STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365401	A. Building B. Wing	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care Center	24613 Broadway Avenue Oakwood Village, OH 44146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on observation, record review, interview and policy review, the facility failed to maintain Resident #94's dignity by not providing a urinary catheter drainage bag cover and Resident #41 for not providing preferred colostomy supplies. This affected two residents (Residents #94 and #41) of three residents reviewed. The facility census was 44. Findings include: 1. Observation of Resident #94 on 07/13/21 at 12:30 P.M. revealed the resident in her room, lying down in bed. The resident had two visitors at her bedside. Resident #94's urinary catheter drainage bag was attached to the bedside and approximately one-third full of urine. The urinary drainage bag was uncovered without a privacy bag. Observation of Resident #94 on 07/13/21 at 12:43 P.M. with certified nurse assistant (CNA) #484 revealed resident had a urinary catheter drainage bag that was not covered with a privacy bag. CNA #484 indicated she had only been working at the facility for two weeks and had not been taught about covering the urinary drainage bag. Review of Resident #94's medical record revealed an admitted [DATE] with diagnoses including bladder dysfunction, diabetes, and anxiety. Review of the care plan dated 04/27/21 revealed the resident required assistance with activities of daily living (ADL) care related to muscle weakness, immobility, and fatigue. Interventions included, assist with oral care, provide set-up assistance to allow resident to participate in self-care as able, and observe for changes in ADL and adjust assistance as needed. Resident #94 had a potential for complications related to a Foley catheter (a sterile tube inserted into the bladder to drain urine). Interventions included change catheter as needed, notify physician of changes to urine color, consistency, and output, and provide catheter care per facility policy. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 had impaired cognition. The resident required extensive assistance with bed mobility, transfers, toileting, and personal hygiene and was incontinent of bowel. Review of the progress note dated 07/10/21 revealed the resident was sent to an area hospital and had returned with a Foley catheter. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders dated 07/12/21 revealed change catheter, flush with 30 milliliters of normal saline and provide catheter care as needed. Review of facility policy titled Foley Catheter Care, revised 10/00, indicated to keep the urinary catheter drainage bag covered with a privacy bag at all times. Interview with the Director of Nursing (DON) on 07/13/21 at 12:45 P.M. confirmed Resident #94 did not have a privacy bag covering her urinary drainage bag. 2. Observation of Resident #41 on 07/13/21 at 8:50 A.M. revealed the resident seated on the side of her bed. Observation of the resident's colostomy bag revealed a plastic bag around the colostomy drainage bag. Resident #41 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, schizoaffective disorder, delusional disorder, and anxiety. Resident #41 had a colostomy. Review of the quarterly MDS 3.0 assessment dated [DATE] indicated Resident #41 was cognitively intact and required only staff supervision for dressing and personal hygiene. She was independent for most other ADL. A care plan relative to Resident #41's potential for body image disturbance related to the colostomy was initiated on 03/31/21. Appropriate interventions and attainable goals were identified. During interview with Resident #41 on 07/13/21 at 8:51 A.M, the resident voiced concerns regarding the care of her colostomy. Resident #41 indicated the staff did not want to change her bag or clean her colostomy site and would say it smells and they could not do it. Resident #41 also indicated she had to wash out her used colostomy bags and reuse them because the facility would only provide her with a limited supply. Resident #41 stated her colostomy bag would leak all over her clothes and the odor would be very strong. Observation and interview with 07/14/21 at 8:48 A.M., Central Supply Staff #490 confirmed no supplies were available for Resident #41's colostomy. Central Supply staff placed an order to be delivered by 07/16/21. She confirmed the resident was washing them out. She had three left. She confirmed they did not have her style. During an interview on 07/14/21 at 9:50 A.M., Corporate Nurse #500 reported Resident #41 had two types of bags in her room and would have the appropriate style obtained from a sister facility and brought here as soon as possible. During observation and interview on 07/14/21 at 10:19 A.M., the DON showed this surveyor the central supply room and verified there were two types of colostomy bags available for Resident #41. The DON indicated Resident #41 preferred one type over the other and she had just given the resident a whole box that morning. The DON confirmed that Resident #41 focused a lot of her attention on her colostomy. The DON stated that the resident was fixated with her colostomy. The type of bags the resident was given were not the style she preferred.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on interview, review of resident funds and policy, the facility failed to notify each resident that receives Medicaid benefits when the amount in the account reached $200.00 less than the resource limit and failed to disperse funds within 30 days of a resident's death. This affected ten residents (Resident's #9, #11, #22, #23, #24, #25, #29, #30, #38 and #39) of 32 resident accounts managed by the facility and one (Resident #47) of two (Resident's #47 and #48) residents that expired. The facility census was 44. Findings include: Review of the resident funds revealed ten residents (Resident's #9, #11, #22, #23, #24, #25, #29, #30, #38 and #39) of 32 accounts managed by the facility had a balance greater than $3,000.00. All these residents were Medicaid recipients. Review of the spend down notices revealed Resident #30 was sent a letter on [DATE] and Resident #22 was sent letters monthly since February 2021 indicating the failure to spend down monies could result in the loss of Medicaid benefits. Review of Resident #47's medical record revealed she was sent to the hospital on [DATE] and the facility stopped billing on that date. Review of the resident fund management services petty cash account report revealed $60.94 was sent to the Medicaid estate recovery act on [DATE]. Interview with Business Office Manager (BOM) #362 on [DATE] at 3:15 P.M. reported she was new to the position and with the stimulus checks she would send notices to residents who had $3,000.00 or greater a letter to indicate a spend down of funds was required to continue to receive Medicaid benefits. BOM #362 indicated Resident's #22 and #30 should have been receiving notices since [DATE] as their funds were greater than $3,000.00 at that time. BOM #362 also verified Resident #47's funds should have been sent to the Medicaid estate recovery act within 30 days. Review of the undated resident trust fund accounting and records policy and procedure indicated a resident's signature would be obtained upon receipt of funds, will give written notification to each resident who received Medicaid benefits and whose funds were managed by the provider when the amount reached $200.00 less than the resource limit. The account must be closed within 30 days of death and funds must be returned to the Estate Recovery for a Medicaid recipient.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 07954 Based on interview, review of the medical record and review of beneficiary notices, the facility failed to inform residents/representatives orally and in writing of changes in services. This affected two residents (Resident's #23 and #27) of three residents (Resident's #23, #27 and #46) reviewed for Notices of Medicare Non-Coverage (NOMNC). The facility census was 44. Findings include: Review of the medical record revealed Resident #23 was discontinued from skilled therapy but would remain in the facility. There was no NOMNC or Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) provided to the resident/representative. Review of the NOMNC indicated Resident #27 was discontinued from skilled services on 06/03/21. The NOMNC did not have the provider contact information, the skilled service(s) the resident was cut from and lacked the Quality Improvement Organization name and toll-free number to appeal. Also, the signature portion of the form was signed by the administrator on 06/01/21 indicating he went over the cut via phone. There was no documented evidence this information was also provided in writing. The SNFABN dated 06/01/21 was also signed by the administrator indicating in the resident/representative signature section was written via phone. Again, there was no evidence the information was given to the resident/representative in writing. Interview with the Administrator on 07/19/21 at 2:08 P.M. verified the notices were not being sent as required.

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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** 07954 Based on observation, interview and record review, the facility failed to provide Resident #24 with nail care and feed him according to speech therapy recommendations for safe swallowing. This affected one (Resident #24) of seven (Resident's #8, #14, #21, #24, #41, #42 and #144) reviewed for activities of daily living. The facility census was 44. Findings include: Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including aphasia, dysphagia, schizoaffective disorder, dementia, heart failure, cardiac pacemaker, impulse disorder, atrial fibrillation, reflux, chronic pulmonary edema, major depressive disorder, hypertension, hyperlipidemia, atherosclerotic heart disease, epilepsy, and cerebral infarction. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated he was moderately cognitively impaired, displayed no behaviors and required the total dependence of one staff for eating and the total dependence of two plus staff for personal hygiene. Review of the activities of daily living care plan initiated 08/02/18 indicated he required the extensive assistance of one staff for eating and hygiene. Review of the physician orders indicated he was to have a pureed diet with nectar thickened liquids. Review of the therapy communication form dated 05/10/21 indicated his diet was to be pureed solids and nectar thick liquids. Staff were to provide a ten second break after swallow before the next food or drink presentation. And to only allow one sip at a time from a straw then remove the cup to allow a ten second break. Observations on 07/13/21 at 12:51 P.M. revealed he was directly fed by Licensed Practical Nurse (LPN) #440. The specific therapy recommendations were not followed. Interview with LPN #440 at that time reported there were no special feeding techniques to be used for Resident #24 you just put food in his mouth. Observations on 07/15/21 at 8:39 A.M. revealed he was directly fed by State tested Nurse Aide (STNA) #487. Resident #24 was coughing at intervals and the STNA asked him if he was okay. He only drank his fluids and a couple of bites of food. Interview with STNA #487 at that time reported there were no special feeding techniques. She stated, I don't know, I don't work here. Resident #24 was observed on 07/12/21 at 10:47 A.M. and 6:10 P.M., 07/13/21 at 11:26 A.M. and 3:46 P.M. and 07/14/21 at 5:43 A.M. and 8:44 A.M. to have long nails with black debris underneath them. Resident #24 was observed with the Administrator on 07/14/21 at 9:44 A.M. and verified he needed nail care. This deficiency substantiates Complaint Number OH00115791.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on observation, record review, interview and policy review, the facility failed to ensure skin assessments and documentation accurately reflected the status of resident's non-pressure wounds and pressure wounds. This affected two (Resident's #8 and #42) of three (Resident's #8, #25 and #42) reviewed for pressure wounds. The facility census was 44. Findings include: 1. Resident #42 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, hypertension, type two diabetes mellitus, moderate protein-calorie malnutrition, depression, and anxiety. A Braden Scale for Predicting Pressure Ulcer Risk was conducted on [DATE] indicated Resident #42 was at low risk for skin impairment. Review of the progress note dated [DATE] indicated Resident #42 arrived at the facility with skin dry and intact. Review of the entry Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #42 was severely cognitively impaired with a BIMS (brief interview for mental status) score of three of 15. Resident #42 required the supervision of one staff for most activities of daily living (ADL) including bed mobility, transfers, toileting, and ambulation. Resident #42 had no skin impairment, was continent of bowel and occasionally incontinent of bladder due to stress incontinence. The MDS indicated Resident #42 was at high for the development of pressure ulcers/injuries. Review of the skin observation forms from [DATE], [DATE] and [DATE] indicated Resident #42's skin was intact without impairment. Review of the medical records revealed a care plan relative to Resident #42's potential for alteration in skin integrity related to incontinence, immobility, impaired cognition and diabetes was initiated on [DATE]. Individualized interventions and measurable goals were identified including to administer diet as ordered and record percentage of intake every meal, administer supplements as ordered, air mattress to bed, application of house barrier as ordered, encourage turn and reposition every two hours and as needed, inspect skin daily for reddened areas, pressure reducing mattress, Prevalon boots (heel protector), pericare with each incontinence episode and weekly skin assessments by licensed nursing staff. The goal of the care plan was for Resident #8 to be free of skin breakdown daily. Review of skin observation forms from [DATE], [DATE] and [DATE] indicated Resident #42's skin was intact without impairment. Review of skin observation form dated [DATE] indicated Resident #42 had a previously identified area of impairment. No location or description of the area was provided on the form. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42 was transferred to the hospital for direct admission after a fall on [DATE] and returned to the facility on [DATE]. A reentry skin observation form dated [DATE] indicated Resident #42's skin was intact without impairment. Review of a readmission skin grid pressure form dated [DATE] indicated a new area of skin impairment was identified on [DATE]. The form indicated the area was described as a stage III sacral pressure (full-thickness skin loss) wound measuring 2.0 centimeters (cm) in length by 2.0 cm in width by 0.2 cm in depth. There was an open area of the sacrum with a red base and a small amount of slough (dried inflammatory fluids that are moist, stringy, and yellow, tan, gray, green or brown). The periwound (area surrounding the wound) was intact. Treatment orders indicated to clean with normal saline and apply alginate (dressing used for heavily draining wounds) and a dry dressing. Review of a second readmission skin grid pressure form dated [DATE] indicated an additional new area of skin impairment was identified on [DATE]. The form indicated the area was described as a deep tissue injury (DTI) right heel pressure wound measuring 1.5 cm in length by 2 cm in width by unable to determine (UTD) depth. A DTI is described as intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. There was discoloration to the heel with the periwound intact. Treatment orders indicated to paint with Betadine (topical germ-killing agent) and off-load heels. Review of the progress note dated [DATE] at 8:22 A.M. indicated Resident #42 observed with a sacral ulcer measuring 1.5 cm in length by 1.0 cm in width by 0.1 cm in depth. No drainage or odor was noted, and the wound bed was intact. The area was cleansed with normal saline and a bordered foam dressing was applied. Skin checks were completed, and a DTI was also noted on the resident's right heel. The wound physician was in the facility at the time and was notified. New treatment orders received including to clean the sacrum with normal saline, pat dry, apply calcium alginate and cover dressing daily, Prevalon boots to feet at all times, and off-load heels on a pillow. Review of the skin observation form dated [DATE] indicated Resident #42 had a new area of skin impairment noted. The skin impairment was identified as sacral and right heel. No description of wounds or measurements were provided. Review of the skin observation form dated [DATE] indicated Resident #42 had a new area of skin impairment noted. The skin impairment was identified as right buttock and left buttock skin tears. The right buttock skin tear measured approximately one inch in diameter. The left upper buttock skin tear measured approximately 2.0 inches by 2.0 inches. Both areas were cleansed, and cream was applied. The resident's physician and family were notified. Resident #42 experienced a significant decline in her condition and was placed on hospice after a hospitalization from [DATE] to [DATE]. An incomplete Significant Change MDS 3.0 assessment indicated Resident #42 remained severely cognitively impaired and required the extensive assistance of staff for ADL including bed mobility, transfers, and toileting. Information regarding bowel and bladder status and skin condition was still in progress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a skin grid pressure form dated [DATE] indicated a sacral wound was present upon readmission and was not related to a LOA (leave of absence) or an emergency room visit. The now unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) sacral pressure ulcer measured 4.5 cm in length by 4.5 cm in width by UTD with brownish, necrotic tissue in the wound bed and a moderate amount of drainage. The form did not indicate whether the wound had improved, remained unchanged, or declined. Review of a skin grid pressure form dated [DATE] indicated the right heel DTI was now being identified as being present upon readmission and was not related to an LOA (leave of absence) or an emergency room visit. The right heel was now being identified as a bluish/black blister without drainage. The wound measured 3.5 cm in length by 4.5 cm in width by UTD with brownish, necrotic tissue in the wound bed and a moderate amount of drainage. The form did not indicate whether the wound had improved, remained unchanged, or declined. Further review of the progress notes indicated Resident #42 was transferred to the emergency roiagnom on [DATE] and admitted for dehydration. The Resident returned to the facility on [DATE] with the sacral wound measuring 5.0 cm in length by 4.0 cm in width and a right heel pressure area with heel soft to touch. No measurements or wound descriptions were provided in the medical record. Review of the undated facility policy titled Wound Treatment Management indicated treatments will be based on etiology of the wound and characteristics of the wound including pressure injury stage, size, volume and characteristics of exudate, presence of pain, presence of infection, condition of tissue wound bed, condition of periwound, location of the wound and goals and preferences of resident/representative. Wound treatments will be documented on the Treatment Administration Record and the effectiveness of treatments will be monitored through ongoing assessments of the wound. Considerations for needed modifications include a) lack of progress towards healing, b) changes in characteristics of the wound, and c) changes in the resident's goals and preferences, such as end-of-life or in accordance with his/her rights. During interview on [DATE] at 4:02 P.M., the Director of Nursing (DON) revealed the wound nurse inadvertently indicated the wounds were facility acquired and submitted an addendum to the initial report. The DON also confirmed that the facility skin assessments were incomplete and inconsistent regarding wound descriptions and measurements. 2. Resident #8 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, hypertension, neuromuscular bladder dysfunction, type two diabetes mellitus, and unstageable sacral pressure ulcer. Review of the MDS 3.0 assessment dated [DATE] indicated Resident #8 was moderately cognitively impaired and required the extensive assistance of at least one staff for most ADL including bed mobility, transfers, and toileting and only supervision for eating. Resident #8 was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #8 had no skin breakdown upon admission and was assessed to be at risk for developing pressure ulcers/injuries. A pressure reducing device was applied to the resident's bed upon admission to the facility. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #8's mental status had significantly declined, and she was severely cognitively impaired. Resident #8 was totally dependent on at least two staff for all ADL. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical records revealed a care plan relative to Resident #8's potential for impairment of skin integrity related to incontinence, diabetes, age and impaired cognition was initiated on [DATE]. Individualized interventions and measurable goals were identified including to administer diet as ordered and record percentage of intake every meal, administer supplements as ordered, air mattress to bed, application of house barrier as ordered, encourage turn and reposition every two hours and as needed, inspect skin daily for reddened areas, pressure reducing mattress, Prevalon boots, pericare with each incontinence episode and weekly skin assessments by licensed nursing staff. The goal of the care plan was for Resident #8 to be free of skin breakdown daily. Review of the Braden Scale for Predicting Pressure Ulcer Risk from [DATE] indicated Resident #8 was at low risk for developing skin breakdown. Upon readmission from the hospitalization from [DATE] to [DATE], Resident #8 was no longer ambulatory. Resident #8's Readmission Braden Scale for Predicting Pressure Ulcer Risk dated [DATE] indicated the resident remained at low risk for developing skin breakdown. A Braden Scale for Predicting Pressure Ulcer Risk dated [DATE] (four days later) indicated Resident #8 was at high risk for developing skin breakdown. Review of the nurse progress note dated [DATE] revealed Resident #8 observed with skin tear on her coccyx area. Resident was confused and unable to state when and how she sustained the skin tear. The area measured 1.0 cm in length by 1.0 cm in width by 1.0 cm in depth. The area was cleansed with normal saline, patted dry and ComfortForm border was applied. Resident #8's family was notified, and the DON was notified to follow-up. Review of the nurse progress note dated [DATE] revealed Resident #8 was observed with open blisters on her left buttock, measuring 4.0 cm in length by 3.0 cm in width by 0.1 cm in depth. The wound site was red in color with no drainage or odor noted. The area was cleansed with normal saline, patted dry, and a ComfortFoam border lite dressing pad was applied for initial protocol. The resident was confused, and no pain was noted. The DON was notified. Resident #8's family was also notified. Further review of the nurse progress notes revealed no information regarding the status of the skin tear of the coccyx noted on [DATE] or the open blisters of the left buttock noted on [DATE]. Review of two separate skin observation forms dated [DATE] indicated Resident #8's skin was intact. Review of the skin observation form dated [DATE] indicated Resident #8's skin was intact. Review of the skin observation form dated [DATE] indicated Resident #8's skin was not intact and a previous area was identified, dressing dry and intact, and no new areas noted. No description of the skin issue was provided on the body diagram or in the site description section of the form. Review of the skin observation form dated [DATE] indicated Resident #8's skin was not intact, no previous areas identified, and a new area was noted. The new area was described as open blisters on the left buttocks. Review of a skin grid non-pressure form dated [DATE] indicated Resident #8 had a new skin problem acquired on [DATE] described as moisture-associated skin disorder (MASD) of the left buttock measuring 2.0 cm in length by 1.0 cm in width by 0.1 cm in depth. The area was described as an open area with red tissue to base of open area with a small amount of drainage, no odor and no signs or symptoms of infection. The physician was notified of the decline in skin on [DATE]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin observation form dated [DATE] indicated Resident #8's skin was not intact, and a previous area was identified, dressing dry and intact, and no new areas were noted. No description of the skin issue was provided on the form. Review of the nurse progress note dated [DATE] indicated the hospital contacted the facility indicating Resident #8 had been admitted for dehydration. Review of the facility eINTERACT Transfer Form dated [DATE] indicated Resident #8 had been sent to the hospital for a percutaneous endoscopic gastrostomy (PEG) tube, (a feeding tube inserted into the stomach) placement. The eINTERACT form indicated Resident #8 had no pressure areas but did have MASD to the left buttock. Review of the nurse progress note dated [DATE] indicated Resident #8 was readmitted to the facility with a sacral wound after hospitalization from [DATE] through [DATE]. The sacral wound measured 8.0 cm in length by 10.5 cm in width by 1.0 cm in depth. The wound bed was dark in color with moderate blood and brownish drainage noted. Resident #8 was also noted to have right heel discoloration and right medial foot discoloration. Review of the skin grid non-pressure form dated [DATE] indicated the MASD noted to the resident's left buttock on [DATE] had resolved on [DATE], and the resident was readmitted on [DATE] with a pressure ulcer to the sacrum. There was no further information documented regarding the skin tear to the coccyx noted on [DATE]. Review of the skin grid pressure dated [DATE] indicated Resident #8 had an unstageable sacral wound measuring 8.0 cm in length by 12.0 cm in width by UTD. The wound was described as wound base 80 percent intact soft, dark eschar, 20 percent pink granulation tissue with edges intact and periwound intact with a small to moderate amount of serosanguinous drainage. The wound was noted to have declined. Treatment with Santyl (an ointment that removes dead tissue), alginate and foam dressing continued. Review of the medical record revealed Resident #8 was re-hospitalized on [DATE] and returned to the facility on [DATE]. Review of nurse progress note dated [DATE] revealed Resident #8's sacral wound was debrided on [DATE] during the hospitalization . Resident #8 also returned to the facility with a Foley urinary catheter in place (a sterile tube entered into the bladder to drain urine). Review of the readmission skin grid pressure dated [DATE] indicated Resident #8 had an unstageable sacral wound measuring 8.5 cm in length by 8.5 cm in width by 1.5 cm in depth. The wound was described as pink granulation tissue, edges intact, periwound intact with a small to moderate amount of serosanguinous drainage. The wound was noted to have declined. Treatment with Santyl, alginate and foam dressing continued. Review of the skin grid pressure dated [DATE] indicated Resident #8's unstageable sacral wound measured 8.0 cm in length by 11.5 cm in width by 1.5 cm in depth. The wound was described with a base with mix tissue granulation and slough, edges intact, periwound intact with a moderate amount of serosanguinous drainage. The wound was noted to have declined. Treatment with Santyl, alginate and foam dressing continued. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin grid pressure dated [DATE] indicated Resident #8's now stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) sacral wound measured 8.0 cm in length by 9.0 cm in width by 1.0 cm in depth. The wound was described with a base with mix tissue granulation and slough, edges intact, periwound intact, with a moderate amount of serosanguinous drainage. The wound was noted to have improved. Treatment with Santyl, alginate and foam dressing continued. Review of the skin grid pressure dated [DATE] indicated Resident #8's stage IV sacral wound measured 8.0 cm in length by 9.0 cm in width by 1.0 cm in depth. The wound was described with a base with mix tissue granulation and less than 25 percent slough, edges intact, periwound intact, with a moderate amount of serosanguinous drainage. The wound was noted to have improved. Treatment with Santyl, alginate and foam dressing continued. Review of the nurse progress note dated [DATE] indicated the Certified Nurse Practitioner (CNP) #501 assessed Resident #8 and ordered a sacral wound culture due to a foul odor from the sacral wound and increased drainage. The progress note dated [DATE] noted the wound culture had not yet been obtained due to the wound culture supplies were expired, and the facility was awaiting new supplies. Review of the medical record revealed on [DATE], Resident #8 was started on antibiotic therapy related to a urinary tract infection. Review of the skin grid pressure dated [DATE] indicated Resident #8's stage IV sacral wound measured 7.5 cm in length by 7.0 cm in width by 1.5 cm in depth. The wound was described with a base with mix tissue granulation and less than 25 percent slough, edges intact, periwound intact, with a moderate amount of serosanguinous drainage. The wound was noted to have improved. Treatment with Santyl, alginate and foam dressing continued. Review of the medical record revealed on [DATE], Resident #8 was noted to be responsive to painful stimuli but verbally unresponsive, short of breath with moist cough. The resident was transferred to the emergency roiagnom on [DATE] at 2:23 A.M. and admitted to the intensive care unit for bilateral lower lobe pneumonia and pelvic infection. Review of the undated facility policy titled Wound Treatment Management indicated treatments will be based on etiology of the wound and characteristics of the wound including pressure injury stage, size, volume and characteristics of exudate, presence of pain, presence of infection, condition of tissue wound bed, condition of periwound, location of the wound and goals and preferences of resident/representative. Wound treatments will be documented on the Treatment Administration Record and the effectiveness of treatments will be monitored through ongoing assessments of the wound. Considerations for needed modifications include a) lack of progress towards healing, b) changes in characteristics of the wound, and c) changes in the resident's goals and preferences, such as end-of-life or in accordance with his/her rights. During interview on [DATE] at 4:02 P.M., the DON confirmed that the facility skin assessments were incomplete and inconsistent regarding wound descriptions and measurements. This deficiency substantiates Complaint Number OH00124056.

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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** 07954 Based on observations, interview and record review, the facility failed to provide an ordered treatment for Resident #24 to increase range of motion/mobility or prevent further decrease in range of motion/mobility. This affected one resident reviewed for range of motion/positioning of 44 residents in the facility. Findings include: Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including aphasia, dysphagia, schizoaffective disorder, dementia, heart failure, cardiac pacemaker, impulse disorder, atrial fibrillation, reflux, chronic pulmonary edema, major depressive disorder, hypertension, hyperlipidemia, atherosclerotic heart disease, epilepsy, and cerebral infarction. Review of the physician orders dated 05/03/21 revealed the resident was to wear a left resting hand splint daily for three hours. The nursing staff was to don the splint at breakfast time and doff the splint at lunch time with intermittent skin checks. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated he was moderately cognitively impaired, displayed no behaviors, required the total dependence of two plus staff for activities of daily living. Resident #24 had impairment in functional range of motion to one upper extremity. Review of the care plan initiated on 08/02/18 indicated to apply a resting hand splint to the left hand, on at breakfast and off at lunch. There was no indication in the care plan that Resident #24 refused to wear the splint. Review of the administration records revealed the splint had been applied daily as ordered. Observations on 07/12/21 at 10:47 A.M., 07/13/21 at 11:26 A.M. and 07/14/21 at 8:44 A.M. revealed Resident #24 to be in bed with his left and clenched tight, and a resting hand splint was on the over bed table. On 07/20/21 at 2:12 P.M. Resident #24 was up sitting in his chair with his splint still on. Interview with the Administrator on 07/14/21 at 9:44 A.M. verified Resident #24 was not wearing the splint. He indicated Resident #24 was known to refuse to wear the splint. Interview with the Director of Nursing (DON) on 07/14/21 at 11:02 A.M. also reported Resident #24 refused to wear the splint routinely. The DON was informed of the observations and that the splint was marked as applied when it had not been applied.

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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** 42733 Based on observation and interview, the facility failed to ensure Resident #6 was provided with timely incontinence care. This affected one resident (Resident #6) of four residents (Resident's #6, #195, #15 and #8) reviewed for incontinence care and one resident (Resident #6) of four residents (Resident's #8, #6, #94 and #42) reviewed for catheter (sterile tube inserted into the bladder to drain urine) care. The facility census was 44. Findings include: Review of Resident #6's medical records revealed an admitted [DATE] with diagnosis including muscle weakness, lupus, and blindness. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. The resident required extensive assistance with toileting and personal care. Interventions included provide incontinence care as needed. Review of the physician orders for June 2021 revealed the resident was to receive catheter care every shift and as needed and irrigation of the catheter with normal saline as needed. Observation on 07/14/21 at 7:35 A.M. with State tested Nursing Assistant (STNA) #484 of Resident #6 revealed the resident was incontinent of a large amount of stool. Further observation revealed the resident had an indwelling urinary catheter. Observation of the resident's catheter revealed it had a thick brown mucus around the tubing near the resident. Interview with STNA #484 revealed she was not aware the resident was incontinent and was unable to state when catheter care had last been performed. She stated catheter care should be performed with each episode of incontinence care. Interview with the resident at the time of the observation revealed she was blind, and she was unable to state if staff was performing catheter care; however, she stated she had not received incontinence care recently. The resident stated she had recently been treated for a urinary tract infection (UTI), and the urinary catheter was painful and burning. Observation on 07/14/21 at 10:42 A.M. with Licensed Practical Nurse (LPN) #313 of Resident #6 revealed the resident remained incontinent of a large amount of stool and resident urinary catheter had continued to have a thick brown mucus on the tubing. LPN #313 stated she was not aware the resident needed incontinence care and was unaware she had not received catheter care. Interview with the resident at time of observation confirmed staff had not provided incontinence care recently. This deficiency substantiates Master Complaint Number OH00124056 and Complaint Number OH00110824.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 07954 Based on interview and review of personnel files, the facility failed to have evidence State tested Nurse Aides (STNA) had annual performance reviews for three STNA's (#315, #417 and #461). This had the potential to affect all 44 residents. Findings include: Review of the personnel records revealed STNA #315 who was hired on 04/21/10, STNA #417 who was hired on 12/05/17 and STNA #461 who was hired on 01/08/19 had no evidence performance reviews had been completed. Interview with Human Resource Director #444 on 07/20/21 at 2:00 P.M. verified the facility had no evidence of annual performance reviews.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07954 Based on interview and record review, the facility failed to ensure the physician/prescriber acted upon pharmacy identified irregularities for Resident #6. This affected one of six residents (Resident's #5, #6, #14, #27, #42 and #96) reviewed for unnecessary medications. The facility census was 44. Findings include: Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including anemia, legally blind, diabetes with neuropathy, adjustment disorder, rheumatoid arthritis, hypertension, systemic lupus, heart failure, atherosclerotic heart disease, major depressive disorder, and the presence of a cardiac defibrillator. Review of the pharmacy recommendation dated 07/13/21 indicated Duloxetine (a selective serotonin and norepinephrine reuptake inhibitors (SNRI) was on backorder and asked if it would be appropriate to change it to Cymbalta (a drug in the same class). On 07/19/21 the Director of Nursing (DON) #402 marked no changes and signed the form in the area specified for the physician/prescribers response. Interview with DON #402 on 07/19/21 at 12:15 P.M. verified he wrote on the form in the section for physician/prescriber response. He indicated he spoke with the nurse practitioner and noted the response on the form. He reported he always made notes on the form intended for physician/prescribers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36307 Based on observation, record review, interview and review of Centers for Disease Control (CDC) Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 04/27/21, the facility failed to provide adequate care and positioning of Resident #18's urinary catheter drainage tubing to prevent infection. This affected one resident (Resident #94) of three residents (Resident's #6, #8 and #94) reviewed for indwelling urinary catheter use; the facility failed to provide adequate care of Resident #94's oxygen tubing to prevent contamination. This affected one resident (Resident #94) of two residents (Resident's #5 and #94) reviewed for oxygen. In addition, the facility failed to use proper infection control procedures to obtain the temperature of food for one resident (Resident #13) and failed to ensure one resident (Resident #10) followed proper infection control protocols after returning from leave of absence. This had the potential to affect all 44 residents residing in the facility. Findings include: 1. Review of Resident #94's medical record revealed an admitted [DATE] with diagnoses including bladder dysfunction, diabetes, and anxiety. Review of the care plan dated 04/27/21 revealed resident required assistance with activities of daily living (ADL) care related to muscle weakness, immobility, and fatigue. Interventions included assist with oral care, provide set-up assistance to allow resident to participate in self-care as able, and observe for changes in ADL and adjust assistance as needed. The resident was at a potential for complications related to the Foley catheter. Interventions included change the catheter as needed, notify the physician of changes to urine color, consistency, and output, and provide catheter care per facility policy. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had impaired cognition and required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. The resident was incontinent of bowel. Review of the progress note dated 07/10/21 revealed the resident was sent to an area hospital and had returned with a urinary catheter. Review of physician orders dated 07/12/21 revealed change catheter, flush with 30 milliliters of normal saline, and provide catheter care as needed. Observation of Resident #94 on 07/14/21 at 10:55 A.M. with Licensed Practical Nurse (LPN) #313 revealed the resident had a urinary catheter that was inserted at the hospital approximately eight days prior. LPN #313 stated the securement device that was on the resident was likely placed very recently due to it appeared to be the same as what the facility used, and it appeared to be strongly secured to the resident's leg. During observation, the resident became tearful and stated her private area hurt. LPN #313 asked the resident which area hurt, and the resident pointed to her genital area and stated it hurt. LPN #313 asked the resident if the area had a burning pain and resident stated yes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of Resident #94 on 07/14/21 at 1:10 P.M. with the Director of Nursing (DON) revealed the resident's urinary catheter tubing was touching the floor. The DON confirmed the tubing was touching the floor and proceeded to adjust the urinary drainage bag and tubing to prevent the tubing from touching the floor. Review of facility policy titled Foley Catheter Care, revised 10/00, indicated to keep the urinary catheter drainage bag tubing off the floor at all times to prevent infections. 2. Review of Resident #94 medical record revealed an admitted [DATE] with diagnosis including congestive heart failure and acute pulmonary embolism. Review of the care plan dated 04/27/21 revealed the resident had the potential for alteration in cardiac output related to congestive heart failure. Interventions included administer oxygen as ordered by the physician and provide oxygen care per facility policy. Review of the MDS 3.0 assessment dated [DATE] revealed the resident had impaired cognition. The resident required the use of oxygen. Review of the progress notes revealed Resident #94 frequently complained of shortness of breath. Resident #94 also requires the use of a continuous positive airway pressure (CPAP) machine at night and as needed. Review of the physician orders dated 07/12/21 revealed the resident was to receive oxygen at five liters per minute via nasal cannula and to change oxygen tubing, mask, cannula every night shift, every Friday and as needed. Observation of Resident #94 on 07/14/21 at 1:10 P.M. with the DON revealed the resident's oxygen concentrator tubing was disconnected, and the section of tubing with the nasal cannula was lying on the floor under the bed. The DON confirmed that the tubing was disconnected and, on the floor, and the resident was not receiving the required oxygen. Review of the facilities infection control policy indicated the resident care equipment should be secured and free from contamination. 3. Observation on 07/12/21 at 12:14 P.M. the lunch meal was set on the over bed table and the dome was removed while Resident #13 was asleep. On 07/12/21 at 12:19 P.M., the Administrator went into the room and checked on the resident. On 07/12/21 at 12:44 P.M., State tested Nurse Aide (STNA) #306 entered the room and began to feed Resident #13. While interviewing STNA #306 on 07/12/21 at 12:45 P.M. inquiring if her meal was still warm, the STNA stuck the back of her four fingers into her plate of pureed food and reported the food was cold. She then removed the food plate and was asked what she was going to do. She reported she was going to heat up the meal in the microwave. STNA #306 was asked if she took the temperature of the food with proper infection control by using the back of her hand to take the temperature of the food. She verified it was not and would order Resident #13 a new meal from the kitchen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Observation on 07/12/21 Resident #10 was out of the building all day according to the staff. On 07/12/21 at 6:37 P.M., the resident had yet to return to the facility. He was observed in the facility in the mornings between 6:05 A.M. and 7:30 A.M. of 07/13/21, 07/14/21 and 07/15/21 out of his room drinking coffee in the hallway and waiting for his 7:30 A.M. cigarette. He did not wear a mask. Review of the vaccine log dated 12/29/20 by Registered Nurse (RN) #498 indicated Resident #10 refused vaccination. Interview and observation with Resident #10 on 07/14/21 a 7:42 A.M. reported he went on a leave of absence via bus to visit his ailing mother at another facility. He reported he did not wear a mask in the facility or when he was visiting his mother. Resident #10 was observed on 07/20/21 at 2:10 P.M. smoking in the smoking room. Review of the leave of absence sign in/out sheets in Resident #10's medical record revealed he had signed himself out on 07/12/21 but no time was listed when he left or when he returned. Review of the log since 05/26/21 revealed he had signed himself out on 19 days and two of the 19 days indicated a return time. Review of the progress notes lacked evidence a general assessment was completed upon his return. During interview on 07/20/21 at 2:18 P.M., the Director of Nursing (DON) stated she, the ADON (Assistant Director of Nursing) and a nurse from outside the facility were trained to perform rapid COVID-19 testing. The DON stated the facility regularly does in-services and education for all staff, including dietary, activities, administrative, and housekeeping, in addition to nursing and state tested nursing aides (STNA). The DON indicated staff was tested twice a week, and all staff were screened, and temperatures were taken upon their entrance to the facility to screen for possible infection. The DON indicated the staff person tested positive during routine testing on 05/21/21, was notified and sent home immediately. The DON indicated no other residents or staff tested positive during the period of 05/17/21 through 05/23/21. The DON stated the facility had no COVID-19 cases, and the area designated as the COVID-19 Unit was not in use. During a follow-up interview with the DON on 07/20/21 at 4:02 P.M., when asked about protocols in place to ensure that non-vaccinated residents returning from a leave of absence were not potentially exposing other residents to COVID-19, the DON indicated that residents are screened upon re-entry, but no other transmission-based precaution protocols are in place. The DON confirmed that Resident #10 does not regularly wear a face mask while in the facility, eats in a communal setting and smokes outside with other residents. The DON also confirmed that Resident #10 had refused the COVID-19 vaccination, was not regularly tested for COVID-19 and his last negative COVID-19 test was in June 2021. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 04/27/21 via the Centers for Disease Control indicated for group activities: If unvaccinated patients/residents are present, then all participants in the group activity should wear source control and unvaccinated patients/residents should physically distance from others. For communal dining: If unvaccinated patients/residents are dining in a communal area (e.g., dining room) all patients/residents should use source control when not eating and unvaccinated patients/residents should continue to remain at least 6 feet from others. Patients/residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces. They should be encouraged and assisted with adherence to all recommended infection prevention and control measures, including source control, physical distancing, and hand hygiene. This deficiency substantiates Complaint Number OH00123780. 07954

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 07954 Based on interview and review of personnel files, the facility failed to ensure State tested Nurse Aides (STNA) received no less than 12 hours of in-service education to ensure continued competence per year. This affected three of three STNA's (#315, #417 and #461) with the potential to affect all 44 residents. Findings include: Review of personnel files for STNA's #315, #417 and #461 lacked in-service records. Review of in-services revealed no times to identify how many minutes/hours the in-service took to be able to calculate if the STNA's met the 12 hours required. Interview with Human Resource Director #444 on 07/20/21 at 2:00 P.M. verified the in-service records lacked indication of how long each in-service lasted. A spread sheet of in-services for 2021 was provided and one hour was given for each in-service. Further interview with the Human Resource Director #444 verified STNA #461 was not on the spread sheet at all.