STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on review of resident medical record, facility's self-reported incident report, facility's abuse policy and procedure, staff personnel file, and staff interview, this facility failed to ensure residents were free from verbal and physical abuse while receiving assistance with care by a staff member. This affected one (Resident #25) of two residents reviewed for abuse. The facility census was 80. Findings include: Review of the medical record for Resident #25 revealed an admitted [DATE] and a re-entry date of 07/01/20. Diagnoses included multiple sclerosis, dementia with behavioral disturbances, need for assistance with personal care, contracture of the right hand, and schizoaffective disorder bipolar type. Review of the plan of care dated 05/09/17 and revised 10/11/19 revealed Resident #25 displayed behaviors including attention-seeking related to resident has repetitive behaviors such as combing hair, wanting ice, and tying of shoes. Interventions included, cognitive/communication skill permitting, discuss behavior with resident, explain reinforce why behavior is inappropriate and unacceptable, medication as ordered. Review of the plan of care dated 01/23/19 and revised 08/29/22 revealed Resident #25 has at times physically aggressive or agitated related to poor impulse control, anger, depression, a history of harm to others, attention seeking obsessive behavior such as asking for hair to be combed, seeking medications, change of clothes, shoes, hoarding attends from other residents territorial, will rip attends to be changed when no sign of incontinence are evident, gets frustrated with staff when these request can not be attended to in residents when asked, request for lotion to be applied infrontal periarea, resident will place object in depends and in private orifices, noncompliant with pericare, will pull as tight as she can on shoes strings prior to letting staff tie them, history of altercations with other residents stacking things high up close to ceiling and heating vent. Resident will hide items in bags of chips or in depends while it is on. Interventions include to complete 15 minute checks, administer medication as ordered, provide physical and verbal cues to alleviate anxiety, redirect , refer to inpatient psych as needed, when becomes agitated, and intervene before agitation escalates. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #25's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating an severely impaired cognition for daily decision making abilities. Resident #25 was noted to display physical and verbal behaviors directed towards others 4 to 6 days a week. Resident #25 was noted to require extensive assistance from two staff members for transfers, dressing, personal hygiene, and required physical help in part of bathing from two staff members. Resident #25 was noted to display impairment to one upper and one lower extremities and required the assistance of a wheelchair for mobility. Resident #25 was receiving antipsychotic, antianxiety, and antidepressant medication seven days a week. Review of Resident #25's physician orders included a treatment order dated 06/15/23 Apply Betadine to abrasion on top of right hand and leave open to air till area is healed. Review of facility's self-reported incident report tracking #236067 dated 06/14/23 revealed an allegation of physical abuse to a resident with the suspected or alleged perpetrator being a facility staff member. Summary of incident included, State tested Nursing Assistant (STNA) #193 was giving Resident #25 a shower along with STNA #199. STNA #193 reported that Resident #25 was agitated prior to shower due to not meeting her needs on her timeline, resident was wanting ice right then and resident was instructed she would get her more after her shower, but did have ice currently in her cup. During the shower Resident #25 became agitated due to wanting her nail care completed right then when she was getting shower, staff told her they would get her nail care after shower was completed. STNA #193 stated words were exchanged between STNA #199 and Resident #25, but couldn't remember what was said and then Resident #25 became more combative. STNA #193 then reported STNA #199 grabbed Resident #25's left wrist and was jerking it back and forth and yelled at Resident #25 I'll fuck you up. During the interview with STNA #199, she denied grabbing the residents wrist, she did report she placed her arm over Resident #25's arm to prevent this resident from hitting her and also did report she was yelling and saying curse words but didn't remember what exactly was said. Skin assessment and pain assessment completed, no pain noted. Did note bruising and abrasion noted to right hand, 3rd and 5th digits, resident was combative with care and the right arm is affected. STNA #193 reported that STNA #199 did not do anything with the right arm, and that Resident #25 was combative and swinging body around and right hand likely hit the shower chair. Resident #25 has a BIMS of 03, resident was interviewed on the night of the incident with no issues noted or any remembrance of situation, Social Services then interviewed the following day with no issues noted as well, Medical Director and Representative aware. STNA #199 was suspended pending investigation. Skin assessment completed on all residents with no issues noted, all alert and oriented residents were interviewed with no issues noted with STNA #199. A whole house education was provided for abuse, and how to address behaviors. Social Services following Resident #25 to see if any emotional or physical issues regarding the situation. Currently Resident #25 is continuing Activities of Daily Living (ADLs), going out to smoke, and coming out of personal room. Shows no signs of any distress regarding the situation. Area to 5th digit to right hand is now resolved and the area to the 3rd digit is now a scab. Reviewed STNA #199's personnel file with no findings. Facility substantiated accusation of verbal abuse, facility unable to determine if physical abuse occurred. As a result of the investigation, the facility has done the following: Reviewed STNA #199's personnel file with no findings, education provided for abuse and how to handle behaviors appropriately, Social Services monitored Resident #25. Skin assessments completed on all residents and interviews with all alert and oriented residents. Staff member STNA #199 was terminated from the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Statement of Witness document dated 06/14/23 created by STNA #193 revealed, STNA #199 and I were going to give Resident #25 a shower prior to going into the shower room, Resident #25 was at the ice cart, she was asking for ice before she got into the shower room. I attempted to redirect Resident #25 by explaining that she will have a fresh cup as soon as we were finished with her shower. Resident #25 became agitated with the situation and screamed, I hate you. Resident #25 then locked her wheelchair brake, STNA #199 then grabbed Resident #25's chair while the brakes was locked and yanked the chair backwards to take her to the shower room while in the shower room, I turned the water on and moved the shower chair. STNA #199 began taking resident #25's shoes and socks off, but while doing so she ripped then off of her feet and was very rushed. STNA #199 then yanked Resident #25's shirt up her back and pulled it forcefully over her head. It was time for Resident #25 to stand and STNA #199 was being aggressive with her. STNA #199 pushed Resident #25's wheelchair to the wall, where the shower bar is located aggressively and with force. STNA #199 failed to look or check to see if Resident #25's affected foot was in a safe position to transfer, STNA #199 continued to push the wheelchair close to the wall which caused Resident #25's affected foot to bend further against the wall. I told STNA #199 that her foot was against the wall, she then forcefully angled the wheelchair correctly. All while this occurred, STNA #199 seemed extremely hostile and rushed. STNA #199 instructed Resident #25 to grab onto the shower bar to pull herself to stand. STNA #199 stated she acts like she can't do anything for herself. I assisted Resident #25 to stand to transfer to the shower chair. Once in the shower chair, something happened between Resident #25 and STNA #199 that triggered and argument. Everything happened so quickly. They became physical with one another. Resident #25 swung her fist multiple times at STNA #199, while Resident #25 was swinging her fist, STNA #199 grabbed her left arm many times. STNA #199 began scramming and drew her fist back at Resident #25 and stated I'll fuck you up. Resident #25 made contact with STNA #199's upper body. STNA #199 then jerked Resident #25's arm and screamed at her. I can not remember what was said again, everything escalated so quickly. I was so overwhelmed and I intervened. I started shouting stop! stop! I help my hand up and attempted to place my arm between the two of them. I was able to hold Resident #25's hand which resulted in Resident #25 grabbing my arm and digging her nails into my arm. STNA #199 tried to get Resident #25 off of my arm, which I told her that Resident #25 was fine, that she needed to calm down. STNA #199 again grabbed Resident #25's arm and threw it down. While dressing Resident #25, I saw the open area to her right hand and a red mark that resembled the material from the shower chair on her right shoulder. After leaving the shower room, STNA #199 was telling everyone about how she was going to hit Resident #25. Shortly afterwards during nail care, STNA #199 acted as if nothing happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Statement of Witness document dated 06/14/23 created by STNA #199 revealed, We took Resident #25 to the shower. When in the shower room, she began to yell about wanting ice, we told her we could get her ice after her shower since we were taking her to bed afterward anyway. As well were undressing Resident #25, she began to insist on brushing her hair, she puts the brush back on her chair, I go to move the brush so that we can get her up into the shower chair. Resident #25 grabs the brush and attempts to hit me with it, she wanted it to stay on the chair arm. I managed to get the brush from her and then she calms down. Then as we begin to shower her again she mentions she wants nail care and we tell her we did not have the stuff to do it in the room but that we would find it after we are done in the shower room. She continues to obsess over nail care (repeatedly asking), we told her again we could not do it in that moment, she began to swing her arms and attempt to hit, she starts grabbing my clothes and hitting at the other aide in the room, at that time, she was wet and covered in soap, we were trying to calm her down. When starting peri care, resident was digging in between her legs, I asked her to mover her hand so that I can clean her. I go to use a rag to wipe her, I mention to her that her nails will cause more infections/irritation to her areas and I needed to wash it, she again asks for nail care and gets aggressive again when we tell her we could not do it in that moment. After shower was over we push the chair up to the rail for her to stand for transfer and she began to get aggressive again and swats at my face, I raise my arm to guard myself and the other aide was also trying to put her arm out to guard her from hitting. Resident #25 grabs the aids arm tightly and would not let go. I tell her we cannot help her if she is going to hit and scratch us. We finally get her calm and she is safely transferred and dressed. After leaving the shower room, I did nail care for her and she was calm. We then took her to her room and helped her to bed. Resident #25 had multiple outburst in the shower room any time she was told we couldn't do something or asked her to wait for us to do a certain task. She hit, scratched, grabbed, and yelled the entire time, but after she was out of the shower room, she calmed down. Review of the Statement of Witness document created by Licensed Practical Nurse (LPN) #145 revealed that approximately 10:00 P.M. on 06/14/23, I was seated at the nurses station charting when STNA #199 came out of the shower room with Resident #25 and approached the nursing station saying that Resident #25 was hitting her in the shower room. STNA #199 stated that she drew her fist back at her (while demonstrating what she did) and stated that she told Resident #25 If you hit me one more time, I'm going to fuck you up. I did not physically see her harming resident nor did I hear her say anything to the resident. This is what STNA #199 stated to me, LPN #77, STNA #133, and STNA #5 following Resident #25's shower. Review of the Statement of Witness document dated 06/14/23 at 10:00 P.M. created by LPN #77 revealed, I was sitting at the nurses station when STNA #199 came up yelling in a loud voice saying If Resident #25 tries to hit me one more time, I told her I would fuck her up. She also said she drew her fist back at her in the shower room. I did not visually see anything done or said to Resident #25, but this was what I witnessed from STNA #199. Review of the Statement of Witness document dated 06/14/23 created by STNA #133 revealed, STNA #199 was talking about when she was showering Resident #25 that she said If you hit me one more time, I'm going to fuck you up and stated that she pulled her fist back. Review of the Statement of Witness document dated 06/14/23 created by STNA #5 revealed, I was up at the nurses station when STNA #199 came out of the shower room with Resident #25 and stated she told resident If you hit me one more time, I'm going to fuck you up, and she said she pulled her fist back. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the personnel file for STNA #199 revealed a hire date of 04/15/21 and the last day worked was 06/14/23. STNA #199 was noted to have received education including Caring for Residents with Dementia on 04/26/21. All required background and abuse checks had been completed with no noted concerns. Interview on 06/29/23 at 1:30 P.M. with the Director of Nursing confirmed the noted incident between STNA #199 and Resident #25 had occurred and was investigated immediately upon being reported. STNA #199 was suspended pending investigation and was later terminated from the facility. STNA #199 was reported to the appropriate agency regarding suspected abuse. Resident #25 was assess and noted to have a scratch to the right hand on the 3rd digit and 5th digit. Review of the incident revealed STNA #199 had grabbed onto Resident #199's left hand and not the right hand so it was difficult to determine what the cause was for the injury to the right hand. Continue monitoring of Resident #25 revealed no concerns or issues regarding the incident. Review of facility policy titled Abuse, Neglect and Exploitation, dated 10/24/22 revealed Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Physical Abuse includes, but not limited to hitting, slapping, bunching, biting, and kicking. It also include controlling behavior through corporal punishment. It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. This deficiency represents non-compliance investigated under Complaint Number OH00143456.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record reviews and interviews the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed to reflect physician documentation of contraindications to Gradual Dose Reductions (GDR's). This affected two residents (#31 and #42) out of the five residents reviewed for unnecessary medications during the annual survey. The facility census was 80. Findings include: 1. Record review for Resident #43 revealed this resident was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, anemia, dependence on supplemental oxygen, bipolar disorder, adult failure to thrive, shizoaffective disorder, contracture of left hand and elbow, muscle wasting, tremor, and muscle weakness. Review of the significant change MDS assessment, dated 06/20/23, revealed this resident was rarely/never understood. This resident was assessed to require extensive assistance from two staff members for bed mobility and toileting, to require extensive assistance from one staff member for eating, and to be dependent upon two staff members for transfers. This resident was assessed to have received antipsychotic medications on a daily basis and to not have the physician document a GDR as being clinically contraindicated. Review of the pharmacy recommendation, dated 11/30/22 and signed by the physican on 12/02/22, revealed a GDR was contraindicated at the time. Review of the quarterly MDS assessment, dated 12/06/22, revealed this resident was assessed to have not had the physician document a GDR as being clinically contraindicated. Review of the quarterly MDS assessment, dated 01/10/23, revealed this resident was assessed to have not had the physician document a GDR as being clinically contraindicated. Review of the quarterly MDS assessment, dated 04/02/23, revealed this resident was assessed to have not had the physician document a GDR as being clinically contraindicated. Review of the quarterly MDS assessment, dated 06/05/23, revealed this resident was assessed to have not had the physician document a GDR as being clinically contraindicated. Interview with MDS Nurse #71 on 06/26/23 at 10:40 A.M. verified the physician had documented a GDR as being contraindicated on 11/30/22 and the contraindication had not been documented on any of MDS assessments following the documentation. 41271 2. Review of the medical record for Resident #31 revealed an admitted [DATE] and re-entry on 08/04/18. Diagnoses included schizoaffective disorder bipolar type, cognitive communication deficit, anxiety disorder, and recurrent major depressive disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy recommendation, dated 02/14/23 revealed a GDR was contraindicated at the time due to the resident with a good response, maintain the current dose. Review of Resident #31's quarterly MDS 3.0 assessment dated [DATE] revealed the resident experienced long and short term memory problems and a severely impaired cognition for daily decision making abilities. Resident #31 was noted to display verbal behaviors directors others multiple times a week. Resident #31 was noted to be receiving antipsychotic, antianxiety, and antidepressant medication 7 days a week. This resident was assessed to have not had the physician document a GDR as being clinically contraindicated. Interview with DON on 06/29/23 at 1:00 P.M. verified the physician had documented a GDR as being contraindicated on 11/30/22 and the contraindication had not been documented on any of MDS assessments following the documentation. Review of the Centers for Medicare and Medicaid Services (CMS) Long Term Care (LTC) Resident Assessment Instrument (RAI) 3.0 Users Manual Version 1.71.0, dated 10/2019, revealed the steps for assessment included: 1. Review the resident ' s medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent. 2. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted. 3. If a gradual dose reduction was not attempted, review the medical record to determine if there is physician documentation that the GDR is clinically contraindicated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure a resident who was depended on staff for assistance with activities of daily living (ADL's) received the assistance needed with the trimming of his fingernails. This affected one (Resident #52) of two residents reviewed for ADL's. The facility census was 80. Findings include: A review of Resident #52's medical record revealed he was originally admitted to the facility on [DATE]. His diagnoses included heart failure, osteoarthritis, chronic pain, chronic fatigue, weakness, need for assistance with personal care, schizo-affective disorder, and major depressive disorder. A review of Resident #52's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and he was cognitively intact. He was not known to display any behaviors nor was he known to reject care during the seven days of the assessment period. He required a limited assist of one for transfers and ambulation in the hall. Supervision with the assist of one was needed for locomotion on the unit and personal hygiene. Supervision with set up help was needed for bathing. A review of Resident #52's care plans revealed the resident needed assistance with ADL's related to weakness, hypotension, bradycardia, obesity, need for assistance with personal care, lack of physical exercise, chronic fatigue, pain, unsteadiness on feet, and obesity. The care plan was originated on 04/24/19 and was last revised on 04/11/23. Interventions included during bathing/ showers they were to check nail length and trim and clean on bath days and as necessary. The care plan indicated he required supervision to limited assist of one with personal hygiene. A review of Resident #52's shower documentation under the task tab of the electronic health record for the past 30 days (05/31/23 to 06/24/23) revealed the resident was scheduled to receive showers every Wednesday and Saturday on the day shift. He was documented as last receiving a shower on 06/24/23. There was nothing under the task tab for the aides to document if nail care had been provided. On 06/26/23 at 10:04 A.M., an observation of Resident #52 noted him to be lying in bed in a supine position. His fingernails on both hands were long and in need of being trimmed. Some of the nails had a dark colored substance under the nails. An interview with the resident, at the time of the observation, revealed he would like to have his nails trimmed and needed the staff's assistance to do so. Subsequent observations on 06/27/23 at 8:45 A.M. and 06/28/23 at 8:35 A.M. noted his fingernails to remain long and in need of being trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/28/23 at 11:38 A.M., an interview with State tested Nursing Assistant (STNA) #155 revealed Resident #52 required some assist with his adl's but did a lot for himself. They provided him with set up help for his showers. The resident was compliant with showers and had already been showered that day. He was asked what care was provided as part of the resident's bathing activity and indicated it included nail care. He was then asked if he had checked the resident's nails that morning and indicated he did. He did not feel they needed to be trimmed when he looked at them. He was asked to check the resident's fingernails and accompanied the surveyor back to the resident's room. The resident was walking out of his room to go to the dining room for lunch. STNA #155 checked his fingernails and confirmed they were long and in need of being trimmed. He asked the resident if he wanted them trimmed and the resident told him he did. He then stated the resident would usually tell them when he wanted them trimmed. A review of the facility's Nail Care policy revised 01/01/22 revealed the purpose of the policy was to provide guidelines for the provision of care to a resident's nails for good grooming and health. Routine cleaning and inspection of nails would be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, would be provided on a regular basis and as the need arises.

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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** 42728 Based on observation, record review, review of online manufacturer guidance, and interview the facility failed to ensure equipment was maintained in a safe manner to prevent falls with injury for Resident #43 and Resident #50. The facility failed to provide adequate supervision and assistance to prevent Resident #48 from falls and eloping. Actual harm occurred on 02/03/23 when Resident #50 sustained a fall when the anti-rollbacks on his wheelchair were not properly functioning. The resident complained of severe pain for three days following the incident, with a decrease in functional mobility without any type of interventions. On 02/06/23 the resident was admitted to the hospital with a fractured right hip. Actual harm also occurred on 06/01/23 when Resident #43, who required staff assistance for personal care fell from a shower gurney after the rail of the gurney broke sustaining a fractured femur. Prior to the incident, there was no evidence the facility conducted any type of preventative maintenance or inspection of the shower gurneys. This affected three residents (#43, #48, and #50) of the six residents reviewed for falls. The facility census was 80. Findings include: 1. Record review for Resident #50 revealed the resident was admitted to the facility on [DATE]. Resident #50 had diagnoses including nondisplaced fracture of greater trochanter of right femur, chronic obstructive pulmonary disease, other seizures, paroxysmal atrial fibrillation, schizophrenia, ischemic cardiomyopathy, dementia with behavioral disturbance, secondary parkinsonism, hypertension, abnormal posture, dysphagia, aphasia, ataxia, need for assistance with personal care, cognitive communication deficit, and difficulty walking. Review of a facility fall investigation, dated 02/03/23, revealed Resident #50 was observed trying to scoot himself back in his wheelchair. When attempting to stand, the wheelchair rolled partially out from under him. The anti-rollback wheels did not lock when the resident stood to shift weight back in his chair. The resident was assessed to complain of some pain to the right leg area. Record review revealed there was no nursing progress note related to this incident on 02/03/23. Review of the facility Fall - Initial assessment, dated 02/03/23, revealed the resident complained of new pain to the right middle leg at a pain level rated a four out of 10 on a scale of one to 10. Review of the facility Fall - Follow-up assessment, dated 02/04/23, revealed the resident have a pain level of three out of ten with bruising noted to the right posterior leg and knee. Review of the facility Fall - Follow-up assessment, dated 02/05/23, revealed the resident had a pain level rated a four out of ten and was refusing to stand or apply weight to the right leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Fall - Follow-up assessment, dated 02/06/23, revealed the resident was assessed to have a pain level rated a seven out of ten and was at the emergency room (ER) for hip pain. Review of the Medication Administration Record for 02/2023 revealed Resident #50 was documented to have been administered as needed Tylenol for pain once on 02/05/23 and twice on 02/06/23 which staff documented to be effective. Review of Resident #50's medical record revealed there were no comprehensive assessments of the resident's hip, range of motion/mobility status, changes in medical condition and/or notification to the physician prior to 02/06/23. Review of the nurse's progress note, dated 02/06/23, revealed Registered Nurse (RN) #173 received during report information that Resident #50 had fallen on 02/03/23 and had been complaining of pain since the fall. STNAs reported to RN #173 that Resident #50 had a substantial decrease in ADL's related to standing, ambulation, and transfers. RN #172 notified the physician at this time and new orders were received to obtain an x-ray of the knee and hip area. Review of the facility Work Order #1751, created on 02/06/23, revealed anti-rollbacks on wheelchair not functioning properly. On 02/07/23 the work order was updated to set to be completed. Review of the hospital progress note dated 02/06/23 revealed Resident #50 was admitted to the hospital on 02/06/23 after being found to have a right intertrochanteric hip fracture which required surgical repair while the resident was in the hospital. Review of the most recent annual MDS 3.0 assessment, dated 04/06/23, revealed Resident #50 had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 03 out of 15. This resident was assessed to require extensive assistance from two staff members for transfers, toileting, and bed mobility and to require supervision with setup assistance only for eating. Review of the care plan, revised 06/14/23, revealed Resident #50 was at risk for falls. Interventions included maintenance to repair anti-rollbacks on 12/14/22 (after sustaining a fall with no injury on 12/14/22) and maintenance to check function of anti-rollbacks and repair as needed on 02/06/23. Interview with RN #173 on 06/27/23 at 9:00 A.M. revealed upon coming back to work after being off for four days facility STNA's reported Resident #50 had a decline in ADL's since falling on 02/03/23 and was not wanting to eat or bear weight. RN #173 stated Resident #50 was ambulatory and fairly independent prior to his fall on 02/03/23. RN #23 further stated Resident #50 did not typically complain of pain and while being assessed by RN #173 the resident verbalized complaints of severe pain to his right hip and leg. RN #23 stated she notified the physician who ordered an x-ray which revealed a fracture, and the resident was sent to the hospital for evaluation and treatment. Interview with Resident #50 on 06/27/23 at 9:12 A.M. revealed the resident had fallen while attempting to stand and had to go to the hospital and have surgery. Resident #50 stated he had severe pain to the right hip and leg which he had verbalized to facility staff in the days following his fall. Interview with Director of Nursing on 06/29/23 at 9:00 A.M. verified Resident #50 had a fall on 02/03/23 and was sent out to hospital on 02/06/23 for evaluation and treatment for right hip fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Record review for Resident #43 revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, anemia, dependence on supplemental oxygen, bipolar disorder, adult failure to thrive, schizoaffective disorder, contracture of left hand and elbow, muscle wasting, tremor, and muscle weakness. Review of a fall investigation, dated 06/01/23, revealed a State tested Nursing Assistant (STNA) opened the door to the room of Resident #43 and informed the nurse the shower gurney had broken prior to the Hoyer lift transfer back into the bed and the resident had fallen on the floor. The STNA stated her, and her partner rolled resident on the gurney when the railing of the gurney snapped. Upon entering the room, the resident was observed lying on the floor and was yelling out in pain. The resident was assessed and found to have a hematoma to her right and left hands, bruising on the left side of her forehead, and was observed to yell out in pain every time her left leg was touched with a pain level of eight using the PAINAD pain scale. The physician was notified, and the resident was sent to the emergency room (ER) for evaluation. Review of the medical record for Resident #43 revealed no nurse's notes regarding the fall that occurred on 06/01/23. Review of the witness statement provided by STNA #133, dated 06/01/23, revealed she and STNA #5 showered Resident #43 on the shower gurney. When finished, the two STNAs took the resident back to her room to put her in bed. While getting the Hoyer lift ready for the transfer, the two STNAs rolled the resident toward them to get a Hoyer pad underneath her and the left side of the gurney came down and the resident fell . Review of the witness statement provided by STNA #5, dated 06/01/23, revealed Resident #43 was on the shower gurney and STNA #133 and STNA #5 were both on the side of the gurney they were rolling her towards when the gurney snapped, and the resident fell on to the floor on her left side. Review of the hospital progress note, dated 06/01/23, revealed this resident was diagnosed with a displaced intertrochanteric fracture of the left femur. Review of the care plan, revised 06/09/23, revealed the resident had a fall. An intervention (initiated 06/02/23) included staff education to inspect shower equipment prior to use. Review of the most recent significant change Minimum Data Set (MDS) assessment, dated 06/20/23, revealed Resident #43 was rarely/never understood. The assessment revealed the resident required extensive assistance from two staff members for bed mobility and toileting, required extensive assistance from one staff member for eating, and was dependent on two staff members for transfers. Interview with Maintenance Director (MD) #47 on 06/27/23 at 3:19 P.M. revealed the pipe on the shower gurney had broken during use with Resident #43. MD #47 was unsure if it was cracked before being used to shower Resident #43 as routine inspection and maintenance of the shower gurney had not been done prior to the residents fall. Maintenance Director #47 stated he was unsure of the recommendations for routine maintenance on the shower gurney but stated he would attempt to find them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Maintenance Crew employee #157 on 06/27/23 at 3:34 P.M. revealed the side rails of the shower gurney were up and the pin went through the PVC pipe on the shower gurney causing it to break and for the resident to fall. Maintenance Crew employee #157 stated prior to Resident #43's fall, there was not routine maintenance or inspection of the shower gurney, but following the incident staff were to inspect them monthly. Interview with the Director of Nursing (DON) on 06/29/23 at 8:51 A.M. verified there had not been routine maintenance or inspections of the facility shower gurneys prior to the fall experienced by Resident #43. The DON also verified the facility did not have a manual or policy for the shower gurney providing instructions on how to use, clean, or maintain the gurney in good, working condition. Review of the online guidance from Healthline Medical Products titled Recommendations from the manufacturer (https://www.healthlinemedical.com/instructions/healthline-medical-shower-gurney-maintenance/), not dated, revealed recommendations regarding gurney maintenance and use procedure revealed drop rails were not designed to hang on them and all joints of the shower gurney should be checked on a regular basis to make sure the pipes and fittings were secured. 3. Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE]. Resident #48 had diagnoses including alcohol-induced persisting dementia, seizure disorder, chronic obstructive pulmonary disease, osteoarthritis, repeated falls, difficulty walking, unsteadiness on his feet and muscle weakness. Review of Resident #48's fall risk assessment completed on 12/20/22 revealed the resident was not indicated to have had any falls occurring in the previous 90 days. He was ambulatory with the use of assistive devices. He had diagnoses and the use of certain medications that increased his risk for falls. His overall score was nine, which did not indicate the need for any fall prevention interventions at that time. A review of Resident #48's nurses' progress notes revealed the resident had an unwitnessed fall on 01/04/23 at 7:45 P.M. The note indicated the resident was previously seen sitting in his wheelchair in the dining room watching a movie. Another resident had come to the nurses' station and informed the nurse that the resident had fallen. The nurse noted the resident was already back in his wheelchair when she was made known of the fall. She asked the resident if he had fallen and he reported to the nurse that he had. He was unable to provide any further description of the fall. A review of the facility's fall investigation for the fall occurring on 01/04/23 revealed the immediate action taken to prevent further falls from occurring included the use of Dycem to his wheelchair. Review of Resident #48's quarterly/significant change evaluation dated 05/03/23 revealed the resident's risk for elopement was assessed as part of the quarterly evaluation under the cognitive/ communication assessment of that evaluation. The resident's risk factors for elopement included being cognitively impaired, having the diagnosis of dementia, being able to ambulate independently with the use of a wheelchair, and being known to wander aimlessly. He was not known to have a history of eloping when at home, leaving the facility unsupervised, or leaving the facility without informing the facility staff. As a result of that assessment, he was not deemed to be at risk for elopement at that time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a nurse's note dated 05/15/23 at 5:00 P.M. revealed the resident had a witnessed fall on that date. The note indicated the resident was in the dining room when staff witnessed the resident had slid out of his wheelchair onto his buttocks on the floor. The resident reported that he had slid out of his wheelchair. The intervention added was again to use Dycem to his wheelchair that had been previously ordered with his fall occurring on 01/04/23. A review of the facility's fall investigation for the fall occurring on 05/15/23 revealed the immediate action taken following the fall included providing staff education to ensure Dycem was in place to his wheelchair as was previously ordered. A review of Resident #48's physician's orders revealed an order, dated 05/15/23 for the use of Dycem to his wheelchair at all times. Review of Resident #48's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident rarely/ never made himself understood and was rarely/ never able to understand others. He had both short- and long-term memory impairment and his cognitive skills for daily decision making was severely impaired. He was not coded on the MDS as having had any behaviors during the seven-day assessment period and was not known to reject care or display any wandering behavior. He required a limited assist of one for transfers. He required supervision with set up help for ambulation in his room. Ambulation in hall only occurred once or twice, but he only required set up help for that when it did occur. He required supervision with the assist of one for locomotion on and off the unit. Balance issues were noted but he was able to stabilize without staff assistance. A wheelchair was the only mobility device used. The resident was identified as having had falls since his prior assessment. He had two or more falls without injury, one fall with injury that was not major injury, and one fall with major injury. A review of Resident #48's active care plans revealed he had a care plan in place for being at risk for falls related to dementia, weakness, unsteadiness on feet, difficulty walking, lack of coordination, and a history of falls. The care plan originated on 12/20/17 and was last revised on 06/14/23. The goals were to reduce the risk of serious injury in the event of a fall and for the resident to be free of falls. The interventions included ensuring his call light was within reach and to encourage the resident to use it for assistance as needed. That intervention was added to the care plan on 12/20/17. The interventions also included the use of Dycem (a tacky pad that could be placed on a seat of a chair to prevent sliding) to his wheelchair. That intervention was added on 01/05/23. The care plan directed them to review information on past falls and attempt to determine the cause of falls. They were to record the possible root causes and to remove any potential causes if possible. The care plan was revised to include the intervention of educating staff to ensure proper placement of Dycem on 05/18/23. On 06/26/23 at 12:47 P.M., an observation of Resident #48 noted him to be lying in bed. His call light was on the floor under his bed and out of his reach. Further observation of Resident #48 on 06/27/23 at 10:29 A.M., noted him to be lying in bed with his call light still on the floor under his bed and out of reach. Findings were verified by LPN #135. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/27/23 at 10:48 A.M., an interview with LPN #135 revealed Resident #48 was at risk for falls. They typically laid him down after meals and one of the aides would have helped him to bed after breakfast. She reported his fall prevention interventions included ensuring his call light was in reach. She confirmed the resident did not have his call light in reach, as it was found under his bed on the floor. She retrieved it from the floor and secured it to the assist bar that was on the right side of his bed near his head. On 06/27/23 at 3:10 P.M., an interview with the DON confirmed Resident #48 has had multiple falls while in the facility. She confirmed the use of Dycem was added as a fall prevention intervention following the fall the resident had on 01/04/23. She also confirmed they provided education to staff to ensure the Dycem was in place in his wheelchair, after he fell again on 05/15/23. She acknowledged the fall on 05/15/23 could not be considered an unavoidable fall due to previously ordered fall prevention interventions not being in place that contributed to his fall. She also acknowledged the fall prevention intervention to ensure his call light was in reach was not implemented as per the plan of care when observations noted it to be under his bed and out of reach on 06/26/23 and again on 06/27/23. In addition, a review of Resident #48's active care plans that were reviewed/revised on 06/14/23 revealed he did not have any care plan in place for being at risk for elopement or for unsafe wandering. Further review of Resident #48's nurses' progress notes revealed a nurse's note dated 06/25/23 at 3:00 P.M. that indicated a door alarm was alarming. The alarm announced was identifying the alarm as coming from the courtyard door on the second floor. The nurse and an aide tried multiple times to silence the courtyard door but was unsuccessful in doing so. The aide informed another staff nurse working that floor who also tried multiple times to silence the alarm without success. A maintenance employee was called to report the problems they were having with an alarm sounding that could not be silenced. While awaiting a return phone call, the aide went to check other residents and found the short hall exit door to be the one alarming. She entered the code to that alarm and was able to get the alarm to stop alarming. The staff then started checking on the residents and found Resident #48 to be missing. A facility search was started, and the resident was found outside in his wheelchair by the dumpsters by one of the nurses working on the second floor and the aide assigned that unit. The resident was found alert and his skin was warm and dry. He was not found with any injuries and was not noted to be in any distress. Staff assisted him back into the facility and into bed without incident. A review of a nurse's note dated 06/25/23 at 3:30 P.M. revealed the facility's DON was notified of the door alarm situation and the resident exciting building. A new order for the use of a Wander guard alarm was given as well and placing the resident on 15-minute checks until further notice. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's investigation for Resident #48's elopement on 06/25/23 revealed the incident description of the event was consistent with what was documented in the progress notes. The resident was not able to provide a description of the event. Predisposing physiological factors of the incident included him being confused and impaired memory. Predisposing situation factors included him being a wanderer. Two staff members (LPN #89 and STNA #25) were identified as being witnesses to the incident and provided statements. LPN #89's statement indicated the resident was found in the parking lot by the dumpster after exiting the back hallway door. STNA #25's statement indicated the resident was found outside the facility in the parking lot after exciting the facility unassisted. The facility's investigation indicated the DON was notified on 06/25/23 at 3:30 P.M. On 06/27/23 at 3:35 P.M., an interview with Maintenance Assistant #157 revealed he was the maintenance employee called by the facility staff when Resident #48 eloped from the facility on 06/25/23. He reported they informed him they had a door alarm going off that they could not get silenced. He recalled the concern was with an alarm on the second-floor courtyard door. He came into the facility to check it out. By the time he arrived, the alarm was already silenced. He was informed the alarm that was going off was from the other door at the end of the hall and not the courtyard door as was being announced overhead. He indicated the courtyard door and the short hall exit door had the same code announcement and the overhead message would refer to them both as the courtyard door, even if it was the one at the end of the hall. He was informed a resident had gotten out when he arrived and was found at the bottom of the ramp by the facility's dumpsters. He confirmed by checking his phone that he received the call at 3:12 P.M. and he was in the facility by 3:30 P.M. in which the resident was already back in the facility. On 06/27/23 at 406 P.M., an interview with the DON revealed she was called about the elopement by Resident #48 on 06/25/23 at 3:28 P.M. The staff informed her of what had happened. It was reported to her that the nurse and the aides were in other residents' rooms. They then heard an alarm go off for the courtyard door. The overhead announcement indicated it was the courtyard door. The staff told her they looked outside but did not see any residents out there. They could not get the alarm to silence and called maintenance to come in to check it out. The staff realized the courtyard door was not flashing and it was the exit door at the end of the short hall that was flashing instead. They checked the residents and found Resident #48 to be missing. They went outside and found the resident at the end of the ramp near the dumpsters. On 06/27/23 at 4:10 P.M., an observation of the courtyard door on the 2nd floor revealed it led to the facility's designated smoking area. The alarm system on the courtyard door allowed the door to be immediately opened by turning the doorknob but would sound an audible alarm if the door was opened without entering the code into a keypad. The keypad alarm box on the wall would flash red if that was the door alarming in addition to an overhead announcement that identified the courtyard door as the door alarm that had been activated. The short hall exit door was checked and noted to have a delayed egress of 15 seconds before that door could be opened. A constant audible alarm sounded when the door's bar was pushed on until the door opened and then a different sounding alarm would go off accompanied by an overhead announcement. The courtyard door and the exit door at the end of the short hall both led to the same ramp that led down to the facility's side parking lot where the dumpsters were. The ramp was made of decking material and had a long, gentle slope with handrails on both sides. The side parking lot had a black tar pavement with a raised curb that enclosed it on the back end and the side. It led to the front parking lot where a steep driveway went down into the road the facility sat on. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/27/23 at 4:13 P.M., further interview with the DON revealed the alarm company had told them they could not program the alarm system to differentiate between the courtyard door and the short hall exit door, due to their proximity to one another. She indicated, when she was called, Resident #48 had already been found and brought back into the facility. She suspected he was not out there very long between the time the alarm sounded and when he was found. On 06/28/23 at 8:51 A.M., an interview with LPN #89 revealed she was one of the two nurses working on the second floor on 06/25/23 when Resident #48 eloped. She was the nurse assigned the long hall and not the short hall where the resident resided. She stated the overhead message indicated the courtyard door was alarming and they could not get it to stop. She confirmed the called maintenance to come in to check the alarm out and did not realize it was another door other than the courtyard door that was going off. STNA #25 noticed the keypad at the end of the short hall exit door did not look right. She punched in the code and the door alarm silenced. They realized at that point that someone could have gone through that door and not the courtyard as was originally thought. She and the aide went out into the courtyard when the door alarm first went off and did not see any residents out there. She was not sure if they exit door at the end of the short hall was sounding for the full 15 seconds, when the door was pushed on and before it released. She was down the long hall at the time and did not hear it alarming until the announcement was made overhead for the courtyard door. She was not sure where the nurse or the aide that was working the short hall was at that time or if they heard the short hall exit door alarm before being opened. They did a head count when they realized the exit door at the end of the short hall was the one sounding and noticed Resident #48 was missing. She and the aide went outside to look for the resident and he was noted to come out from behind the dumpsters still sitting in his wheelchair. She suspected he was only out there for five to seven minutes between the time the courtyard door alarm sounded and being found in the side parking lot. This deficiency represents non-compliance investigated under Complaint Number OH00143456.

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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, resident and staff interview and facility's hydration review, this facility failed to ensure residents with a fluid restriction was monitored for appropriate fluid intake. This affected one (Resident #38) of one resident reviewed for fluid intake. Facility census was 80. Findings include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] and a re-entry date of 03/01/22. Diagnoses included end stage renal disease, heart failure, and difficulty in walking. Review of the plan of care created 03/26/21 and revised 04/27/23 revealed Resident #38 had a potential fluid volume overload related to kidney failure, dialysis, non complaint with fluid restrictions such as drinking pop as desired, wants cups with ice and-or water at bedside. Interventions included to administer medication as ordered and monitor, provide diet as ordered, encourage that all snacks and beverages offered at activities comply with diet and fluid restrictions, monitor vital signs, and monitor for fluid overload and report, resident is on fluid restriction. Review of Resident #38's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating an intact cognition for daily decision making abilities. No behaviors were noted with this assessment review. Resident #38 required supervision with set up assistance only for eating. Resident #38 was noted to be 61 inches tall and weighted 208 pounds with a noted weight gain. Resident #38 was noted to receive diuretics daily as well as dialysis services out side the facility. Review of the behavior charting for Resident #38 revealed no behaviors related to the resident being non-complaint with the physician ordered fluid restriction. Review of Resident #38's progress notes from 04/01/23 through 06/28/23 revealed no documentation indicating this resident was non-complaint with the physician ordered fluid restriction. Review of physician order revealed orders for Dialysis on Monday, Wednesday, and Friday with a chair time of 9:30 A.M. and pick up time varies between 8:45 A.M. and 9:15 A.M. A no added salt, renal diet, with regular textured food, and thin liquid consistency. 1500 milliliter (ml) fluid restriction, 360 ml with breakfast, 240 ml with lunch, 360 ml with dinner, 120 ml at bedtime, and nursing to provide 210 ml twice a day with medication administration. Torsemide 100 milligrams (mg) tablet, give 0.5 tablet daily for fluid overload related to end stage renal disease. Review of Resident #38's fluid intake for April 2023, May 2023, and June 2023, revealed most days of the month, Resident #38 was noted to go over her physician ordered fluid restriction of 1500 ml daily from the recorded fluid intake from meals and medication administration. Observation on 06/26/23 at 11:00 A.M. of Resident #38's room revealed two styrofoam cups sitting on the bedside table, noted to be filled with clear fluids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/27/23 at 12:00 P.M. and again at 3:00 P.M. of Resident #38's room revealed one styrofoam cup filled with a clear fluid and a full unopened can of soda sitting on the bed side tablet. Interview on 06/28/23 02:48 PM with the Director of Nursing (DON) revealed when the nurses complete their charting, they try to keep the behaviors charting the same as what the STNA chart on and they are limited on how many target behaviors they can put in the chart for the nurses to chart on each shift. Due to this, there is not a specific behavior to monitor related to being non-compliant with her fluid restriction. The DON claimed that Resident #38 will get her own fluids and her roommate will also give her cans of soda to drink almost daily. The DON claimed that dietary told her that even today the resident requested a extra bowl of chicken broth even though she was on a fluid restriction. The DON confirmed Resident #38's lacked documentation indicating the resident was non-complaint with the physician ordered fluid restriction and had been having a noted weigh gain. Review of provided policies and procedures revealed the facility did not have a policy and procedure related to fluid restrictions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 28923 Based on review of the facility's infection control logs, record review, staff interview, and policy review, the facility failed to ensure they maintained an effective infection control program that adequately identified organisms causing infections within the facility and properly track those infections to identify any trends or patterns. This had the potential to affect all residents residing in the facility. The facility's census was 80. Findings include: A review of the facility's infection control logs for the past 12 months revealed the facility's infection preventionist was utilizing a floor plan to identify where infections were noted throughout the facility for each month. She had a floor plan for the second floor and a floor plan for the third floor. The floor plan was color coded to show the locations of the rooms in which different types of infections occurred. One color was used to signify each type of the following infections: urine, respiratory, skin, and other. The floor plan did not indicate what organisms were present for the different types of infections identified. There were also infection line listing reports and antibiotic usage reports for each month reviewed. The antibiotic usage report included the resident's name, infection category (soft tissue, respiratory, UTI, or other), antibiotic ordered to include dose/ route, start date, stop date, and a place to document the organism involved. The antibiotic usage report did not have any organisms identified with any of the 13 entries made to include the infection categories that should have an organism easily identifiable such as with Urinary Tract Infections (UTI's). The infection preventionist typed in null under the column for organism with all 13 entries made. The infection line listing report included similar information as the antibiotic usage report and also failed to identify any organisms identified with the infections recorded. Under the column for organism, the infection preventionist entered no response for each of the 13 entries made to record resident infections. On 06/29/23 at 1:35 P.M., an interview with Registered Nurse (RN) #91 revealed she was the facility's infection preventionist. She confirmed the facility was not obtaining microbiology testing on a routine basis to identify organisms causing infections within the facility. She stated their medical director did not like ordering laboratory testing when treating residents for infections. She stated it was rare that the physician would order a urinalysis before treating a resident for a UTI based solely on symptoms and when he did he usually did not order a culture and sensitivity along with it. She acknowledged, without obtaining cultures when able, they were not identifying the organisms present that were causing the infections they were recording on their infection control logs. Without identifying the organism, they were not able to determine if there were any trends or patterns occurring in the facility involving any specific type of infection. She reported some of the residents were ordered antibiotics for wound infections when they were sent out for an appointment with the wound clinic or surgeon. Cultures were reported as having been obtained at those appointments but they had difficulty getting those culture results, even when requested, to be able to see what organism was causing the infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Infection Surveillance policy revised 10/24/22 revealed it was the facility's policy to develop a system of infection surveillance that served as a core activity of the facility's infection prevention and control program. Its purpose was to identify infections, monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. Infection surveillance was defined as an ongoing systematic collection, analysis, interpretation, and dissemination of infection-related data. The infection preventionist served as the leader in surveillance activities, maintained documentation of incidents, findings, and any corrective actions made by the facility and reported surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required. The facility would collect data to properly identify possible communicable diseases or infections before they spread by identifying data to be collected to include the infection site, pathogen (if available), signs and symptoms, resident locations, and the identification of unusual or unexpected outcomes, infection trends, and patterns. Data to be used in the surveillance activities may include, but was not limited to lab reports and antibiograms obtained from lab.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on review of the facility's infection control log, infection reports, record review, review of the McGeer's criteria, staff interview, and policy review, the facility failed to maintain and implement an effective antibiotic stewardship program to ensure residents only received antibiotics when warranted and antibiotics prescribed were appropriate for the infections being treated. This affected four (Resident #33, #75, #77, and #235) of five residents reviewed for infections. The facility census was 80. Findings include: 1. A review of Resident #33's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult onset diabetes mellitus and peripheral vascular disease. A review of Resident #33's physician's orders revealed she had an order in place to cleanse a wound to the left sole of her foot, pat dry, apply Betadine to the wound bed, and cover with a foam dressing daily. The treatment was ordered on 05/04/23. A review of Resident #33's skin and wound assessments revealed she had what was classified as a surgical wound to her left plantar foot. The wound progress was indicated to be stable and she was followed by wound care. A review of Resident #33's progress notes revealed a nurse's note dated 06/25/23 at 9:28 A.M. that indicated documents were received from the resident's appointment she had with the podiatrist on 06/23/23. The podiatrist recommended Doxycycline 100 milligrams (mg) for 3 weeks. The recommendation was reported to her primary care physician at the facility and he ordered Doxycycline 100 mg twice a day (BID) for three weeks. A review of Resident #33's consultation reports revealed she was sent out for a podiatry appointment on 06/23/23 as indicated in her nurse's progress note dated 06/25/23. The consultation report revealed the resident had increased redness of an unspecified area and it was recommended that she take Doxycycline 100 milligrams for three weeks. No other documentation was provided on the consultation report. A review of Resident #33's infection report dated 06/26/23 revealed someone had transcribed a 3 over the 6 for the day that was originally specified in the date of that report. The infection report indicated it pertained to a wound to the left foot per the podiatrist. Under skin, there was no indication of the resident having any symptoms to include heat, swelling, pain, redness, drainage, or odor. The bottom of the infection report included a section for infection management and specified the antibiotic ordered as Doxycycline 100 mg BID for three weeks. The treatment was to be initiated on 06/26/23 and continued through 07/17/23. Additional comments indicated the physician was aware and wanted to continue the antibiotic. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/29/23 at 1:35 P.M., an interview with Registered Nurse (RN) #91 revealed she had been the facility's infection preventionist since August 2022. She reported the facility followed the McGeer's criteria to ensure residents met the criteria for treating infections. She indicated Resident #33 was started on Doxycycline as recommended by the podiatrist when she went out for her appointment on 06/23/23. She stated the physician agreed with the treatment and wanted the antibiotic continued despite her not meeting criteria for the treatment of cellulitis or soft tissue wounds. 2. A review of Resident #75's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia, neurocognitive disorder with Lewy Bodies, and a need for assistance with personal care. A review of the facility's antibiotic usage report for May 2023 revealed she was ordered to receive Bactrim DS 800 -160 mg from 05/10/23 through 05/17/23 for the treatment of a Urinary Tract Infection (UTI). There was no organism recorded on the report to show what pathogen was causing her UTI. A review of an infection report for Resident #75 revealed the date symptoms were noticed was on 05/08/23. Symptoms included increased frequency/ urgency, dysuria, strong urine odor, and cloudy sediment in her urine. Under other comments, a urinalysis was indicated to have been obtained on 05/08/23 and results were obtained on 05/09/23. Under infection identification process, it was specified she had symptoms only. There was no indication a culture was done and organism was not identified. The section for infection management revealed Bactrim DS 800/ 160 mg was ordered BID for one week. A review of Resident #75's urinalysis report revealed nitrites were negative and 2+ Leukocyte Esterase was noted, which was abnormal. The urinalysis was not ordered to have a culture and sensitivity done with it so the organism involved was not identified and it was not clear if the antibiotic ordered was sufficient to properly treat her infection. A review of the McGeer's criteria used by the facility revealed UTI's without a catheter must have both criteria #1 and #2 met. In criteria #1, they must have at least one of the following, which included dysuria, fever or leukocytosis, and other symptoms. Criteria #2 must have at least 100,000 colonies/ milliliter of no more than two species of microorganisms in a voided urine sample or at least 100,000 colonies of any number of organisms in a specimen collected by in and out catheterization. On 06/29/23 at 1:35 P.M., an interview with RN #91 revealed their medical director did not usually order urinalysis to be completed when he suspected a resident had a UTI. He typically went by symptoms and just ordered the antibiotic he felt would be adequate to treat the infection. She stated even when a urinalysis was ordered he rarely ordered a culture and sensitivity to be done along with it. She acknowledged Resident #75 would not have met criteria for treatment of a UTI based on symptoms alone with out a urinalysis and culture being done to identify the presence of greater than 100,000 colonies of a microorganism being present in the urine sample. 3. A review of Resident #77's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a history of a stroke with hemiplegia and hemiparesis affecting his right dominant side, aphasia, difficulty walking, and need for assistance with personal care. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #77's infection report revealed he had a symptom onset date of 06/13/23. The symptom section on the report indicated that he was having increased frequency/ urgency, pain, and hematuria. The section for the infection identification process revealed he had symptoms only. There was no indication a urine specimen had been obtained for a culture and no organisms were identified. The section for infection management revealed he was started on Bactrim DS BID for three days. Additional comments added revealed they were to continue the antibiotic per the resident's attending physician. A review of a urinalysis report for a urine specimen collected on 06/09/23 revealed his urine was positive for nitrites and Leukocyte Esterase. It was the final report and there was no indication that a culture was done to identify the organism involved or a sensitivity report to confirm whatever organism was present, it was susceptible to the antibiotic ordered. On 06/29/23 at 1:35 P.M., an interview with RN #91 confirmed there was not a culture and sensitivity (C&S) done as part of Resident #77's urinalysis. She acknowledged, without a C&S, it was not clear what organism was causing the resident's UTI or if the antibiotic ordered was effective in treating that infection. 4. A review of Resident #235's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a complete traumatic amputation of the left great toe, peripheral vascular disease, and atherosclerosis of a native artery of an unspecified extremity with gangrene. A review of the facility's infection control log for May 2023 revealed he was known to have a soft tissue skin infection with a date of onset as 05/30/23. He was started on both Levofloxacin and Doxycycline. The infection control log did not identify what organism was present that was causing the infection. A review of Resident #235's infection report revealed he had a date of onset as 05/30/23. Symptoms identified under skin included heat, swelling, and redness at the left great toe amputation incision site. Under the section for infection identification process, a specimen was indicated to have been collected for a culture on 05/30/23 at the podiatrist's office. There was no indication of what organism, if any, had been identified as a result of the culture obtained. The section for infection management indicated antibiotics were ordered by mouth that included Levofloxacin and Doxycycline. Additional comments indicated the antibiotics were to be continued per the attending physician. On 06/29/23 at 1:35 P.M., an interview with RN #91 revealed she did not receive a copy of the wound culture that had been obtained at the podiatrist's office as the infection report had indicated was collected on 05/30/23. She stated she called the podiatrist's office and requested the wound culture report, but it was never sent. She stated it was not uncommon for a wound culture to be done at another physician's office or the wound clinic that they could not get a hold of the results. She did not have access to the labs from the local hospital and was dependent on the physician's offices to send them to her. She acknowledged without those C&S reports she could not be certain the antibiotics ordered were effective in treating the organisms causing the infections. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Antibiotic Stewardship Program policy revised 10/24/22 revealed it was the policy of the facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. The purpose of the program was to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The infection preventionist, with oversight from the DON, served as the leader of the antibiotic stewardship program and received support from the Administrator and other governing officials at the facility. The medical director and attending physicians were to support the program via active participation in developing, promoting, and implementing a facility-wide system for monitoring the use of antibiotics. The program included antibiotic use protocols and a system to monitor antibiotic usage. Antibiotic use protocols included laboratory testing being completed in accordance with current standards of practice. The facility was to use the McGeer's criteria to define infections. Antibiotics orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.