pain due to a history of falls, acetabular fracture, rhabdomyolysis, anxiety and depression. Interventions included to administer pain medication as ordered, ensure non-medication interventions are ineffective, give medication before activities of therapy, educate resident on pain management treatment plan and on pain medication, and evaluate pain. Review of Resident #13's physician orders dated 06/16/23 revealed an order for oxycodone hydrochloride (hcl) (a narcotic pain medication) five milligrams (mg), half a tablet every four hours as needed for pain for seven days and then half a tablet every four hours as needed for pain. Also noted a order dated 06/21/23 for Tylenol eight hours for arthritis pain 650 mg, take one tablet three times a day for pain. Review of Resident #13's medication administration record (MAR) dated July 2023 revealed from 07/01/23 through 07/20/23 the resident had experienced pain almost daily with most days pain ranging from a five of 10 to a 10 of 10 on the numeric pain scale. Interview on 07/18/23 at 9:09 A.M., with Resident #13 revealed he was always in pain and no one was helping him. (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 07/20/23 at 2:30 P.M., with the Director of Nursing (DON) confirmed Resident #13's reported pain was noted as moderate to severe pain multiple times a day. The DON also confirmed there was a time when Resident #13's pain was not relieved after receiving pain medication. The DON verified the residents physician was not updated on his unrelieved pain and the need for additional or new pain management interventions. Review of the policy titled Pain Management Program, revised 01/2016 revealed, 2) Determine whether the resident's pain is acute, incidence, persistent, or a combination. Persistent pain may be defined as pain that last longer that 2-4 weeks, constant in nature, and multiple interventions or history of interventions have not been successful. Persistent pain is best treated with scheduled medication times. Avoid the use of as needed (PRN) medication whenever possible. 9) Evaluate and document the effectiveness of pain medication of pain medication on the Medication Administration Record (MAR) and pain progress notes in the electronic medical record. 10) Notify the physician if pain interventions are not effective.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on medical record review, review of the hospital continuity of care form, review of a pharmacy faxed correspondence, and interview, the facility failed to properly monitor a resident on antibiotics and prescribe medications as ordered. This affected one resident (#20) of two residents reviewed for antibiotic use. This had the potential to affect five residents (#09, #10, #13, #20, and #244) who were receiving antibiotics in the facility. The facility census was 34. Findings included: Record review revealed Resident #20 admitted to the facility on [DATE] with diagnoses including meningitis, acute diastolic congestive heart failure, hypertensive heart disease with heart failure, chronic respiratory failure, gastro-esophageal reflux disorder, obstructive sleep apnea, hypothyroidism, hyperlipidemia, unspecified dementia without behavioral disturbance, and osteoarthritis. Review of the hospital paperwork revealed Resident #20 started vancomycin 1000 milligrams every 12 hours for 14 days intravenously on 05/01/23 for treatment of meningitis. Resident #20 received her last dose of vancomycin at the hospital on 05/03/23 at 11:53 A.M. Instructions from the infectious disease physician revealed the stop date for vancomycin would be 05/13/23. Review of admission orders revealed an order on 05/04/23 for CBC w diff (complete blood count with differential), CMP (comprehensive metabolic panel), vancomycin trough one time a day every Thursday for labs, an order from 05/04/23 for vancomycin HCl Intravenous solution 1000 MG/10 ML (milligrams per milliliters) Use 1000 mg intravenously two times a day for meningitis with a start date of 05/05/23 which was discontinued on 05/04/23, an order from 05/04/23 for vancomycin HCl Intravenous solution 1000 MG/10 ML Use 1000 mg intravenously two times a day for meningitis for 14 days with a start date of 05/05/23 which was discontinued on 05/08/23, and an order from 05/08/23 for vancomycin HCl Intravenous solution 1000 MG/10 ML Use 1000 mg intravenously two times a day for meningitis until 05/19/23 with a start date of 05/08/23 and was discontinued on 05/16/23. Review of a fax from PharMerica revealed vancomycin one gram intravenously every 12 hours had a stop date of 05/13/23. Review of medication administration record (MAR) from May 2023 revealed Resident #20 did not receive the first dose of vancomycin on 05/05/23 and did not receive the second dose of vancomycin on 05/15/23. MAR indicated to check nursing notes for information about missed doses. MAR revealed Resident #20's last dose was at midnight on 05/16/23. Review of labs revealed Resident #20 had bloodwork drawn on 05/08/23 to check the vancomycin trough. Results were received by the facility on 05/08/23 and revealed Resident #20 had a vancomycin trough of 15. 6 milligrams per liter (mg/L) which was high. Lab results documented Patient drug level exceeds published reference range. Evaluate clinically for signs of potential toxicity. Reference range was listed as 10-15 mg/L. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes revealed no information on 05/05/23 regarding a missed dose of vancomycin. A provider progress note on 05/08/23 revealed Resident #20 missed a dose of vancomycin and after discussion with the Director of Nursing (DON) the vancomycin would be extended one dose. A provider progress note on 05/10/23 revealed the provider spoke with the clinical educator regarding labs needing faxed to the pharmacy for dosing of vancomycin. Provider continued note stating, labs were currently stable and states stop date for vancomycin is 05/13/23. A practitioner progress note dated 05/11/23 revealed facility was awaiting vancomycin trough labs and will adjust dose based on pharmacy recommendations. A nursing note on 05/15/23 stated, Resident was still on IV antibiotic. Interview on 05/20/23 at 8:58 A.M. with DON confirmed Resident #20 missed first dose of vancomycin at the facility as well as an additional dose on 05/15/23. The DON confirmed the original end date for vancomycin was 05/13/23 but was extended to 05/14/23 and the resident received four extra doses after receiving final dose the morning of 05/14/23. The DON confirmed there was no additional documentation from the physician, nurses, lab, or pharmacy to provide regarding vancomycin dosing. The DON confirmed Resident #20 only had one vancomycin trough drawn while receiving the antibiotic and her trough was high. The DON stated vancomycin should have been timed out until repeat labs were drawn to ensure Resident #20's labs returned to a safe level prior to restarting vancomycin. The DON #10 also confirmed the dose of vancomycin was not reduced after receiving high lab values. Review of the Antibiotic Time Out Policy dated 01/20/23 revealed review of treatment plans is recommended within a reasonable time after initiation of therapy to consider whether or not treatment is still indicated or to determine if de-escalation of therapy is viable. This also provides an opportunity for a provider to perform a retrospective audit of the initial prescribed regimen and rationale. The procedures portion of the policy stated the facility staff will review a patient's antibiotic treatment plan within blank hours of initiation of therapy or transfer to facility. Facility failed to determine a specific time period for the review.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, staff interview, observation, and policy review, the facility failed to ensure resident medications were administered with less than five percent error rate. There were two medication errors out of 25 opportunities for error with a calculated error rate of eight percent. This affected two residents (#11 and #17) out of four residents observed during medication administration. The facility census was 34. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with a re-entry date of 06/25/23. Diagnosis included joint replacement, atrial fibrillation, hypertension, hemarthrosis of the right hip, and muscle weakness. Review of Resident #11's medication administration record (MAR) for July 2023 revealed an order dated 07/20/23 for a slow-release iron oral tablet, extended release 160 milligrams (mg). Give one tablet by mouth once a day for iron deficiency. Review of Resident #11's MAR for July 2023 revealed Licensed Practical Nurse (LPN) #112 marked ON on the date 07/20/23 for the Slow Release Iron 160 mg tablet. Review of the nurses note dated 07/20/23 at 8:44 A.M. created by LPN #112 revealed, Slow-Release Iron Oral Tablet Extended Release 160 (50 Fe) mg. Give one tablet by mouth one time a day for iron deficiency. Not available. Observation on 07/20/23 at 8:45 A.M. of LPN #112 prepared medication for Resident #11 revealed the slow-release Iron tablet, 160 mg was not available for administration to the resident. Interview on 07/20/23 at 8:48 A.M., with LPN #112 revealed this was a newly ordered medication which had not arrived to the facility yet. LPN #112 claimed this certain medication was not available in the facility's emergency medication box and this medication could not be administered until it was delivered by the pharmacy. LPN #112 claimed the ON marked on Resident #11's MAR for 07/20/23 indicated to See Nurses Notes. 2. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnosis included cerebral infarction, type two diabetes, acute embolism and thrombosis, and seasonal allergies rhinitis. Review of Resident #17's physician order for July 2023 revealed an order for Zyrtec allergy 10 mg tablet, give one tablet daily for allergies. Review of Resident #17's MAR for July 2023 revealed on 07/20/23 LPN #44 marked ON in the area for the medication Zyrtec 10 mg tablet. Observation on 07/20/23 at 9:08 A.M. of LPN #44 prepared and administered medication for Resident #17 revealed the Zyrtec 10 mg tablet for allergies was not available for administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/20/23 at 9:10 A.M., with LPN #44 revealed this medication was not available for administration and she was going to mark it on the MAR not available. Interview on 07/20/23 at 2:30 P.M., with the Director of Nursing (DON) revealed Zyrtec is a medication that the facility supplies and it is always available as a over the counter medication. If the nurse ran out of this medication they could have went to the medication room to get a new bottle of this medication. Review of the facility policy titled Medication Administration, dated 06/2014 revealed, 11) Ensure newly ordered medications are available for administration for the next scheduled dose. 12) Give resident the correct medication, correct dosage, by correct route, and position resident properly.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 47985 Based on observation, staff interview and menu review, the facility failed to ensure diets met the needs of residents. This had the potential to affect four residents (#07, #10, #13, and #22) who received a mechanically altered diet in the facility. The facility census was 34. Findings included: Review of the menu for lunch on 07/19/23 revealed the facility planned to serve grilled cheeseburgers, grilled hot dogs on a bun, Boston baked beans, soft potato salad, creamy coleslaw, and fresh fruit salad. Observation of the tray line on 07/19/23 at 12:00 P.M. revealed residents receiving a pureed diet were receiving pureed hamburger, with no cheese or bun, served with one 3.25-ounce scoop, two ounces of baked beans, and a container of apple sauce. Residents' with a mechanical soft diet were served a chopped cheeseburger with no bun. Interview on 07/19/23 at 12:15 P.M. with Director of Dietary Services (DDS) #87 confirmed residents with a pureed diet did not receive a bun, coleslaw, sweet potato salad, or fruit cocktail and that residents receiving mechanical soft texture did not receive a bun with their chopped cheeseburger. Review of the spreadsheet for 07/19/23 revealed a resident receiving a regular diet with pureed texture were to be served a pureed cheeseburger or pureed hot dog on bun at six ounces, pureed baked beans at four ounces, pureed sweet potato salad, pureed creamy coleslaw, and pureed fruit cocktail. Resident on a regular diet with mechanical soft texture were to receive a cheeseburger cut up or a hotdog on bun at six ounces, three ounces of baked beans, four ounces of creamy coleslaw, and four ounces of fresh fruit. Review of recipes revealed a pureed diet should receive an eight-ounce scoop of cheeseburger or a four-ounce scoop of hotdog, four ounces of baked beans, four ounces of potato salad, four ounces of creamy coleslaw, and four ounces of fruit cocktail. Review of a policy titled Portion Control Guidelines dated 01/16 revealed portion sizes shall be denoted on standardized recipes, therapeutic diet spreadsheets, and production sheets.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47985 Based on observation, staff interview and menu review, the facility failed to follow the menu. This affected four residents (#07, #10, #13, and #22) out of four residents on a mechanical altered diet. The facility census was 34. Findings included: Review of the menu for lunch on 07/19/23 revealed the facility planned to serve grilled cheeseburgers, grilled hot dog on a bun, Boston baked beans, soft potato salad, creamy coleslaw, and fresh fruit salad. Observation of the tray line on 07/19/23 at 12:00 P.M. revealed residents receiving a pureed diet were receiving pureed hamburger, with no cheese or bun, served with 3.25-ounce scoop, two ounces of baked beans, and a container of apple sauce. Resident with a mechanical soft diet were served a chopped cheeseburger with no bun. Interview on 07/19/23 at 12:15 P.M., with the Director of Dietary Services (DDS) #87 confirmed residents with a pureed diet did not receive a bun, coleslaw, sweet potato salad, or fruit cocktail and that residents receiving mechanical soft texture did not receive a bun with their chopped cheeseburger.

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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. 47985 Based on observation, interview, review of the tray line temperature log, and policy review, the facility failed to serve foods at the appropriate temperature. This had the potential to affect all residents who ate food in the facility. The census was 34. Findings included: Observation on 07/19/23 at 11:33 A.M. revealed Diet Tech (DT) #90 taking the temperature of foods prior to meal service. DT #90 pulled a hot dog that was ready to serve from the tray line and its temperature was 150 degrees Fahrenheit (F). DT #90 tested two other hot dogs with temperatures of 140 degrees F and 120 degrees F. After reheating the hot dogs for eight minutes, the temperature was 168 degrees F. DT #90 taking the temperature of a hamburger patty from the tray line that was ready to serve and the temperature was 158 degrees F. DT #90 took the temperature of the coleslaw which was 53 F degrees and the fruit cocktail was 57 degrees F. Interview on 07/19/23 at 11:33 A.M. with DT #90 confirmed the hotdog temperature were 120 to 160 degrees F, the hamburger was 158 degrees F, the coleslaw was 53 degrees F, and the fruit cocktail was 57 degrees F. Review of Trayline Taste and Temperature Log revealed hot entrees should be served at 165 degrees F and cold items should be served between 36 and 38 degrees F. Review of a policy titled Recording Final Cooking Food Temperatures, dated 01/2016 revealed if the food item tested does not meet acceptable temperatures, the item shall continue to be cooked to the proper cooking temperature. If the food item does not meet acceptable temperatures and cannot be corrected prior to meal service, an appropriate menu substitution shall be assigned and served.

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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. 44070 Based on observation, resident and staff interviews, review of the meal times, and policy review, the facility failed to ensure meals were provided timely. This affected all 34 residents who ate meals in the facility. The facility census was 34. Findings include: Observation on 07/17/23 at 12:00 P.M. revealed a sign posted by dining room revealed lunch was to be served at 11:45 A.M. There were seven residents sitting in the dining room waiting for the meal service. Observation 07/17/23 at 12:20 P.M. no residents had received lunch meal trays in the dining room or room trays. Observation on 07/17/23 at 12:24 P.M. revealed the first of four meal carts was delivered to dining room. No drinks had been served prior to the meal tray arrival. Observation on 07/17/23 at 12:34 P.M. revealed staff started serving lunch trays to the residents. Observation on 07/17/23 at 12:34 P.M. revealed Residents #09 was sitting at the dining room table and had not received a lunch tray with all the other residents. Resident #27 was sitting at a separate table and also had not received his lunch tray. Interview on 07/17/23 at 12:36 P.M., with State tested Nursing Aide (STNA) #32 reported the kitchen had not sent a tray for Resident #09. STNA contacted the kitchen and had a tray brought brought for Resident #09. Resident #27's tray was in the warming cart. STNA #32 reported Resident #27 required assistance with eating and she would get his tray out when she was done feeding another resident. Observation on 07/17/23 at 12:42 P.M. revealed Resident #09 was served his lunch tray. Observation and interview on 07/17/23 at 12:45 P.M. revealed STNA #23 was passing out meal trays to resident rooms in the skilled unit and revealed the second to last tray had been passed out and only one remained. STNA #23 reported the final resident required some set up assistance. STNA #23 was observed to check on several lights and pass coffee and water refills to residents. At 12:58 P.M. Resident #244 was provided the meal tray STNA #23 confirmed lunch trays frequently came out late. Observation on 07/17/23 at 12:46 P.M. with STNA #32 revealed the STNA brought Resident #27's tray to him. At 12:53 P.M. a staff member came on unit and took Resident #27 away from table. Resident had not eaten anything yet, and had not had anyone assisting with eating yet. Observation on 07/20/23 at 12:22 P.M. revealed the first lunch cart arrived to the unit on 12:22 P.M. Prior to the arrival five residents were in the dining room waiting on their meals. At 12:25 P.M. staff began passing trays on the skilled unit and finished with the trays at 12:40 P.M. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 07/20/23 at 12:34 P.M. revealed the first tray arrived to the long term care (LTC) unit. Staff dropped off the cart and walked away without informing staff. The first tray was passed to a resident at 12:39 P.M. The second food cart was brought to the unit on 12:40 P.M. and was fully passed out at 12:49 P.M. Observation on 02/20/23 at 12:43 P.M. Resident #14 was brought out to the dining room in her geri chair. Resident #14 was reclined back around a 45 degree angle and was unable to reach her tray and and take the lids and covers off the food. Resident #14 was calling out for assistance with no staff in the near vicinity. At 12:50 P.M. Resident #14 received assistance from staff to get adjusted to a proper position and to have food uncovered. Resident #14 was able to feed herself once she received the set up assistance. Interview on 07/20/23 at 12:50 P.M. Resident #14 said she was hungry while waiting for the food to come and reported the food had a cold temperature. Review of the meal schedule revealed breakfast was scheduled for 7:45 A.M. lunch was scheduled for 11:45 A.M. and dinner was scheduled for 5:45 P.M. Review of facility policy titled Meal Tray Service,dated 01/2016 revealed once the cart arrives, the trays must be passed out timely. The policy does not include verbiage related to the timeliness of carts being delivered to the units. This deficiency represents non-compliance investigated under Complaint Number OH00144055.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, interview, and policy review, the facility failed to store and serve food in a sanitary manner to prevent potential contamination. This had the potential to affect all 34 residents who eat in the facility. Findings included: 1. Observation on [DATE] at 9:56 A.M. revealed an undated tub of coleslaw and an uncovered and undated container of fruit in the tray line refrigerator. Interview on [DATE] at 9:56 A.M. with Director of Dietary Services (DDS) #87 confirmed the coleslaw and fruit were not dated and the fruit was uncovered. 2. Observation on [DATE] at 9:58 A.M. revealed a large tub of flour which was undated. Interview on [DATE] at 9:58 A.M. with DDS #87 confirmed the tub of flour was undated. 3. Observation on [DATE] at 10:05 A.M. revealed a tray of bread and a box of freezer burnt chicken uncovered in the walk-in freezer. Interview on [DATE] at 10:05 A.M. with DDS #87 confirmed the tray of bread and box of freezer burnt chicken were uncovered. 4. Observation on [DATE] at 10:09 A.M. revealed one full half-gallon of buttermilk and one half-gallon of buttermilk with approximately 50 percent left had expired on [DATE], two five-pound containers of cottage cheese expired on [DATE], two two-pound blocks of goat cheese expired on [DATE], one box containing 20 32-ounce cartons of egg whites expired on [DATE], four four-pound bags of yogurt expired on [DATE], and two three-pound blocks of cream cheese expired in June of 2023. Interview on [DATE] at 10:15 A.M. with DDS #87 confirmed the buttermilk, cottage cheese, goat cheese, egg whites, yogurt, and cream cheese had expired. 5. Observation and interview on [DATE] at 10:25 A.M. revealed the ceiling in the dish area was leaking into clean dish water. DDS #87 confirmed the ceiling was leaking into clean dish water. 6. Observation on [DATE] at 11:40 A.M. revealed Dietary Aid (DA) #89 walking through tray line area without a hairnet. Interview on [DATE] at 11:40 A.M. with Dietetic #90 confirmed DA #89 did not have a hairnet on. 7. Observation on [DATE] at 11:46 A.M. revealed [NAME] #86 wearing gloves during tray line. [NAME] #86 used tongs to handle the hamburger patties, but used her gloved hands to handle the buns, lettuce, tomatoes, and pickles. [NAME] #86 walked to a refrigerator with her gloves still on, opened the refrigerator, came back to the tray line and proceeded to handle the food without changing gloves or washing hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 12:15 P.M. with DDS #87 confirmed [NAME] #86 did not change her gloves or wash her hands after touching the refrigerator. 8. Observation on [DATE] at 11:52 A.M. revealed [NAME] #88 coughing into her left elbow while her left hand touched her right shoulder as she was standing in front of the stove cooking hamburger patties. [NAME] #88 continued to work without changing gloves or washing hands. [NAME] #88 was standing next to the stove with her left hand on her hip while still wearing gloves. At 11:53 A.M. [NAME] #88 used her left hand, still gloved, to push her glasses up on her nose and continued cooking. At 12:05 P.M. [NAME] #88 did get new gloves and proceeded to cook while her left hand rested on her hip. Interview on [DATE] at 12:15 P.M. with DDS #87 confirmed [NAME] #88 had coughed into her left elbow and touched her right shoulder, nose, and hip while cooking and did not change gloves or wash her hands. DDS #87 stated, we will have in-services immediately after this. Review of the policy titled Dry Storage and Supplied, dated ,d+[DATE] revealed working containers holding food/ingredients that are removed from their original package for use shall be identified by the common name of the food and opened boxes or cans shall be stored in resealed containers/food bags that are labeled/dated. Review of the policy titled Storage of Potentially Hazardous Foods, dated ,d+[DATE] revealed meats and other potentially hazardous foods shall be dated, labeled, and properly covered or wrapped tightly. Review of the policy titled Refrigerated Storage revealed refrigerated items shall bear a label indicating product name and date product was received or first opened. Review of the policy titled Hand Hygiene Procedures revealed staff should wash hands before and after handling contaminated items, eating, sneezing, coughing, blowing, or wiping nose. Instructions for hand hygiene include rub hands together vigorously with soap, apply friction to all surfaces of the hands for at least 20 seconds, use moderate amount of water for rinse, dry hands thoroughly with paper towels, use a dry paper towel to turn off the faucet.

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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** 41266 Based on resident record review, observation, staff interviews, review of the infection control logs, and policy review, the facility failed to ensure infection control logs were completed for tracking trends and patterns. This had the potential to affect all 34 residents who reside in the facility. In addition, the facility failed to follow proper infection control policies and procedures during catheter care. This affected one resident (#24) of one resident reviewed for catheter care. The facility census was 34. Findings include: 1. Review of the Infection Control Logs dated April, May, and June 2023 revealed the logs lacked tracking of the disease organism, isolation type identification, and culture dates. For months May and June 2023, there was no mapping of the house-acquired infections (HAI) or mapping of the organism in the facility. For all three months, the logs did not indicate which infections were in-house acquired infections, did not include culture dates or isolation types, and were inconsistent with documenting signs and symptoms that appeared. Interview on 07/20/23 at 2:45 P.M. with the Director of Nursing (DON) confirmed the infection control logs were missing identification of HAI, tracking disease organisms, culture dates, and isolation types. The DON confirmed there was no mapping of infections or organisms for the months of May and June 2023. The DON had only been in the position for three weeks and had identified the infection control logs as an area of improvement and had already began revisions of the logs. Review of the facility policy, Infection Control-Monthly Infection Control Log-Guidelines, dated 10/2006, revealed the policy stated, the facility will ensure infections meet the approved criteria and gather the following information on all infections (community acquired and nosocomial (HAI): resident name, admitted , room number, unit or hall, type and/or site of infection, date of onset, date and results of culture, type of antibiotic therapy and date started, place a checkmark in the appropriate column indicating if the infection met the Centers for Disease Control (CDC) definition, state type of organism identified, and classification of infection (infectious, community acquired, nosocomial). 2 Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnosis included urinary tract infection, obstructive and reflux uropathy, retention of urine, and benign prostatic hyperplasia. Review of Resident #24's physician orders for July 2023 revealed a order to maintain a indwelling Foley catheter 16 French size 10 cubic centimeters (cc) balloon size to straight drain for diagnosis of urinary retention related to obstructive uropathy, and to provide catheter care daily and as needed. Review of Resident #24's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 indicated a moderately impaired cognition for daily decision making abilities. Resident #24 required extensive assistance from two staff members for toilet use, and required an indwelling catheter for urine elimination. (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 the plan of care dated 01/11/23 and revised 01/23/23 revealed Resident #24 had an indwelling urinary Foley catheter, 16 french 10 cc balloon for the diagnosis of obstructive uropathy, and urinary retention Interventions include to provide catheter care and to monitor for signs and symptoms of discomfort and infection. Observation on 07/19/23 at 2:34 P.M. of State tested Nursing Assistant (STNA) #32 completing catheter care for Resident #24 revealed infection control was not maintained during catheter care. STNA #32 was observed using the wet and soapy wash cloth to complete catheter care where after this was completed she placed the dirty wash cloth on the stand next to the residents bed. The STNA #32 then used the wet wash cloth to rinse off any soap followed by placing that dirty wash cloth on the stand beside the residents bed. The STNA #32 then used the dry hand towel to dry up any water and then used that hand towel to grab up the two wet and used wash cloths. Interview on 07/20/23 at 12:30 P.M. with the Director of Nursing (DON) revealed when catheter care or incontinence care is completed, the dirty or used wash cloth should have been placed in a bag and not on the bedside table. Review of the facility policy titled Catheter-Urinary-Care and Maintenance-Nurse Aide, dated 03/2019 revealed under Daily Indwelling Catheter Care, 6) Gently cleanse about three inches of the catheter from the urethra outward avoiding traction. 7) Rinse thoroughly and gently dry. 8) Check drainage bag and tubing for proper placement. 9) Remove gloves and place gloves and other used supplies in plastic bag. Wash hands.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 41266 Based on record reviews, staff interview, and policy review, the facility failed to monitor antibiotic use appropriately as part of an antibiotic stewardship plan. This had the potential to affect all 34 residents. The facility census was 34. Findings Include: Review of documents dated April, May, and June 2023, provided by the Director of Nursing (DON), revealed there was no documentation and analysis of appropriate indications for the use of antibiotics. Interview on 07/20/23 at 2:45 P.M. with the DON confirmed the facility used McGreer's criteria for the antibiotic stewardship program. The DON had no evidence how the facility was monitoring antibiotic medications using the McGreer criteria. The DON verified there was no documentation of an antibiotic stewardship program. The DON stated she had only been in the position for approximately three weeks and had identified antibiotic stewardship as an area of improvement for the facility. Review of the facility policy, Antibiotic Stewardship Program Policies and Procedures Annual Authorization, dated 01/20/23, revealed the policy stated, facility leadership commits to executing the Centers for Disease Control's (CDC) The Core Elements of Antibiotic Stewardship for Nursing Homes. Antibiotic Stewardship can be defined as any interdisciplinary activity that supports appropriate drug selection, dose, and duration of antibiotic use while reducing adverse events associated with antibiotic use. The DON duties included: oversee adherence to and enforcement of antibiotic prescribing practices and ensure proper communication templates are being used to document antibiotic use upon admission to the facility and during stay.