STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365268	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Wadsworth	147 Garfield St Wadsworth, OH 44281

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review and interview, the facility failed to invite one resident, Resident #60's, Power of Attorney (POA) to all care plan meetings. This affected one resident (#60) of one resident reviewed for care plan meetings. The facility census was 77. Findings include: Record review for Resident #60 revealed an admitted [DATE]. Diagnoses included muscle weakness, lack of coordination, hemiplegia and hemiparesis following cerebral infarction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired and dependent for activities of daily living. Interview on 04/23/24 at 9:39 A.M. with Resident #60's POA revealed she was only invited to two of Resident #60's care plan meetings. Resident #60's POA revealed she would prefer to attend all care conference meetings. Review of the Resident Care Conferences revealed Resident #60 was scheduled to have a quarterly care plan meeting on 05/05/24, 08/04/24, 12/06/24 and 03/10/24. Review of the quarterly Care Conference notes dated 12/06/24 and 03/10/24 revealed Resident #60's representatives were not present. Interview on 04/24/24 at 10:50 A.M. with Licensed Social Worker (LSW) #557 confirmed Resident #60 was scheduled to have a care plan meetings on 12/06/24 and 03/10/24. LSW #557 revealed notification of the scheduled care plan meetings to resident responsible parties were mailed out at the beginning of the previous month prior to when the care plan meeting was scheduled. LSW #557 revealed she made a list for the receptionist. The list consisted of each resident's name who was schedule to have a care plan meeting the following month. The invitation was then sent through the mail by the receptionist to each responsible party. There were no follow up calls made and no further notifications. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 04/24/24 at 11:00 A.M. with LSW #557 of the list provided to the receptionist dated as mailed 11/01/23 for the care plan meetings scheduled for the month of December revealed Resident #60's name was not on the list for the receptionist to mail the invitation to the care plan meeting for December 2023. LSW #557 revealed she was unsure what happened and confirmed Resident #60 was not on the list. Review of the list provided to the receptionist dated as mailed 01/19/23 for the care plan meetings scheduled for the month of March revealed Resident #60's name was the last name on the list.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, observation and interview, the facility failed to ensure the resident and/or responsible party was notified of changes in wound treatment and skin injury. This affected two (#26 and #60) of three residents reviewed for wounds. The facility census was 77. Findings include: 1. Record review for Resident #60 revealed an admitted [DATE]. Diagnoses included muscle weakness, lack of coordination, hemiplegia and hemiparesis following cerebral infarction. Review of Resident #60's face sheet revealed Resident #60 had a Power of Attorney (POA) for Health Care. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired, dependent for activities of daily living, and had no ulcers, wounds or skin problems. Review of the care plan for Resident #60 dated 05/04/23 revealed Resident #60 was incontinent of bowel and bladder and was at risk for skin breakdown. Interventions included to observe and report any noted redness, excoriation, or open areas with incontinence care. Observe protective pads, briefs for skin tolerance if used. Review of the physician order for Resident #60 dated 04/19/24 revealed to cleanse the right upper and anterior thigh with wound cleanser, pat dry, apply Xeroform (petroleum based gauze) and dry clean dressing, change every Tuesday, Thursday and Saturday. Review of the wound grid dated 04/16/24 completed by Assistant Director of Nursing (ADON)/Wound Care Nurse #505 revealed Resident #60 had an in-house wound observed 04/16/24 to the right upper lateral thigh. Further record review revealed the POA was not notified. Observation on 04/23/24 at 9:22 A.M. of wound care for Resident #60 completed by Wound Care Physician #599 and ADON/Wound Care Nurse #505 confirmed Resident #60 had wounds to the right thigh. Interview on 04/23/24 at 9:39 A.M. with Resident #60's POA revealed she was not made aware Resident #60 had any wounds. Interview and review of Resident #60's medical record including the wound grid (dated 04/16/24) on 04/23/24 at 2:25 P.M. with ADON/Wound Care Nurse #505 revealed the tape from Residents #60's incontinence brief was placed directly on Resident #60's skin and when removed caused abrasions. ADON/Wound Care Nurse #505 confirmed Resident #60's POA was not notified of the wounds to the right upper and anterior thigh. Per ADON/Wound Care Nurse #505 she had not had time to notify the POA yet. Interview on 04/23/24 at 03:36 P.M. with the Director of Nursing revealed residents' responsible parties should be notified of any changes in condition immediately if they were serious or within a shift if the change was not serious. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated Change in Resident's Conditions or Status policy revealed the nurse was to immediately notify the resident, consult with the resident's attending physician or on-call physician, and notify the resident's Authorized Representative or an interested family member when there was an accident or incident involving the resident which resulted in injury and had the potential for requiring physician intervention. 43063 2. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, chronic kidney disease and diabetes mellitus. Review of the wound provider's progress note dated 03/21/24 revealed Nurse Practitioner #597 was there to re-evaluate Resident #26's wound healing process and the resident's condition to define the treatments that would help the wounds continue the healing process. Wound #1 was to his right buttock and was noted to be a healed stage three pressure ulcer that was closed and intact. Nurse Practitioner #597 ordered a preventative treatment with Medihoney (has antibacterial properties and hastens the healing of wounds through anti-inflammatory effects) to the wound bed and to continue the treatment for a preventative dressing. Review of the physician's orders revealed Resident #26 had an order dated 03/23/24 for treatment to his buttocks, cleanse with wound cleanser, pat dry, apply Medihoney, and cover with a dry dressing. He also had an order dated 03/23/24 for Medihoney treatment to buttocks dated 03/23/24. Review of Resident #26's nursing assessments revealed there were no nursing assessments dated for 03/21/24 through 03/23/24 that would have included an update to the resident or his responsible party. Review of the nursing progress notes for Resident #26 revealed no documentation that Resident #26 or his responsible party were notified of the new physician's orders for treatment to buttocks. Interview on 04/22/24 at 3:36 P.M. with Assistant Director of Nursing (ADON) #505 verified staff did not notify Resident #26 and his responsible party of the new physician's orders for treatment to his buttocks on 03/23/24. Interview on 04/23/24 at 3:37 P.M. with the Director of Nursing verified notifications on changes with residents should be made timely and should be made within the same shift. Review of the facility policy titled, Change in Resident's Conditions or Status, undated, revealed the nurse would immediately notify the resident and notify the resident's authorized representative when there was a new form of treatment.

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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 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** 43063 Based on record review and interview, the facility failed to ensure residents were ambulated per physician order to maintain function abilities. This affected one (Resident #65) of two residents reviewed for restorative programs. The facility census was 77. Findings include: Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses including Parkinsonism (having the same symptoms of Parkinson's Disease), muscle weakness and age-related physical debility. Review of the admission Minimum Data Set 3.0 assessment dated [DATE] for Resident #65 revealed he had intact cognition, had no behaviors or refusals of care and was able to understand staff and be understood. Review of the Restorative Program Initial Observation dated 03/25/24 authored by Assistant Director of Nursing (ADON) #505 revealed therapy had referred Resident #65 for a restorative ambulation program related to weakness. Review of the physician's order dated 03/25/24 revealed a restorative program, staff were to encourage and assist Resident #65 to ambulate up to 326 feet with his walker with one staff member for 15 minutes a day, four to seven days a week as tolerated. Review of the point of care history (documentation completed by the aides) for April 2024 revealed Resident #65 was not offered to ambulate or there was no documentation for 04/03/24, 04/09/24, 04/10/24, 04/12/24, 04/13/24, 04/14/24, 04/15/24, 04/16/24, 04/17/24, 04/19/24, 04/21/24, 04/22/24 and 04/23/24. He was assisted with his ambulation restorative program only three days the week of 04/07/24 and two days the week of 04/14/24. Interview on 04/22/24 at 10:29 A.M. with Resident #65 revealed he was no longer receiving skilled therapy services from the facility. He stated since then, staff would not assist him to ambulate with his walker. Resident #65 stated he wanted to maintain his walking ability as long as possible. Interview on 04/24/24 at 10:05 A.M. with ADON #505 revealed therapy made recommendations and a physician's order was obtained for the restorative programs. The programs were to assist in maintaining a resident's abilities such as range of motion and ambulation. She verified the staff were not following the physician's order for Resident #65 on the dates listed above. Review of the facility policy titled, Restorative Nursing Care, updated April 2024, revealed the restorative program was provided for each resident, as indicated, to maintain their highest level of physical functioning. The restorative nursing program would be performed four to seven days a week as tolerated for residents who required those services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, and record review, the facility failed to follow physician orders regarding application of Tubigrip (a tubular stocking that provides compression) and elevation of an extremity and failed to ensure incontinence briefs fit appropriately and did not cause skin injury. This affected one (#60) of three residents reviewed for activities of daily living and one of four residents (#60) reviewed for incontinence care. The facility census was 77. Findings include: 1. Record review for Resident #60 revealed an admitted [DATE]. Diagnoses included muscle weakness, lack of coordination, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and aphasia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired and dependent for activities of daily living. Review of the care plan dated 05/04/23 revealed Resident #60 had potential for fluid imbalance/complications related to edema. Interventions included to evaluate edema. Review of the physician orders for Resident #60 revealed orders dated 03/18/24 to elevate right arm and Tubigrip to right upper extremity, on in A.M. and off at hs (night) also dated 03/18/24. Observation on 04/23/24 at 9:22 A.M. of wound care for Resident #60 with Wound Care Physician #599 and Assistant Director of Nursing (ADON)/Wound Care Nurse #505 revealed Resident #60's right hand was swollen. Resident #60's right hand was not elevated and there was no Tubigrip on the right upper extremity. ADON/Wound Care Nurse #505 confirmed the arm was not elevated, it was swollen and there was no Tubigrip on. ADON/Wound Care Nurse #505 revealed Resident #60's arm was paralyzed and he was unable to apply the Tubigrip or elevate the arm himself. Observation and interview on 04/23/24 at 3:12 P.M. with State tested Nursing Assistant (STNA) #513 confirmed Resident #60's right arm was not elevated and he did not have the Tubigrip on to the right upper extremity. Observation on 04/24/24 at 8:36 A.M. revealed Resident #60's right arm was not elevated and he did not have the Tubigrip on to the right upper extremity. Resident #60's right hand was very swollen. Observation and interview on 04/24/24 at 8:44 A.M. with Licensed Practical Nurse (LPN) #594 confirmed Resident #60's right arm was not elevated and he did not have the Tubigrip on to the right upper extremity. Resident #60's right hand was very swollen. LPN #594 revealed his hand was always like that, then left the room without attempting to elevate the arm or apply the Tubigrip. Interview at the nurses station with LPN #594 confirmed she did not attempt to elevate the arm or apply the Tubigrip. LPN #594 revealed Resident #60 did not like it. LPN #594 re-entered Resident #60's room and asked Resident #60 if she could elevate his arm. Resident #60 said, yes. LPN #594 elevated the right arm on a pillow and asked Resident #60 if he was comfortable. Resident #60 said, yes. LPN #594 then stated, Well I am just agency. LPN #594 did not offer or attempt to apply the Tubigrip. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/24/24 at 1:45 P.M. with State tested Nursing Assistant (STNA) #524 revealed she did not know Resident #60 was supposed to wear a Tubigrip. STNA #524 confirmed she was Resident #60's caregiver and worked with him frequently. After applying the Tubigrip, STNA #524 confirmed Resident #60 did not refuse the Tubigrip. Interview on 04/25/24 at 7:36 A.M. with the Director of Nursing (DON) confirmed Resident #60 had physician orders to include elevating the right arm and Tubigrip to right upper extremity, on in A.M. and off at hs, both dated 03/18/24. The DON revealed the order to elevate the right arm only showed up in the aids profile for Resident #60 and confirmed it did not require them to sign it off. The DON revealed the Tubigrip order was on the treatment record and was signed off in the A.M. and hs by the nurses daily as completed. 2. Record review for Resident #60 revealed an admitted [DATE]. Diagnoses included muscle weakness, lack of coordination, hemiplegia and hemiparesis following cerebral infarction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired, dependent for activities of daily living, had no ulcers, wounds or skin problems, and was always incontinent of bowel and bladder. Review of the care plan for Resident #60 dated 05/04/23 revealed Resident #60 was incontinent of bowel and bladder and was at risk for skin breakdown. Interventions included to observe and report any noted redness, excoriation, or open areas with incontinence care. Observe protective pads, briefs for skin tolerance if used. Review of the physician orders for Resident #60 dated 04/12/24 revealed cleanse right hip with wound cleanser, pat dry, apply chamosyn, clean dry dressing, do not tape to secure. Review of the physician order dated 04/18/24 revealed treatment to right upper and anterior thigh included cleanse with wound cleanser, pat dry, apply Xeroform (petroleum based gauze) clean dry dressing once a day on Tuesday, Thursday and Saturday and as needed. Observation on 04/23/24 at 9:22 A.M. of wound care for Resident #60 with Wound Care Physician #599 and Assistant Director of Nursing (ADON)/Wound Care Nurse #505 revealed three wounds to the right thigh. Observation revealed there were also eight healed scarred areas surrounding the three open areas. ADON/Wound Care Nurse #505 revealed the scarred areas and open areas were caused from the tape on Resident #60's incontinence briefs. Interview on 04/23/24 at 2:25 P.M. with ADON/Wound Care Nurse #505 revealed the wounds to Resident #60's thigh were caused by the tape on the briefs being placed directly on Resident #60's skin. When the tape was removed it caused abrasions to his skin. ADON/Wound Care Nurse #505 revealed nothing had been done to prevent further injury caused by the tape from the incontinence briefs and confirmed the briefs were not looked at for resizing and there was no education completed to staff regarding placing the tape on the brief, not the skin. Observation on 04/23/24 at 3:12 P.M. with State tested Nursing Assistant (STNA) #513 revealed Resident #60 was wearing a medium incontinence brief and the brief on the right side was taped to Resident #60's skin right on top of a current red area. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/23/24 at 3:36 P.M. with Director of Nursing (DON) confirmed there was no education provided to staff within the last four months or since Resident #60 had repeated abrasions related to the tape on the briefs applied to his skin. The DON revealed he would have expected staff to address the cause of the wounds to prevent continued injuries. The DON was unsure of the process for sizing briefs Observation, interview, and review of Resident #60's record on 04/23/24 at 4:03 P.M. with the DON revealed the packaging on the incontinence briefs (provided by the facility) had a height and weight chart on the back of the package. The DON confirmed Resident #60's briefs were provided by the facility and according to Resident #60's height and weight, Resident #60 should have been wearing a large brief.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview and record review, the facility failed to follow orders and implement new orders for a resting hand splint for one resident (#60) of one resident reviewed for splints. The facility census was 77. Findings include: Record review for Resident #60 revealed an admitted [DATE]. Diagnoses included muscle weakness, lack of coordination, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired and dependent for activities of daily living. Review of the care plan dated 05/04/23 revealed Resident #60 had potential for fluid imbalance/complications related to edema. Interventions included to evaluate edema. Review of the physician orders for Resident #60 revealed an order dated 05/23/23 for a resting hand splint to the right hand during hours of sleep four to six hours every shift. Observation on 04/23/24 at 9:22 A.M. of wound care for Resident #60 with Wound Care Physician #599 and Assistant Director of Nursing (ADON)/Wound Care Nurse #505 revealed Resident #60 did not have a resting hand splint on the right hand. ADON/Wound Care Nurse #505 confirmed Resident #60 was unable to move his right arm and was unable to apply the splint himself. Observation on 04/24/24 at 8:36 A.M. of Resident #60 revealed the resting hand splint to the right hand was not on. Interview on 04/24/24 at 9:09 A.M. with State tested Nursing Assistant (STNA) #524 confirmed Resident #60 did not have a resting hand splint on the right hand. STNA #524 revealed the hand splint was to be applied at 12:00 P.M. and removed when she left her shift at 3:00 P.M. Observation and interview on 04/24/24 at 1:45 P.M. with STNA #524 confirmed Resident #60 did not have his right hand splint on. STNA #524 revealed she forgot to apply the hand splint. Interview on 04/24/24 at 1:47 P.M. with Licensed Practical Nurse (LPN) #594 confirmed Resident #60 did not have the right hand splint on and revealed she thought it was to be worn during the night shift only. LPN #594 verified the order was for every shift. Interview on 04/24/24 at 2:15 P.M. with LPN #594 revealed she again read the order for Resident #60 wrong for the right hand splint. LPN #594 revealed the order read while sleeping so she would have to wait until he was sleeping then she could put it on but if he woke up while she was putting it on, she would have to stop because she could not put it on because he was awake because the order read while sleeping. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/24 at 2:30 P.M. with the Director of Nursing (DON) verified the order for Resident #60 for the right hand splint was written for every shift on 05/23/23. The DON revealed Resident #60 did not get out of bed and he slept on and off throughout the day taking frequent naps. The DON confirmed he was unable to find the original recommendation from therapy to confirm the splint should be on every shift. Interview and record review for Resident #60 on 04/24/24 at 2:30 P.M. with the DON and Occupational Therapy Assistant (COTA) #604 revealed per COTA #604 that the order for Resident #60's resting hand splint to the right hand written 05/23/23 was no longer in place. COTA #604 revealed that splint was discontinued on 04/10/24 and a new order was written for a different splint. COTA #604 presented a copy of the form titled Inservice/Meeting for Resident #60 dated 04/10/24 which revealed Resident #60 was to utilize right volar inflatable resting hand splint at night up to six hours. Perform passive range of motion to entire upper extremity prior to donning and at removal, skin check every two hours with wear. Place forearm on flat part of splint, wrap fingers around inflated portion of the splint. Strap over knuckles with slit allowing access to inflate valve. Wrap remaining two straps around the forearm. The form was signed on the 7:00 A.M. to the 3:00 P.M. shift by two unknown staff members. The DON confirmed they were nursing staff members. COTA #604 verified Occupational Therapist (OTR) #606 signed and verified the order to be implemented 04/10/24. COTA #604 revealed and the DON confirmed this was how the therapy orders were completed, the new order was written on the form, given to the nurse, the nurse put the new order in to the electronic medical system as the order to be followed. The DON confirmed the order was not completed by the nursing staff who signed the form which resulted in the order not being implemented as it should have been on 04/10/24.

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F 0690 Level of Harm - Minimal harm or potential for 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** 36650 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure Resident #21's urinary catheter bag was placed below his bladder at all times. This affected one (#21) of four residents reviewed for bowel and bladder/incontinence care. The facility census was 77. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnosis included neuromuscular dysfunction of the bladder. Review of the physician order with a start dated on 03/30/24 revealed suprapubic catheter to straight drain for neuromuscular dysfunction of bladder. Review of the plan of care dated 01/09/24 revealed interventions included resident would not develop complications related to Foley (urinary) catheter such as urinary tract infection. Keep drainage bag below bladder and off of the floor. Observation of Resident #21 on 04/22/24 at 11:27 A.M. revealed his urinary catheter drainage bag was lying on the bed with clear yellow urine in the tubing and in the drainage bag. The urinary catheter drainage bag was not positioned below Resident #21's bladder. Observation of Resident #21 on 04/22/24 at 3:20 P.M. revealed Resident #21 resting in bed with eyes closed with the urinary catheter drainage bag lying on the bed above Resident #21's bladder. The catheter drainage bag was full of clear yellow urine. Interview on 04/23/24 at 11:11 A.M. with Licensed Practical Nurse (LPN) #538 revealed Resident #21 had a urinary catheter related to a neuromuscular neurogenic bladder. Resident #21 had a suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder) and his urinary drainage bag laid on his bed all the time. LPN #538 indicated the urinary drainage bag should be hanging below his bladder. LPN #538 stated if the catheter bag was not kept below the bladder the urine would back up in his bladder and could cause an infection. Interview on 04/23/24 at 2:07 P.M. with Resident #21 revealed he had a Foley catheter for [AGE] years and he knew the drainage bag should be below the bladder. Resident #21 stated the suprapubic catheter was created three weeks ago and since then the drainage bag had always been positioned on the bed and not below his bladder. Interview on 04/23/24 at 2:15 P.M. with Director of Nursing (DON) verified Resident #21's suprapubic catheter drainage bag was laying on Resident #21's bed, and above his bladder. The DON indicated urinary catheter drainage bags should be below the bladder, hanging off the side of the bed. Review of the facility's undated policy Catheter Care, Urinary, revealed the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and policy review, the facility failed to provide enteral nutrition per physician's order. This affected one (#60) of one resident reviewed for enteral nutrition. The facility census was 77. Findings include: Record review for Resident #60 revealed an admitted [DATE]. Diagnoses included esophagitis, gastroparesis, and dysphagia, oropharyngeal phase, and hemiplegia and hemiparesis following cerebral infarction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired, dependent for activities of daily living, and received tube feeding. Review of the care plan dated 05/05/23 for Resident #60 revealed Resident #60 was at risk for altered nutrition related to a diagnosis of recent stroke with percutaneous endoscopic gastrostomy (peg) tube placement (feeding tube). Resident #60 received nothing by mouth (NPO) and was dependent on tube feed for nutrition and hydration. Interventions included to provide diet per physician order, NPO, see tube feed and water flush orders. Review of the physician order dated 11/13/23 for Resident #60 revealed enteral feeding formula Peptamen 1. 5 to run at 65 milliliters (ml) per hour (hr) to run for 18 hours, on at 6:00 A.M. until 12:00 A.M., off six hours 12:00 A.M. until 6:00 A.M. Observation on 04/25/24 at 7:30 A.M. revealed Resident #60 was lying in bed. Resident #60's tube feeding was not running. Interview on 04/25/24 at 7:31 A.M. with Licensed Practical Nurse (LPN) #515 verified she was Resident #60's nurse. LPN #515 confirmed Resident #60's tube feeding was not running. Observation on 04/25/24 at 9:11 A.M. revealed Resident #60 was lying in bed and his lips and mouth had a thick, dry, pasty film. Resident #60's tube feeding was not running. Interview with LPN #515 at the time of the observation revealed Resident #60's tube feeding was only to run from 12:00 A.M. to 6:00 A.M. LPN #515 confirmed Resident #60's lips and mouth had a thick, dry, pasty film. Upon review of Resident #60's physician orders with LPN #515, LPN #515 confirmed Resident #60's tube feeding was to run from 6:00 A.M. until 12:00 A.M., off six hours 12:00 A.M. until 6:00 A.M. Review of the facility's undated policy Enteral Nutrition revealed it was the facility policy to ensure adequate nutrition support through enteral feeding would be provided to residents unable to consume adequate nutritional intake by mouth. Enteral feeding orders would be written to consistent volume infusion.

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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** 42011 Based on observation, interview and record review, the facility failed to monitor oxygen saturation levels for residents receiving continuous and as needed oxygen. This affected three residents, Residents #26, #31 and #60 of six residents reviewed for oxygen therapy. The facility census was 77. Findings include: 1. Record review for Resident #60 revealed an admitted [DATE]. Diagnoses included muscle weakness, esophagitis, lack of coordination, hemiplegia and hemiparesis following cerebral infarction, atherosclerotic heart disease and emphysema. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was severely cognitively impaired, dependent for activities of daily living, and had medically complex conditions. Review of the care plan for Resident #60 dated 05/04/23 revealed Resident #60 had alteration in respiratory function related to emphysema and former smoker. Interventions included to administer oxygen as ordered. Review of the physician orders dated 03/25/24 for Resident #60 revealed an order for oxygen at two liters per nasal cannula as needed (PRN) to keep saturation of peripheral oxygen (SP02) greater than 92 percent. Review of Resident #60's medical records revealed two oxygen saturation levels were assessed for the month of April 2024, 04/16/24 and 04/11/24. Interview on 04/24/24 at 5:00 P.M. with the Director of Nursing (DON) verified Resident #60's order for oxygen at two liters per nasal cannula PRN to keep SP02 greater than 92 percent. The DON revealed oxygen saturation levels were to be assessed every shift for residents with an as needed order to keep the SP02 above the ordered given level. Observation on 04/24/24 at 5:07 P.M. revealed the DON obtained Resident #60's SPO2 level which was 90 percent on room air. Interview on 04/25/24 at 9:38 A.M. with Certified Nurse Practitioner (CNP) #595 revealed she only wrote as needed oxygen orders for residents to keep there oxygen saturation level above a specified level if the resident was having problems. CNP #595 confirmed saturation levels were to be checked every shift to assess and monitor the saturation level. 36650 2. Review of the medical record for Resident #31 revealed Resident #31 had intact cognition. Diagnoses included chronic obstructive pulmonary disease with (acute) exacerbation, acute bronchitis, unspecified, and dependence on supplemental oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders from 04/01/24 through 04/25/24 revealed an order for continuous oxygen at two to four liters per nasal cannula, check placement, record oxygen saturation every shift. Review of the vital signs documentation from 04/01/24 through 04/25/24 revealed Resident #31's oxygen saturation was last documented on 04/05/24. Review of Treatment Administration Record (TAR) for April 2024 revealed continuous oxygen at two to four liters per nasal cannula, check placement, record oxygen saturation every shift. The TAR did not include a record of Resident #31's oxygen saturation every shift. Interview on 04/24/24 at 5:00 P.M. with the Director of Nursing (DON) verified Resident #31 physician order for oxygen continuous at two to four liters, per nasal cannula, check placement and record oxygen saturation every shift. The DON also verified Resident #31's oxygen saturation was not being checked and recorded in the medical record as ordered. The DON indicated oxygen saturation levels were to be assessed every shift to monitor oxygen saturation for residents with orders for continuous or as needed oxygen. Interview and observation on 04/25/24 at 10:15 A.M. with Resident #31 revealed the nurses did not check his oxygen saturation every shift, maybe once a day. Interview on 04/25/24 at 10:18 A.M. with Licensed Practical Nurse (LPN) #595 confirmed Resident #31 had an order for continuous oxygen and to check his oxygen saturation every shift; however it was not being done and there was no place to record the oxygen saturation levels. 43063 3. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, chronic kidney disease and diabetes mellitus. Review of the care plan for Resident #26 dated 12/21/18 revealed he was at risk for cardiovascular impairment due to diagnoses of hypertension and atrial fibrillation. Interventions included to administer oxygen as ordered. Review of the physician's orders revealed Resident #26 had an order dated 12/01/20 for oxygen one to four liters nasal cannula as needed if pulse oximeter was below 92 percent or shortness of breath. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2024 revealed nursing had not documented a pulse oximeter reading since 04/03/24. Review of the vitals record from 04/05/24 through 04/25/24 for Resident #26 revealed nursing staff had not assessed his oxygen saturation level since 04/05/24. Interview on 04/24/24 at 5:00 P.M. with the Director of Nursing (DON) verified Resident #26 had an order for oxygen one to four liters nasal cannula as needed if pulse oximeter was below 92 percent or shortness of breath. The DON stated oxygen saturation should be assessed every shift to monitor oxygen saturation levels for residents on oxygen as needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure dialysis residents were monitored after dialysis treatments. The facility also failed to maintain communication with the dialysis center. This affected one (#16) of one resident reviewed for dialysis. The facility census was 77. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including end stage renal disease. Review of the physician's order dated 03/30/24 revealed Resident #16 received dialysis on Tuesdays, Thursdays and Saturdays. Review of Resident #16's dialysis assessments revealed he did not have post-dialysis assessments on 04/06/24, 04/09/24, 04/11/24, 04/18/24 and 04/20/24. Review of Resident #16's medical record revealed there was no documentation received from the dialysis center for Resident #16 from 03/30/24 through 04/22/24. Interview on 04/23/24 at 2:44 P.M. with Dialysis Nurse #598 revealed the facility did not send communication with Resident #16 at times and never required any information to be sent back to the facility from the dialysis center. Interview on 04/23/24 at 3:08 P.M. with the Director of Nursing (DON) verified the nursing staff were to perform dialysis assessments prior to the residents going to dialysis and after returning. The post-dialysis assessments were to include the residents return date and time to the facility, mental status, vitals signs, skin assessment, dialysis access site assessment, lung sounds, edema, if pain was present and if there were any new orders from the dialysis center. The DON verified the nursing staff had not performed assessments on the dates listed above and verified there was no documentation received from the dialysis center for Resident #16 since 03/30/24. Review of dialysis center documentation provided by Registered Nurse (RN) #596 on 04/23/24 at 3:44 P.M. for Resident #16 revealed the facility had received the documentation from the dialysis center via fax on 04/23/24 at 3:44 P.M. Review of the facility policy titled, Dialysis Care Planning Policy, undated, revealed the dialysis center would send reports from the resident's dialysis treatments to the facility after each visit. Upon return to the facility following dialysis, the nurse was to perform a complete body check and observe the dialysis site for any complications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, interview, and review of facility policy, the facility failed to ensure the physician's order for an as needed psychotropic medication had a time-frame for usage for Resident #13. This affected one resident (#13) of six residents reviewed for unnecessary medications. The facility census was 77. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, dementia with anxiety, major depressive disorder, and psychotic disorder with delusions. Review of the Psychotropic Medication Regimen Evaluation, dated 03/04/24, revealed a gradual dose reduction (GDR) would be attempted for Ativan. Resident #13's new orders included Change routine Ativan to 0.5 milligrams (mg) twice daily (BID) and add Ativan 0.5 mg as needed (PRN) with no stop date to monitor PRN usage and GDR attempt. Review of the physician's orders for April 2024 identified orders for Ativan 0.5 mg as needed ordered on 03/04/24 with no end date. On 04/24/24 at 11:19 A.M., interview with Registered Nurse (RN) #545 verified Resident #13 had a PRN order for Ativan and stated she had never administered the PRN dose of Ativan for Resident #13. On 04/24/24 at 4:30 P.M., interview with the Director of Nursing (DON) verified Resident #13's PRN order for Ativan did not have an end date and stated the physician had discontinued the order on 04/24/24. Review of facility policy titled Behavior Management Policy, not dated, revealed PRN orders for psychotropic medications would be limited to 14 days unless the prescribing practitioner believed it was appropriate for the PRN order to be extended beyond 14 days. Their rationale would be documented in the medical record and the duration for the PRN order would be indicated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43063 Based on record review and interview, the facility failed to ensure accurate documentation in the medical record for residents. This affected two (#26 and #40) of 26 residents reviewed. The facility census was 77. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, chronic kidney disease and diabetes mellitus. Review of the physician's orders revealed Resident #26 had an order dated 11/09/23 for Medihoney to his left buttock, cleanse with wound cleanser, pat dry, apply Medihoney and cover with dry dressing twice a day. This order had a discontinue date of 01/16/24. Review of the wound provider's progress note dated 12/14/23 revealed Nurse Practitioner (NP) #597 had assessed Resident #26 for a left buttock abrasion. NP #597 documented the wound was intact and healed. NP #597 provided an order for staff to gently cleanse the wound, pat dry, apply Medihoney (treatment for the management of wounds and burns that help in the management of chronic and stalled wounds and to assist in debridement of necrotic tissue) to the wound bed and place a dry clean dressing twice daily and as needed for one week as a preventative. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #26 revealed staff continued to perform treatments to the left buttock 12/21/23 until 01/16/24 when the order was discontinued. Review of the nursing progress notes for Resident #26 revealed no documentation as to why Resident #26's treatment to the left buttock with Medihoney continued when NP #597 had indicated the treatment should be discontinued one week after her assessment on 12/14/23. Review of the wound provider's progress notes dated 03/21/24 and 03/28/24 revealed NP #597 signed and reviewed the progress notes on 04/22/24 at 4:54 P.M. The provider's progress notes were provided on 04/23/24 at 8:49 A.M. by Registered Nurse (RN) #596. Review of the physician's orders from April 2024 revealed Resident #26 had an order dated 03/23/24 for treatment to his buttocks, cleanse with wound cleanser, pat dry, apply Medihoney, and cover with a dry dressing. He also had an order dated 03/23/24 for Medihoney treatment to buttocks dated 03/23/24. Review of Resident #26's nursing assessments (observations) revealed there were no nursing assessments dated for 03/21/24 through 04/22/24 to indicate why he had a physician's order for Medihoney to his buttocks. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #26's nursing progress notes dated from 03/04/24 through 04/11/24 revealed no indication as to why he had an order dated 03/23/24 for Medihoney to his buttocks. There were no progress notes dated from 04/11/24 through 04/23/24 when the report was ran on 04/23/24 at 9:09 A.M. Interview on 04/23/24 at 1:30 P.M. with Assistant Director of Nursing (ADON) #505 verified NP #597's order had not been followed to discontinue the preventative treatment for Medihoney to Resident #26's left buttock wound one week after her assessment on 12/14/23. She was unsure why the order had continued until 01/16/24. Additional interview on 04/22/24 at 3:36 P.M. with ADON #505 verified Resident #26 had a stage two pressure ulcer that had been identified on 04/19/24. ADON #505 stated she had not placed any documentation into his medical record as she had not had time. Interview on 04/23/24 at 1:30 P.M. with RN #596 verified NP #597's wound progress notes were not in the electronic medical record for 03/21/24 and 03/28/24. 36650 2. Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnosis included Alzheimer's disease and weakness. Review of the physician orders for April 2024 revealed cleanse left buttock with normal saline, pat dry, apply Medihoney, alginate silver, lightly fill wound bed with alginate silver and cover with dry dressing. Another order indicated cleanse sacrum with normal saline, pat dry, apply alginate lightly fill wound, do not pack and cover with dry dressing. Review of the April 2024 Treatment Administration Record (TAR) revealed both treatments were signed off as being completed. Observation on 04/23/24 at 10:34 A.M. of Resident #40's wound with Registered Nurse (RN) #505 and Wound Physician #599 revealed there was one pressure ulcer on the sacrum. There was not a pressure ulcer on the left buttock. Interview on 04/23/24 at 10:42 A.M. with RN #505 revealed the left buttock and sacrum were the same pressure ulcer; the left buttock ulcer was renamed a sacrum ulcer. RN #505 stated when the pressure ulcer got changed to sacrum the treatment order for the left buttock was not discontinued, so there were two different orders for the same area. RN #505 verified the current treatment orders were not correct because she forgot to discontinue the left buttock order and staff were marking both treatments as being completed. RN #505 verified Resident #40 medical record was not accurate.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44808 Based on record review and interview, the facility failed to have the designated infection control preventionist participate in the quality assurance committee and attend meetings as required. This had the potential to affect all residents. The facility census was 77. Findings include: Review of the certificate of completion of the infection preventionist training course revealed Registered Nurse (RN) #596 completed the course on 03/01/23. Review of the Quality Assurance Performance Improvement (QAPI) Committee members revealed RN #596 was not listed as a member. Review of the QAPI monthly committee meetings for 12/15/23, 01/11/24, 02/23/24 and 03/22/24, revealed RN #596 had not attended the meetings. Interview on 04/22/24 at 9:12 A.M. with RN #596 revealed she was the interim infection preventionist for the facility and had been in that role since December 2023. She stated the Director of Nursing was in the process of completing the infection preventionist training. Follow up interview on 04/24/24 at 10:23 A.M. with RN #596 verified she was not on the document provided by the facility listing the QAPI committee members. Review of the committee meeting sign-in sheets with RN #596 for the meetings held from December 2023 through March of 2024 verified she had not signed that she was present for those meetings. RN #596 stated she went to every meeting, even if she was late, so that she could present her infection control information, but she was unable to provide evidence of her attendance.