STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365559	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Rehab and Care Ctr	68222 Commercial Drive Bridgeport, OH 43912

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on record review, observation, interview, and policy review the facility failed to ensure privacy was maintained during the administration of an injectable medication and transdermal patch. This affected one resident (#160) out of four residents observed for medication administration. The facility census was 50. Findings include: Review of the medical record for Resident #160 revealed an admitted [DATE]. Diagnoses included diabetes mellitus (DM), acute respiratory failure, and asthma. Review of Resident #160's November 2024 physician orders revealed an order to inject Lovenox (a medication utilized for DM) 30 milligrams/0.3 milliliters to be injected subcutaneously every 12 hours and Lidocaine external patch four percent to be applied to the rib area topically one time a day for pain. Observation on 11/20/24 at 8:24 A.M. revealed Registered Nurse (RN) #351 gathered medication and entered Resident #160's room. Upon entering the room, RN #351 left the resident's door open and did not close the resident's individual curtain. Resident #160 was sitting in her wheelchair positioned in front of the open door. Resident #160 was able to be visualized from the hallway. RN #351 applied gloves, lifted the resident's shirt exposing her abdomen, and injected her with the Lovenox injection. After administering her oral medications and applying a wrap to the resident's foot, she lifted the resident's shirt exposing her rib cage and applied a Lidocaine patch to the resident's left rib cage. Interview on 11/20/24 at 9:06 A.M., RN #351 verified she did not provide privacy to Resident #160 during the administration of her Lovenox injection and the application of her Lidocaine patch. She confirmed that the resident's abdomen and rib cage were exposed and visible from the hallway during the administration of the Lovenox injection and the Lidocaine patch. Review of the facility policy, Quality of Life, Dignity dated August 2009 revealed staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on self-reported incident review, medical record review, resident interview, staff interview, and policy review, the facility failed to ensure allegations of abuse were reported to the state agency in a timely manner. This affected one (Resident #30) of three residents (Resident #14, Resident #30, and Resident #53) reviewed for abuse. The facility census was 50. Findings include: Review of the facility on-line self-reported incidents (SRI) revealed from January 2024 through November 2024 the facility had not filed an SRI with the state agency, indicating the facility was investigating an allegation of an incident involving misappropriation. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, bipolar disorder, and anxiety disorder. Review of Resident #30's quarterly minimum data set (MDS) 3.0 assessment with a reference date of 09/12/24 revealed the resident had an intact cognition level and he had not experienced hallucinations or delusions during the review period. Interview on 11/18/24 at 11:08 A.M. with Resident #30 revealed he had approximately one hundred and thirty-two dollars taken from him. He stated that he reported the allegation to the previous administration (Administrator #500) three months ago, but the money was never returned, and no one had followed up with him regarding who had taken his money. Interview on 11/20/24 at 10:27 A.M. with Social Work Director (SWD) #348 revealed sometime in August 2024, Resident #30 reported to the previous Business Office Manager (BOM) that he had missing money. The previous BOM reported the allegation during their morning meeting. She continued that herself and the (previous) Administrator #500 interviewed Resident #30 after the allegation was made. While conducting the interview with the resident, he reported that either forty or fifty dollars was taken from him. He stated he kept the money between his phone and phone case. SWD #348 and Administrator #500 questioned the resident as to why he did not keep the money in his lock box, and he reported he liked to have it on hand. SWD #348 went on to say Administrator #500 asked the resident where he got the money, and he reported his girl friend brought it in. Administrator #500 asked the resident if he could check with the girlfriend to see how much she brought, and the resident responded that would be fine. SWD #348 continued that she had not heard anything about the missing money after their initial interview with Resident #30. She stated the Administrator was responsible for the continued investigation and reporting after an allegation of misappropriation was made. Interview on 11/20/24 at 12:47 P.M. with the (current) Administrator verified that (previous) Administrator #500 did not report the allegation of misappropriation to the state agency. She continued that it would be her expectation that all allegations of misappropriation were reported to the state agency timely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated 11/01/19 revealed the facility would not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property. It was the facility's policy to investigate all alleged violations involving misappropriation of resident property in accordance with this policy. The policy defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The Administrator or his designee would notify the Ohio Department of Health (state agency) of all alleged violations including misappropriation of resident property as soon as possible, but no later than twenty-four hours from the time the incident/allegation was made to a staff member. This deficiency represents non-compliance investigated under Complaint Number OH00159928.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on self-reported incident review, medical record review, resident interview, staff interview, and policy review, the facility failed to investigate an allegation of misappropriation of resident property. This affected one (Resident #30) of three residents (Resident #14, Resident #30, and Resident #53) reviewed for abuse. The facility census was 50. Findings include: Review of the facility on-line self-reported incidents (SRI) revealed from January 2024 through November 2024 the facility had not filed an SRI with the state agency, indicating the facility was investigating an allegation of an incident involving misappropriation. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, bipolar disorder, and anxiety disorder. Review of Resident #30's quarterly minimum data set (MDS) 3.0 assessment with a reference date of 09/12/24 revealed the resident had an intact cognition level and he had not experienced hallucinations or delusions during the review period. Interview on 11/18/24 at 11:08 A.M. with Resident #30 revealed he had approximately one hundred and thirty-two dollars taken from him. He stated that he reported the allegation to the previous administration (Administrator #500) three months ago, but the money was never returned, and no one had followed up with him regarding who had taken his money. Interview on 11/20/24 at 10:27 A.M. with Social Work Director (SWD) #348 revealed sometime in August 2024, Resident #30 reported to the previous Business Office Manager (BOM) that he had missing money. The previous BOM reported the allegation during their morning meeting. She continued that herself and the (previous) Administrator #500 interviewed Resident #30 after the allegation was made. While conducting the interview with the resident, he reported that either forty or fifty dollars was taken from him. He stated he kept the money between his phone and phone case. SWD #348 and Administrator #500 questioned the resident as to why he did not keep the money in his lock box, and he reported he liked to have it on hand. SWD #348 went on to say Administrator #500 asked the resident where he got the money, and he reported his girl friend brought it in. Administrator #500 asked the resident if he could check with the girlfriend to see how much she brought, and the resident responded that would be fine. SWD #348 continued that she had not heard anything about the missing money after their initial interview with Resident #30. She stated the Administrator was responsible for the continued investigation and reporting after an allegation of misappropriation was made. SWD #348 also revealed she was unable to find any soft investigation into the allegation or notes addressing the report from morning meetings in August 2024. Interview on 11/20/24 at 12:47 P.M. with the (current) Administrator verified that she was unable to find an investigation, completed by Administrator #500, regarding the allegation of misappropriation made by Resident #30. She continued that it would be her expectation that all allegations of misappropriation were investigated timely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated 11/01/19 revealed the facility would not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property. It was the facility's policy to investigate all alleged violations involving misappropriation of resident property in accordance with this policy. The policy defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The policy stated, the investigation must be completed within five working days, unless there were special circumstances causing the investigation to continue beyond five working days. This deficiency represents non-compliance investigated under Complaint Number OH00159928.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, interview, and policy review, the facility failed to ensure residents and/or the resident representatives were provided with transfer notices after the residents were transferred to the hospital. This affected two residents (#45 and #55) of three residents reviewed for hospitalization and discharge. The facility census was 50 residents. Findings include: 1. Medical record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare following surgical amputation, diabetes mellitus, psychoactive substance abuse, chronic kidney disease, heart failure, and chronic obstructive pulmonary disease. The resident was discharged on [DATE] following a hospitalization . Further review of the resident's electronic and paper based medical record revealed no evidence that a transfer/discharge form was completed and given or sent to the resident/resident representative. Interview on 11/19/24 at 12:05 P.M., the Director of Nursing (DON) confirmed there was no evidence that a transfer form was completed and was given to the resident/resident representative in writing when Resident #55 was transferred to the hospital on 11/15/24. Review of the facility policy titled, Transfer or Discharge Notice, dated December 2016, revealed the facility shall provide a resident and/or the resident's representative (sponsor) with a thirty-day written notice of an impending transfer or discharge. Under the following circumstances, the notice would be given as soon as it was practicable, but before the transfer or discharge: an immediate transfer or discharge was required by the resident's urgent medical needs. The resident and/or representative would be notified in writing of the following information: the reason for the transfer or discharge; the effective dated of the transfer or discharge; the location to which the resident was being transferred or discharged ; a statement of the resident's rights to appeal the transfer or discharge; and the facility bed-hold policy. 46195 2. Review of medical record for Resident #45 revealed an admitted [DATE]. Diagnoses included acute kidney failure, severe protein calorie malnutrition, dysphagia (difficulty swallowing), urinary tract infection, acute embolism (a blood clot that travels through a blood vessel) and thrombosis (a blood clot that forms in a blood vessel) of an unspecified lower extremity, bacteremia (bacteria in the blood stream), acute on chronic systolic (congestive) heart failure, neuromuscular dysfunction of bladder, atrial fibrillation (an irregular and often rapid heart rhythm), atherosclerotic heart disease, hematuria (blood in the urine), and a wedge compression fracture of the second lumbar vertebra. Resident #45 was paying for his stay privately. Review of Medicare five-day Minimum Data Set (MDS) assessment, dated 11/05/24, revealed the resident was moderately impaired cognitively and required substantial to dependent assistance for activities of daily living. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for Resident #45 revealed on 10/30/24 the resident had an episode of unresponsiveness and his foley catheter was not patent (free flowing). A new catheter was placed, it was also not patent, and was unable to be flushed. The physician was made aware and ordered the resident to be transported to the hospital emergency department for an evaluation. On 10/31/24 when the facility had called to check on the resident, they were advised the resident had been admitted with sepsis (a life threatening condition that happens when the body's immune system has an extreme response to an infection). Review of the census section in Resident #45's medical record confirmed the resident had been out of the facility from 10/30/24, when the resident was sent out to the hospital, until 11/05/24, when the resident had been readmitted from the hospital. Review of Resident #45's medical record revealed no evidence of a transfer notice for the 10/30/24 hospital stay. Interview on 11/21/24 at 3:55 P.M. with the Administrator confirmed there was no transfer notice for Resident #45's 10/30/24 hospitalization . She stated the person who had been completing the form left unexpectedly. Review of the facility policy titled, Transfer or Discharge Notice, dated December 2016, revealed the facility shall provide a resident and/or the resident's representative (sponsor) with a thirty-day written notice of an impending transfer or discharge. Under the following circumstances, the notice would be given as soon as it was practicable, but before the transfer or discharge: an immediate transfer or discharge was required by the resident's urgent medical needs. The resident and/or representative would be notified in writing of the following information: the reason for the transfer or discharge; the effective dated of the transfer or discharge; the location to which the resident was being transferred or discharged ; a statement of the resident's rights to appeal the transfer or discharge; and the facility bed-hold policy.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, interview, and policy review, the facility failed to ensure residents and/or resident representatives were provided with bed hold notices following hospital transfers. This affected two residents (#45 and #55) of two residents reviewed for hospitalization s. The facility census was 50 residents. Findings include: 1. Medical record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare following surgical amputation, diabetes mellitus, psychoactive substance abuse, chronic kidney disease, heart failure, and chronic obstructive pulmonary disease. The resident was transferred to the hospital on 11/15/24. Further review of the resident's electronic and paper based medical record revealed no evidence that a bed hold notice was given or sent to the resident/resident representative. Interview on 11/19/24 at 12:05 P.M. with the Director of Nursing (DON) confirmed there was no evidence that a bed hold notice was completed and given to Resident #55 or the residents representative, in writing, when the resident was transferred to the hospital on 11/15/24. Review of the facility policy titled, Bed-Holds and Returns, undated, revealed prior to transfers and therapeutic leaves, residents or resident representatives would be informed in writing of the bed-hold and return policy. 46195 2. Review of medical record for Resident #45 revealed an admitted [DATE]. Diagnoses included acute kidney failure, severe protein calorie malnutrition, dysphagia (difficulty swallowing), urinary tract infection, acute embolism (a blood clot that travels through a blood vessel) and thrombosis (a blood clot that forms in a blood vessel) of an unspecified lower extremity, bacteremia (bacteria in the blood stream), acute on chronic systolic (congestive) heart failure, neuromuscular dysfunction of bladder, atrial fibrillation (an irregular and often rapid heart rhythm), atherosclerotic heart disease, hematuria (blood in the urine), and a wedge compression fracture of the second lumbar vertebra. Resident #45 was paying for his stay privately. Review of Medicare five-day Minimum Data Set (MDS) assessment, dated 11/05/24, revealed the resident was moderately impaired cognitively and required substantial to dependent assistance for activities of daily living. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes in Resident #45's medical record revealed on 10/30/24 the resident had an episode of unresponsiveness and his foley catheter was not patent (free flowing). A new catheter was placed, which was also not patent, and was unable to be flushed. The physician was made aware and ordered the resident to be transported to the local hospital emergency department for evaluation. On 10/31/24 when the facility had called to check on the resident, they were advised the resident had been admitted with sepsis (a life-threatening condition that happens when the body's immune system has an extreme response to an infection). Review of the census section in Resident #45's medical record confirmed the resident had been out of the facility from 10/30/24 when the resident was sent out to the hospital, until 11/05/24 when the resident had been readmitted to the facility from the hospital. Review of the medical record for Resident #45 revealed there was no bed hold notice for the hospital stay from 10/30/24. Interview on 11/21/24 at 3:55 P.M. with the Administrator confirmed there was no bed hold notice for Resident #45's 10/30/24 hospitalization . She stated the person who had been completing the form left unexpectedly. Review of the undated facility policy Bed-Holds and Returns, prior to a transfer, written information would be given to the residents and the residents' representatives. For a non-Medicaid resident who requested a bed hold, the resident would be responsible for the facility's basic per diem rate while his or her bed was held.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on medical record review and staff interview, the facility failed to ensure psychiatric progress notes were obtained from the provider, failed to ensure a new diagnosis of schizoaffective disorder was identified and added to the medical record and care plan, and failed to accurately transcribe changes to psychiatric medications. This affected one resident (#37) out of one resident reviewed for mood and behavior. The facility census was 50. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included encephalopathy, post-traumatic stress disorder (PTSD), unspecified psychosis, major depressive disorder and anxiety disorder. The medical record did not indicate that the resident had a diagnosis of schizoaffective disorder. Continued review of the medical record revealed the facility had not obtained the residents psychiatric notes from her outside provider. Review of Resident #37's annual minimum data set (MDS) 3.0 assessment with a reference date of 10/13/24 revealed the resident was cognitively intact and was receiving antipsychotic medications. Review of Resident #37's Behavioral Health Care Note and order form dated 10/22/24 revealed the resident's functional/behavioral changes were worsening. The note stated the resident's diagnosis was schizoaffective disorder verses an other physical neurological disorder. An order was written to continue Abilify (an antipsychotic medication) 10 milligrams (mg) by mouth daily for two weeks (with a discontinue date of 11/07/24), start Olanzapine (an antipsychotic medication) 7.5 mg by mouth (starting 10/23/24), and call for progress in two weeks. Review of Resident #37's physician orders revealed an order dated 10/23/34 for Olanzapine oral tablet 7.5 mg by mouth one time a day for behaviors and an order for Abilify oral tablet 10 mg by mouth one time a day for mood dated 09/11/24. Review of Resident #37's Medication Administration Record for November 2024 revealed Resident #37 was receiving Abilify 10 mg by mouth daily as of 11/21/24. Review of Resident #37's psychotic encounter report (obtained from the psychiatric office after the surveyor requested missing progress notes) revealed on 05/06/24 the resident received a new diagnosis of schizoaffective disorder. Review of Resident #37's comprehensive care plan revealed as of 11/21/24, the resident did not have a care plan indicating she had a diagnoses of schizoaffective disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/20/24 at 9:23 A.M. with the Director of Nursing (DON) revealed Resident #37 had been seeing an outside psychiatrist for several months. She reported the facility had not followed up with the psychiatrist's office by receiving chart notes from her visits. She stated she spoke with the office, and it was determined that she was diagnosed in May 2024 with schizoaffective disorder, but due to not receiving the notes, the facility was unaware and did not add the diagnosis to her medical record or initiate a care plan related to the new diagnoses. Additionally, she confirmed the facility did not accurately transcribe the physician order from 10/22/24 causing the resident to receive 12 extra doses of the antipsychotic medication Abilify. The DON reported it was her expectation that the facility nurses ensured all chart notes were obtained after an appointment and orders were accurately transcribed and provided to her for monitoring.

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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** 42015 Based on medical record review, staff interview and policy review, the facility failed to obtain a physician ordered urinalysis (UA) and culture and sensitivity (C&S) for Resident #38, delaying antibiotic treatment. This affected one resident (#38) out of two residents reviewed for urinary tract infections (UTI). The facility census was 50. Findings Include: Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included unspecified dementia, end stage renal disease, and muscle wasting and atrophy. Review of Resident #38's annual minimum data set (MDS) 3.0 assessment with a reference date of 10/16/24 revealed the resident had a severe cognitive impairment. Review of Resident #38's nursing progress note dated 10/24/2024 at 2:31 P.M. revealed the resident had complaints of pain upon urination and the resident complained of abdominal pain. The resident reported that his stomach hurt and he could not urinate. Review of Resident #38's nursing progress note dated 10/25/2024 at 4:08 P.M. revealed the nurse spoke with the Nurse Practitioner (NP) about the resident's complaints and the NP agreed to order a UA. Review of Resident #38's nursing progress note dated 10/29/2024 at 2:40 P.M. revealed a urine sample was obtained via clean catch, and the patient tolerated it well. Review of Resident #38's physician orders revealed an order dated 10/25/24 to obtain a urine sample for a UA C&S due to complaints of burning with urination, an order dated 10/29/24 for the facility to obtain a UA C&S STAT (immediately) for pain and burning upon urination, and an order dated 11/04/24 for Macrobid (an antibiotic) Oral Capsule 100 milligrams (mg) by mouth two times a day for seven days for a UTI. Review of Resident #38's UA's from October 2024 revealed a UA C&S was obtained on 10/30/24. The culture results completed on 11/03/24 indicated the urine was positive for Escherichia coli (E-coli). Additional review of the lab work for October 2024 revealed a UA C&S was not completed on 10/25/24 as ordered. Interview on 11/21/24 at 1:52 P.M. with the Director of Nursing (DON) revealed Resident #38 became symptomatic of a UTI and an order was obtained on 10/25/24 for a UA C&S. When the nurse entered the order, it did not get transcribed correctly to the Medication Administration Record (MAR) therefor the UA C&S was never obtained. She stated the error was caught on 10/29/24 and a new order was put in place. The DON confirmed the laboratory results revealed the resident was positive for a UTI requiring antibiotic therapy and that the error delayed Resident #38's treatment by several days. (continued on next page)

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Rolling Hills Rehab and Care Ctr	68222 Commercial Drive Bridgeport, OH 43912

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Medication and Treatment Orders dated July 2016 revealed orders for medications and treatments would be consistent with the principles of safe and effective order writing. The policy did not describe the process for transcribing physician orders to the medication administration record.

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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** 46195 Based on record review, staff interview, observation, and facility policy, the facility failed to ensure weights were obtained per the residents individual needs and as ordered for Resident #16, #25, and #158; Additionally, the facility failed to ensure nutritional supplements were received for Resident #16. This affected three residents (#16, #25, and #158) out of four residents reviewed for nutrition. The facility census was 50. Findings include: 1. Review of medical record for Resident #25 revealed an admitted [DATE]. Pertinent diagnoses include acute kidney failure, chronic obstructive pulmonary disease (COPD), morbid obesity, type two diabetes mellitus, heart failure, personal history of other malignant neoplasm of large intestine, and major depressive disorder. Review of Resident #25's physician orders revealed an order dated 02/01/24 for a no added salt diet, regular texture, and thin liquids, and an order dated 03/06/24 for monthly weights. Review of Resident #25's weights revealed a weight of 425 pounds (lbs) on 08/05/24, a weight of 419 lbs on 09/12/24, a weight of 418 lbs on 10/14/24, and a weight of 436 lbs on 11/04/24, indicating an 18-pound (4.3 percent) increase from 10/24/24 to 11/04/24. Review of Resident #25's care plan, dated 11/05/24, revealed Resident #25 had a history of congestive heart failure and interventions included observe/document/report, as needed, any signs or symptoms of congestive heart failure which included weight gain that was unrelated to intake. Interview on 11/21/24 at 11:43 A.M. with Resident #25 revealed her weight normally fluctuated, but she was worried about her weight increase. She stated she was not sure why this month she weighed 436 lbs since she had been adjusting her diet to help promote some weight loss by cutting down on her carbohydrate intakes. Interview on 11/21/24 at 11:51 A.M. with Licensed Practical Nurse (LPN) #366 revealed the normal criteria to reweigh a resident would be if there was a difference of five pounds from the previous weight. LPN #366 confirmed the 18 lb weight increase for Resident #25 from 10/14/24 to 11/04/24 and stated the resident should have been reweighed. Interview on 11/21/24 at 11:55 A.M. with LPN #360 also confirmed there had been an 18 lb weight increase from 10/14/24 to 11/04/24 for Resident #25. She also stated with Resident #25's weight increase, she would have thought the resident would have been reweighed. Interview on 11/21/24 at 11:59 A.M. with Certified Nursing Assistant (CNA) #333 revealed the CNAs would obtain the monthly weights and write the weights down on a paper. When the nurses would put the weights in the computer, they would let the CNAs know if a resident needed reweighed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/21/24 at 12:03 P.M. with the Director of Nursing (DON) revealed the CNAs obtained the weights and she (the DON) would enter the weights into the computer. She stated if something looked abnormal they would reweigh the resident. The DON confirmed with Resident #25's 18 lb weight increase from 10/14/24 to 11/04/24, the resident should have been reweighed. When asked why a reweight hadn't been obtained for the resident, the DON stated she, along with the dietitian who also reviewed the weights, missed it. 44810 2. Review of the medical record for Resident #158 revealed an admitted [DATE]. Diagnoses included unspecified focal traumatic brain injury with loss of consciousness, colostomy status, gastrostomy status, and acute respiratory failure. Review of the recorded weight dated 11/06/24 revealed Resident #158 weighed 125.5 pounds (lbs). No other weights were recorded. Review of the admission assessment and care plan dated 11/06/24 revealed Resident #158 was oriented to person only and the resident required total assistance of staff for nutrition. Review of physician's order dated 11/07/24 revealed an order for Jevity 1.5 (tube feeding) 65 milliliters (ml) per hour continuously. The order also stated the resident was to receive nothing by mouth. Review of the nutrition assessment dated [DATE] revealed Resident #158 was tolerating the tube feeding and it was meeting the residents estimated calorie and protein needs. Review of the nutrition review dated 11/11/24 revealed that the last weight was on 11/06/24 when Resident #158 weighed 125.5 lbs. The review also stated the resident was to receive nothing by mouth and was provided tube feedings. Review of reweigh on 11/19/24 revealed Resident #158 weighed 127 lbs. Interview on 11/18/24 at 10:22 A.M. with Resident #158's family member revealed the resident had only been in the facility for a short time, but he was concerned that Resident #158 was loosing weight. Interview on 11/19/24 at 4:48 P.M. with the Administrator confirmed the facility had only checked the weight for Resident #158 on 11/06/24 and no other weights had been obtained. The Administrator reported that weights were to be checked weekly for a month upon admission, for all new admissions. Interview on 11/20/24 at 8:23 A.M. with Registered Dietician (RD) #501 revealed that all new admissions had their weight checked weekly for a month. She confirmed Resident #158 only had his weight checked upon admission. Review of the facility policy titled, Weight Assessment and Interventions, updated 01/10/23, revealed the nursing staff would measure resident weights on admission and then weekly for four weeks. If no weight concerns were noted at that point, weights would be measured monthly thereafter. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42015 3. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included Alzheimer's Disease, dysphagia, and constipation. Review of Resident #16's quarterly minimum data set (MDS) 3.0 assessment, with a reference date of 08/28/24, revealed Resident #16 was severely impaired and needed maximum assistance for most activities of daily living including eating. Review of Resident #16's current physician orders revealed an order dated 08/27/24 for Pro-Stat (a ready-to-drink concentrated liquid protein) 30 milliliters (ml) three times a day as a dietary supplement, and an order dated 02/23/24 for the facility to obtain weekly weights. Review of Resident #16's weights revealed on 08/14/24 the resident weighed 73.6 lbs, on 09/12/24 the resident weighed 71.6 lbs, on 10/14/24 the resident weighed 69.8 lbs, and on 11/18/24 the resident weighed 65 lbs. A reweight completed on 11/20/24 revealed the resident's weight had increased to 69.8 lbs. There was no evidence in the residents record indicating the facility had been obtaining weekly weights. Review of Resident #16's Medication Administration Record (MAR) from 08/27/24 through 11/13/24 revealed the facility had not administered the residents ordered Pro-Stat supplement. Review of Resident #16's Nutrition/Weight progress note dated 08/25/24, completed by Registered Dietitian (RD) #500, revealed the resident had a Stage Three pressure ulcer (a pressure ulcer with full thickness tissue loss where subcutaneous fat was visible but bone, tendon, or muscle was not exposed) to her left heel. RD #500 suggested to add 30 ml of Pro-Stat twice a day for wound healing. The note stated the residents established needs included 1500 calories and 60 to 70 grams of protein. The note also indicated the RD would continue to monitor the residents intakes and the wound. Review of Resident #16's Comprehensive Care Plan dated 10/23/24 revealed the resident was a nutritional risk due to leaving food uneaten on trays, wounds, body mass index suggesting an underweight status, dysphasia and diagnoses. Interventions included to monitor the residents weight per the facility policy and provide supplements as ordered. Observation on 11/19/24 at 8:45 A.M. revealed Resident #16 was resting in bed. She appeared very thin, and her legs were noted to be slightly contracted. The facility staff had placed pillows around her body to assist with positioning. Interview on 11/20/24 at 12:35 P.M. with Registered Dietitian (RD) #501 revealed Resident #16 was on several different supplements for weight gain. She was not aware the staff were supposed to be obtaining weekly weights for Resident #16. She also revealed she was unaware the resident was not receiving her Pro-Stat supplement from 08/27/2024 until 11/14/24. Interview on 11/20/24 at 2:06 P.M. with the Director of Nursing verified the facility had not obtained weekly weights for Resident #16 as ordered. She also verified the resident did not received her Pro-Stat supplement as ordered from 08/27/2024 until 11/14/24. The DON stated there was a transcription error, where the supplement was not added correctly to the medication administration record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, observation, staff and resident interviews, and facility policy, the facility failed to ensure the mask of a resident's nebulizer (a device which turns liquid medicine into a fine mist that can be inhaled) was properly stored after use. This affected two residents (#25 and #47) out of three residents reviewed for respiratory care. The facility identified eight residents (#2, #5, #19, #25, #30, #47, #159, and #161) as utilizing nebulizers. The facility census was 50. Findings include: 1. Review of medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) and nicotine dependence from cigarettes. Review of Resident #47's quarterly Minimum Data Set (MDS) assessment, dated 09/26/24, revealed the resident was cognitively intact with no refusal of care. Review of the care plan dated 06/20/24 revealed Resident #47 had Emphysema/COPD with an intervention to give the resident her aerosol or bronchodilator as ordered and to monitor/document any side effects and effectiveness. Review of Resident #47's physician orders revealed an order dated 06/21/24 for Levoalbuterol HCl inhalation solution 1.25 milligram (mg) (a medicine to relax the smooth muscles of the airways to relieve tightened muscles which can cause wheezing, chest tightness, shortness of breath, and chronic cough) with directions to inhale orally via nebulizer three times a day for a bronchodilator; an order dated 10/11/24 for Budesonide 0.5 mg/2 milliliter (ml) suspension (a corticosteriod used in the long term management of asthma and COPD) with directions to inhale one unit dose via nebulizer twice daily every morning and at bedtime for antiasthma; and an order dated 11/13/24 for Ipratropium Bromide 0.02 percent (%) solution (a medicine which relaxes muscles in the airway and increases air flow to the lungs) with instructions to inhale one unit dose via nebulizer three times a day for antiasthma. Observation and interview on 11/18/24 at 10:05 A.M. revealed Resident #47's nebulizer mask was sitting on top of her nebulizer machine and was uncovered. Interview at the time of observation with Resident #47 revealed her mask was never covered when not in use. Observations on 11/19/24 at 7:52 A.M, 10:17 A.M. and 4:40 P.M. revealed Resident #47's nebulizer mask remained uncovered when not in use. Observation on 11/20/24 at 7:34 A.M. revealed Resident #47's nebulizer mask was uncovered and hanging off the metal clip of the call cord, which was draped over the bedside table. Interview on 11/20/24 at 7:35 A.M. with Certified Nursing Assistant (CNA) #334 confirmed Resident #47's mask was hanging off the metal clip of the call cord and was uncovered. CNA #334 further verified nebulizer masks were to be stored in a bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/20/24 at 11:11 A.M. with Licensed Practical Nurse (LPN) #361 revealed as soon as the nebulizer treatment was done, the nurse was to rinse and dry out the parts of the nebulizer and then store them in a plastic bag. Review of facility policy Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, revealed when treatment was complete, the nebulizer equipment should be rinsed and disinfected, and once dried, should be stored in a plastic bag with the resident's name and the date on it. 33019 2. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus, morbid obesity, acute kidney failure, and heart failure. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/27/24, revealed Resident #25's Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognition. There were no behaviors or rejection of care and the resident received oxygen therapy. Review of the Care Plan, dated 11/05/24, revealed Resident #25 had emphysema and COPD related to physiological atrophy and history of smoking with the interventions that included to administer oxygen as ordered. Review of Resident #25's physician order, dated 05/03/23, revealed an order to titrate oxygen via nasal cannula to keep oxygen saturations above 92%, not to exceed 4 liters per minute (LPM). Observation on 11/18/24 at 12:02 P.M. revealed Resident #25's oxygen flow rate was set at 5 LPM via nasal cannula and the oxygen humidification bottle was empty of water. Interview on 11/18/24 at 12:02 P.M., Licensed Practical Nurse (LPN) #361 confirmed Resident #25's oxygen flow rate was incorrectly infusing at 5 LPM as it should have been infusing at 4 LPM and the oxygen humidification bottle was empty of water. Interview on 11/19/24 at 8:10 A.M., the Director of Nursing confirmed Resident #25's oxygen flow rate should have been infused as ordered by the physician and the oxygen humidification bottle should have been observed each shift by staff to ensure the bottle was not empty of water. Review of facility policy titled, Oxygen Administration, dated October 2021, revealed the purpose of this procedure was to provide guidelines for safe oxygen administration. Steps in the procedure included to adjust the oxygen delivery device so that it was comfortable for the resident and the proper flow of oxygen was being administered, ensure there was water in the humidifying jar and that the water level was high enough that the water would bubble as oxygen flowed through.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on record review, interview, observation, and policy review, the facility failed to ensure Resident #21 was provided pain gel medications as ordered for tooth pain. This affected one resident (#21) out of three residents (Resident #21, Resident #43, and Resident #51) reviewed for pain. The facility census was 50. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, dysphagia, and muscle weakness. Review of Resident #21's Comprehensive Care Plan dated 12/27/23 revealed the resident had the potential for oral/dental health problems with a goal that the resident would be free of infection, pain or bleeding in the oral cavity. Interventions included to administer medications as ordered and to coordinate arrangements for dental care and transportation as needed/as ordered. Review of Resident #21's current physician orders revealed, and order dated 06/20/24 for Anbesol Maximum Strength Mouth/Throat Gel 20 percent with instructions for one application orally every four hours as needed for tooth/mouth pain. Review of Resident #21's Medication Administration Record from 06/20/24 until 11/19/24 revealed the facility had not administered Anbesol Maximum Strength Mouth/Throat Gel to the resident. Review of Resident #21's Nurse Practioner progress note dated 06/11/2024 at 3:19 P.M. revealed Resident #21 stated that she was set up for dental and was to possibly have some of her teeth removed. She asked if she could have some Orajel (medicated oral gel) to help with the pain with her teeth. Review of Resident #21's dental note dated 10/03/24 revealed a limited exam with discomfort was completed. Probable cause of the discomfort was broken teeth and a cavity. The dental recommendation included an extraction. Interview on 11/18/24 at 1:25 P.M. with Resident #21 revealed she was in the process of getting dental work completed. She stated the physician had ordered Anbesol gel (a topical medication that could provide temporary pain relief for mouth and dental issues). The resident continued that the medication was ordered several months ago, and she had asked for it several times. She went on to say the facility staff told her that the medication needed to be picked up since it was not available at the facility pharmacy. Observation and interview on 11/19/24 at 9:20 A.M. of the 100 hall medication cart (the hall where Resident #21 resided) with Licensed Practical Nurse (LPN) #363 revealed Anbesol gel was not in the cart. Interview at this time with LPN #363 revealed she did not believe the facility had ever had the medication available for the resident. She continued that she had been providing Resident #21 Tylenol occasionally for her dental pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/19/24 at 10:25 A.M. with Laundry and Housekeeping Manager (LHM) #313, who also identified herself as the person responsible for obtaining over the counter medications for the facility, revealed none of the facility nurses made her aware that she needed to order Resident #21's Anbesol gel. She stated when a medication was not obtained from the facility pharmacy, it was the facility nurses responsibly to make her aware of the medication and she would either order it online or go to the store to pick it up. She verified the medication was not obtained for Resident #21 until 11/19/24. Follow up Interview on 11/20/24 at 10:03 A.M. with Resident #21 revealed that she received her medicated gel yesterday (11/19/24) and it helped a lot with her dental pain. She confirmed she had been receiving Tylenol as needed for her tooth pain since the medicated gel was not available, but she preferred the medicated gel and she stated it worked better. Interview on 11/19/24 at 4:49 P.M. with the Administrator verified the resident did not receive her medicated gel due the facility nurses not communicating the need for the medication to be picked up, which caused a delay in Resident #21's pain management. Review of the undated policy, Medication and Treatment Orders, Dental Services revealed medication orders and treatment would be administered by nursing service personnel as soon as the order had been received. Review of the policy, Pain Assessment and Management dated March 2015 revealed the purpose of the procedure was to help the staff identify pain in the resident, and to develop interventions that were consistent with the resident's goals and needs, and to ensure the underlying causes of pain were addressed. The general guidelines stated the pain management program was based on a facility-wide commitment to resident comfort, and pain management was defined as the process of alleviating the resident's pain to a level that was acceptable to the resident and was based on his or her clinical condition and established treatment goals.

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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** 33019 Based on record review and staff interview, the facility failed to ensure a pharmacy recommendation for laboratory monitoring was addressed by the physician. This affected one (Resident #43) of five residents reviewed for unnecessary medications. Findings include: Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including epilepsy, seizure disorder, dysphagia, chronic obstructive pulmonary disease, diabetes mellitus, and chronic kidney disease. Review of the Minimum Data Set (MDS) quarterly assessment, dated 11/05/24, indicated Resident #43's Brief Interview for Mental Status (BIMS) assessment was not conducted due to the resident rarely/never understood and the resident had a diagnosis of seizure disorder. Review of Resident #43's physician orders revealed an order, dated 06/28/24, for valproic acid (a medication used for seizures) oral solution 250 milligrams (mg)/5 milliliters (ml). Review of the Monthly Regimen Reviews (MRR), dated August 2024, September 2024, and October 2024, revealed the pharmacist recommended a valproic acid level and an ammonia level to be ordered since the resident was taking Depakene (the Brand name for valproic acid). The physician did not address or sign the pharmacy recommendations. Interview on 11/21/24 at 2:10 P.M. with the Director of Nursing (DON) confirmed the physician did not address or sign Resident #43's pharmacy recommendations dated August 2024, September 2024, and October 2024. She stated the physician would be notified and the labs would be ordered today (11/21/24). The DON further confirmed Resident #43's last valproic level was obtained in June 2024. Interview on 11/21/24 at 5:43 P.M. with Pharmacist #710 confirmed the physician did not address the pharmacy recommendations in August 2024, September 2024, and October 2024. Pharmacist #710 stated his normal course of action would be to call the physician to inquire after a second pharmacy recommendation was issued. Pharmacist #710 stated his recommendation would be for Resident #43's valproic acid level to be obtained/monitored every six months.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on interview, observation, record review, and policy review the facility failed to ensure Resident #21 received timely dental services after experiencing dental pain. This affected one out of two residents (Resident #21 and Resident #8) reviewed for dental services. The facility census was 50. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, dysphagia, and muscle weakness. Interview on 11/18/24 at 1:25 P.M. with Resident #21 revealed she was in the process of getting dental work completed. She stated she started experiencing dental pain several months ago but just recently saw the dentist. Review of Resident #21's Comprehensive Care Plan dated 12/27/23 revealed Resident #21 had potential for oral/dental health problems. The resident's goal indicated the resident would be free of infection, pain or bleeding in the oral cavity by review date. Interventions included administer medications as ordered and to coordinate arrangements for dental care, transportation as needed/as ordered. Review of Resident #21's current physician orders revealed, and order dated 06/20/24 for Anbesol Maximum Strength Mouth/Throat Gel 20 percent. With instructions to give one application orally every four hours as needed for tooth/mouth pain. Review of Resident #21's Nurse Practitioner progress note dated 06/11/2024 timed 3:19 P.M. revealed Resident #21 stated that she was set up for dental and was to possibly have some of her teeth removed. She asked if she could have some Orajel (medicated gel) to help with the teeth pain. Review of Resident #21's dental note dated 10/03/24 revealed a limited exam with discomfort was completed. Probable cause of the discomfort was broken teeth and a cavity. Recommendation included extraction. Additional review of dental notes verified this was the first time Resident #21 was seen by the dentist since her admission to the facility. Interview on 11/19/24 at 12:22 P.M. with Social Work Director (SWD) #338 revealed that she was not notified Resident #21 was experiencing dental pain. SWD #338 said if she was aware she would have ensured the resident was seen sooner. Resident #21 was set up to be seen on 07/17/24 but the visit was rescheduled until November 2014 because there was not enough residents to be seen in July. Interview on 11/19/24 at 4:49 P.M. with the Administrator verified Resident #21 did not receive timely dental services after experiencing discomfort due to miscommunication with the facility staff. Review of the undated facility policy, Dental Examination/Assessment revealed residents would receive dental services as needed, upon conducting a dental examination a resident needed dental services will be promptly referred to a dentist.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, staff interviews, review of the Ohio Dietetics website, and review of the nutritional consulting company's contract with the facility, the facility failed to ensure the nutritional staff member who was completing quarterly reviews was qualified to assess the nutritional status for resident quarterly reviews. This affected one (Resident #25) of three residents who were reviewed for nutrition and had the potential to affect all residents who required a nutritional quarterly review. The facility census was 50. Findings include: Review of medical record for Resident #25 revealed an admitted [DATE]. Pertinent diagnoses included acute kidney failure, chronic obstructive pulmonary disease (COPD), morbid obesity, type two diabetes mellitus, heart failure, personal history of other malignant neoplasm of large intestine, and major depressive disorder. Review of 10/27/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #25 was cognitively intact, had no rejection of care, required set up or clean up assistance for eating, had no significant changes, and was on a therapeutic diet. Review of Resident #25's Dietary Review, dated 10/24/24, and authored by Certified Dietary Manager (CDM) #600, revealed CDM #600 assessed Resident #25 as not having had a significant weight change, and her meal intakes were meeting her nutritional needs. Interview on 11/21/24 at with CDM #600 confirmed she was a certified dietary manager (a non-licensed professional without a bachelor's degree in nutrition). CDM #600 completed all the quarterly nutritional reviews and the Registered Dietitian, Licensed Dietitian (RDLD) completed all the annual, new or readmission, and significant change assessments. CDM #600 confirmed she assessed, while completing the quarterly reviews, if there had been a significant change by using a calculator and if nutritional needs were being met by intakes of the diet. Interview on 11/21/24 at 3:30 P.M. with Human Resource Director #364 revealed the CDM and the RDLD were employed by a dietetic consulting company the facility used. Review of the Ohio Medical Board's website https://www.med.ohio.gov/help-center/questions/dietitian, revealed unlicensed assistive personnel could collect and record nutritional data to assist the dietitian with assessments and counseling. Evaluating or interpreting nutritional data was considered the practice of dietetics and a person who did not meet the criteria for licensure or exemption from licensure could not practice dietetics even under supervision. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the contract between the facility and the consulting dietetics company, dated 12/01/20, revealed the parties expressly acknowledged that it was the intent of the parties to comply fully with all federal, state, and local laws, statutes, rules, regulations and ordinances and with federal, state and private payer health care programs. The provider agreed to provide a nutritionist/dietitian with the minimum education of a graduation from a four-year college or university with a bachelor's degree in nutrition or dietetics and one year nutrition experience or completion of an American Dietetic Association (ADA) approved dietetic internship with ADA commission on dietetic registration eligibility or an equivalent combination of education and experience.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 42015 Based on record review, review of Quality Assurance Performance Improvement (QAPI) sign-in sheets, staff interview, and policy review, the facility failed to ensure the governing body was engaged and involved in the oversight of the functions of the facility in regards to the QAPI program. This affected all 50 residents in the facility. The facility census was 50. Findings include: Review of the facility's survey tracking history revealed the facility had an annual survey completed on 11/17/22 and complaint surveys on 10/17/24, 09/12/24, 05/13/24, 01/17/24, and 03/08/23 which all resulted in citations under the care areas of nursing services, quality of care, admission discharge and transfer, freedom from abuse neglect and exploitation, and food and nutrition services. Review of the facility quarterly QAPI attendance logs revealed the committee had not meet since before their last annual survey on 11/17/22. Interview on 11/21/24 at 3:00 P.M. with the facility's Administrator revealed the facility could not provide evidence of quarterly QAPI meetings since before last annual survey on 11/17/22. The Administrator said they had a meeting on 11/20/24 but the Medical Director was not present. Phone interview on 11/21/24 at 4:03 P.M. with Medical Director #550 revealed he was aware of the Medical Director's role in the facility's QA committee and the need for quarterly meetings. Medical Director #550 said the facility had not held a QAPI meeting since he was hired and he was not made aware the facility did not have a QAPI program in place since prior to their last annual survey. Phone interview on 11/21/24 at 4:24 P.M. with [NAME] President of Clinical Operations (VPCO) #650 revealed the facility was responsible for sending the governing body QAPI information quarterly for the governing body to review. It was the responsibility of the governing body to ensure compliance with the QA committee. It was also the governing body's responsible to occasionally attend QA meetings to ensure compliance. Additionally, VPCO #650 verified the governing body did not have evidence that the facility had a QAPI program in place since prior to their last annual survey cycle or had attended any QA meetings since prior to the facility's last annual survey cycle. Review of the facility policy, Administrative Management (Governing Board), dated April 2011, revealed the governing board was responsible for the management and operation of the facility. The facility's governing board was the supreme authority and had full legal authority and responsibility for the management and operation of the facility. The Administrator was accountable to the governing board. The governing board was responsible for, but was not limited to, the establishment of policies and procedures governing the facility's corporate compliance program; provision of facility services and quality resident care in accordance with professional standards of practice and principles; establishment and implementation of a system whereby resident and staff grievances and/or recommendations could be identified and acted upon within the facility. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy, Quality Assurance and Performance Improvement (QAPI) Committee revealed the committee was a standing committee of the facility and would provide reports to the Administrator and governing board (body). The QAPI Committee advised the Administrator and owner and/or governing board (body). The committee had the full authority to oversee the implementation of the QAPI program, including, but not limited to, establishing performance and outcome indicators for quality of care and services delivered in the facility; choosing and implementing tools that best captured and measured data about the chosen indicators; appropriately interpreting data within the context of standards of care, benchmarks, targets and the strengths and challenges of the facility; and communicating the information gathered and their interpretation to the owner/governing board (body). Review of Job Description and Performance Standard, dated November 2014, revealed the administrator would operate the facility in accordance with the established policies and procedures of the governing body in compliance with federal, state and local regulations; act as liaison to the governing body for the medical, nursing and other professional staffs and all facility departments; and assume responsibility for implementation of an effective Quality Assurance program.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 44810 Based on interview, record review, and review of the facility arbitration agreement, the facility failed to ensure residents or their representative were educated regarding their right to communicate with local, state, or federal officials before signing an arbitration agreement or within thirty days of signing the agreement. This affected all residents residing in the facility. The facility census was 50. Findings include: Review of the facility's undated arbitration agreement revealed that the resident or representative did not have to sign the agreement to receive healthcare services and they could cancel the agreement by providing written notice of cancellation to the facility within thirty days after signing the agreement. There was no information regarding communication with local, state, and federal officials. Interview on 11/20/24 at 12:54 P.M. with the Administrator confirmed the arbitration agreement did not provide guidance to residents or representatives that they could reach out of local, state, and federal officials for guidance before signing the agreement or within thirty days of signing the agreement. Interview on 11/20/24 at 1:00 P.M. with Admission Staff #502 revealed she went over the arbitration agreement with each resident or representative on admission. She reported that she did not offer guidance to residents or their representatives regarding communication with local, state, or federal officials before signing the agreement or within thirty days of signing the agreement. She reported she was unfamiliar with the guidance. Subsequent interview on 11/21/24 at 10:50 A.M. with the Administrator revealed the facility did not have a policy and procedure regarding arbitration agreements.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 44810 Based on interview, record review, and review of the facility arbitration agreement, the facility failed to ensure their arbitration agreement allowed for a mutually agreeable arbitrator and venue. This had the potential to affect all residents residing in the facility. The facility was census was 50. Findings include: Review of the facility's undated arbitration agreement revealed matters would be resolved by binding arbitration administered by the American Arbitrators Association, under their rules and procedures. If the American Arbitrators Association did not enforce pre-dispute arbitration agreement, then any other reasonable arbitration association chosen solely by the facility would be an acceptable replacement. The agreement also indicated the venue for arbitration would be in a proper closer venue to the facility's principal place of business. Interview on 11/20/24 at 12:54 P.M. with the Administrator confirmed that the arbitration agreement clearly stated who the facility had chosen for an arbitrator. The Administrator also reported that she was not sure where the closest venue would be since the facility was located in one town and the corporate headquarters were in another. Interview on 11/20/24 at 1:00 P.M. with Admission Staff #502 revealed she went over the arbitration agreement with each resident and representative on admission. Admission Staff #502 reported she was unaware that the venue and the arbitrators must be a mutually agreed upon third party that was decided by the resident or representative and the facility. She confirmed the agreement did not give the resident or representative a choice of arbitrator or venue. Subsequent interview on 11/21/24 at 10:50 A.M. with the Administrator revealed the facility did not have a policy and procedure regarding arbitration agreements.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 42015 Based on interview, review of survey history, review of approved plans of corrections, and policy review, the facility failed to establish a Quality Assurance and Performance Improvement (QAPI) program that thoroughly evaluated identified areas in need of improvement, and monitored and evaluated the effectiveness of corrective action making revisions to systems and practices as needed to ensure ongoing compliance. This affected all 50 residents residing in the facility. Findings include: Review of the facility's survey tracking history revealed the facility had an annual survey completed on 11/17/22 and complaint surveys on 10/17/24, 09/12/24, 05/13/24, 01/17/24, and 03/08/23 which all resulted in citations under the care areas of nursing services, quality of care, admission discharge and transfer, freedom from abuse neglect and exploitation, and food and nutrition services. Review of the facility submitted plans of corrections revealed findings would be reported to QAPI for review and further intervention. Interview on 11/21/24 at 3:00 P.M. the facility's Administrator revealed the facility could not find evidence that they had implemented a comprehensive QAPI program since before last annual survey on 11/17/22. The Administrator was unable to find documentation that the facility held quarterly meetings, that the committee thoroughly evaluated and identified areas in need of improvement, and prior deficient practices were being monitored to determine if the plan of correction was being implemented as written and corrections were being sustained. Review of the undated facility policy, Quality Assurance and Performance Improvement (QAPI) Committee revealed the facility would establish and maintain a QAPI Committee to oversees the implementation of the QAPI Program. The primary goals of the QAPI Committee were to establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services; promote the consistent use of facility systems and processes during provision of care and services; help identify actual and potential negative outcomes relative to resident care and resolve them appropriately; support the use of root cause analysis to help identify where patterns of negative outcomes pointed to underlying systematic problems; help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care; coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, residents, and family members.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42015 Based on review of Quality Assurance and Performance Improvement (QAPI) attendance logs, staff interview, and policy review, the facility failed to hold quarterly meetings composed of staff who understood the characteristics and complexities of the care and services delivered by each unit, and/or department including the director of nursing (DON), Medical Director, Infection Preventionist (IP), and at least three other staff, one of whom was the facility's administrator, owner, board member, or other individual in a leadership role who had knowledge of facility systems and the authority to change those systems. This affected all 50 residents residing in the facility. Findings include: Review of the facility's survey tracking history revealed the facility had an annual survey completed on 11/17/22 and complaint surveys on 10/17/24, 09/12/24, 05/13/24, 01/17/24, and 03/08/23 which all resulted in citations under the care areas of nursing services, quality of care, admission discharge and transfer, freedom from abuse neglect and exploitation, and food and nutrition services. Review of the facility submitted plans of corrections for each survey revealed findings would be reported to QAPI for review and further intervention. Review of the facility quarterly QAPI attendance logs revealed the committee had not meet since before their last annual survey on 11/17/22. Interview on 11/21/24 at 3:00 P.M. with the facility's Administrator revealed the facility could not find evidence that they held quarterly QAPI meetings since before the last annual survey on 11/17/22. The Administrator said they held a meeting on 11/20/24 (two days after the most recent survey cycle) but the Medical Director was not present. Phone Interview on 11/21/24 at 4:03 P.M. with Medical Director #550 revealed upon hire he was aware of the Medical Director's role in the facility's QA committee and the need for quarterly meetings. Medical Director #550 went on to say the facility had not held a QAPI meeting since his hire. Upon hire he was not made aware the facility did not have a QAPI program in place since prior to their last annual survey. Medical Director #550 indicated a QAPI program was important so the facility was aware of how things were going in the facility, what needed addressed, and if interventions implemented were effective. Review of the Medical Director Agreement dated 06/01/24 revealed Medical Director #550 entered into a agreement on 06/01/24. Duties included participating in the facility's Quality Assessment and Assurance Committee (QAA Committee) or assigning a designee to represent him/her, assisting in overall care coordination in the facility, assisting in the development of educational programs for facility staff and other professionals, and reviewing and evaluating facility processes and practices. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy, Quality Assurance and Performance Improvement (QAPI) Committee revealed the facility would establish and maintain a QAPI Committee that oversaw the implementation of the QAPI Program. The Administrator would appoint both permanent and rotating members of the committee. The Administrator would appoint individuals to fill any vacancies occurring on the committee. A Committee Chairperson, Administrator, DON, Medical Director, Dietary Representative, Pharmacy Representative, Social Services Representative, Activities Representative, Environmental Services Representative, Infection Control Representative, Rehabilitative/Restorative Services Representative, Staff Development Representative, Safety Representative, and Medical Records Representative would serve on the committee. The committee would meet monthly at an appointed time and special meetings could be called by the coordinator as needed to address issues that could not be held until the next regularly scheduled meeting.