STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365832	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Manor Health & Reha	2186 Ambleside Rd Cleveland, OH 44106

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34297 Based on record review, interview, and policy review the facility failed to ensure Resident #198's monies from the authorized resident fund account (RFA) were dispersed timely upon the resident's death. This affected one (Resident #198) of five residents reviewed for resident funds. Findings include: Review of Resident #198's medical record revealed an admitted [DATE] and diagnoses including other specified schizophrenia and pulmonary heart disease. Resident #198 expired in the facility on [DATE] at 12:28 A.M. Review of Resident #198's medical record revealed the RFA dispersal check was dated [DATE]. Interview on [DATE] at 11:25 A.M. with Business Office Manager (BOM) #402 confirmed Resident #198's RFA monies were not dispersed timely upon the resident's death as required. Review of the Resident Personal Funds Management Policy revised [DATE] revealed if the resident expired, personal funds deposited, would be refunded within 30 days with an accounting of these funds to the individual, probate jurisdiction administering the resident's estate, or other entities or individuals as required by State law or regulation.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review, interview, and review of the facility policy and procedure the facility failed to ensure advanced directives were accurate and readily available. This affected three residents (#87, #99 and #143) of four residents reviewed for advanced directives. The facility census was 148. Findings include: 1. Review of the medical record for Resident #87 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, hypertension, chronic kidney disease stage three, edema, and obstructive sleep apnea. Review of Resident #87's physician orders for December 2024 revealed an active order for code status of Do Not Resuscitate Comfort Care Arrest (DNRCC-A) dated 07/17/24. Further review of Resident #87's medical record revealed there was not a completed and signed Do Not Resuscitate (DNR) form. Interviews on 12/03/24 at approximately 9:20 A.M. and 3:52 P.M. with Licensed Practical Nurse (LPN) #308 verified a completed and signed DNR form was not in Resident #87's medical record. LPN #308 stated she talked with Resident #87 and asked if he wanted any changes to his advance directive as per physician order and the resident said no. LPN #308 stated she then contacted the nurse practitioner to complete a DNR form reflecting the resident's advance directives as per physician order. Review of the facility policy titled Advanced Care Planning Protocol, revised 10/01/24 revealed in the event there were legal documents to be obtained, the patient, family, and facility staff would coordinate as a team to obtain such documents and place in the clinical record. 42733 2. Review of Resident #99's medical records revealed an admitted [DATE]. Diagnoses included adult failure to thrive and chronic kidney failure. Review of the care plan dated 09/11/24 revealed Resident #99's advanced directive was Do Not Resuscitate Comfort Care Arrest (DNR-CCA). A DNR-CCA allows for life saving treatments until the resident's heart or breathing stops after which only comfort care is provided. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #99 had intact cognition. Review of Resident #99's physician orders for December 2024 revealed an order for DNR-CCA. Review of the signed DNR paperwork dated 10/24/24 revealed Resident #99's advanced directive indicated DNR-CC (comfort care only). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/03/24 at 12:21 P.M. with Licensed Practical Nurse (LPN) #357 confirmed Resident #99's signed DNR-CC paperwork and confirmed the electronic medical records indicated Resident #99 as having a DNR-CCA advanced directive. Review of the facility policy titled Advanced Care Planning Protocol, revised 10/01/24 revealed in the event there were legal documents to be obtained, the patient, family, and facility staff would coordinate as a team to obtain such documents and place in the clinical record. 3. Review of Resident #143's medical records revealed an admitted [DATE]. Diagnoses included stroke with right sided weakness, drug abuse and dysphasia (difficulty swallowing). Review of the Minimum Data Set assessment dated [DATE] revealed Resident #143 had impaired cognition. Review of the care plan dated 10/31/24 revealed Resident #143 had a full code status (all life saving measures were to be performed). Review of Resident #143's physician orders for December 2024 revealed a full code order. Review of Resident #143's paper chart revealed hospital paperwork dated 10/07/24 indicating Resident #143 was a presumed full code, however staff were unable to contact next of kin for confirmation. Review of Resident #143's electronic medical records revealed there was not a code status indicated on the main screen. Interview on 12/03/24 at 12:21 P.M. with Licensed Practical Nurse (LPN) #357 revealed a resident's code status should be displayed on the main screen in the electronic medical record. LPN #357 also confirmed Resident #143's code status was blank on the main screen. Interview on 12/04/24 at 10:19 A.M. with Regional Registered Nurse #467 confirmed a resident's code status should be displayed on the main screen in the resident's electronic medical record. Review of the facility policy titled Advanced Care Planning Protocol, revised 10/01/24 revealed in the event there were legal documents to be obtained, the patient, family, and facility staff would coordinate as a team to obtain such documents and place in the clinical record.

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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** 34297 Based on record review and interview, the facility failed to provide Residents #29, #43 and #47 and/or their resident representatives, at the time of transfer or in cases of emergency transfer within 24 hours, written information which explained the duration of the bed-hold and the reserve bed payment policy including the resident's return to the next available bed. This affected three (Residents #29, #43 and #47) of four residents reviewed for hospitalization . Findings include: 1. Review of Resident #29's medical record revealed the resident was admitted on [DATE] with diagnoses including schizophrenia, anxiety disorder and violent behavior. Further review of Resident #29's medical record revealed the resident's insurance payor source was Medicaid. The medical record did not reveal evidence Resident #29 or the resident's representative were provided a bed hold notice upon the residents transfer to the hospital on 10/14/29. Review of Resident #29's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #29's progress note dated 10/14/24 timed 12:00 P.M. revealed the nurse observed the resident with difficulty breathing and Resident #29 was transferred to the hospital. Review of Resident #29's progress note dated 10/28/24 timed 4:37 A.M. revealed Resident #29 arrived from the hospital to the facility around 10:45 P.M. Interview on 12/03/24 at 1:15 P.M. with Regional Registered Nurse #467 confirmed Resident #29 was not provided a bed-hold notice which identified the bed-hold policy with bed-hold days and included the policy for returning to the facility with the reserve bed payment policy upon transfer. Review of the Bed Hold Letter Policy revised 09/26/20 revealed it was the policy of the facility to track Medicaid bed hold days and notify the appropriate parties via Medicaid Bed Hold Letter. 2. Review of Resident #43's medical record revealed the resident was admitted on [DATE] with diagnoses including bipolar disorder, epilepsy and anemia. Further review of the medical record revealed Resident #43's insurance payor source was Medicaid. The medical record did not reveal evidence Resident #43 or the resident's representative were provided a bed hold notice upon transfer to the hospital on 10/05/24. Review of Resident #43's quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #43's progress note dated 10/05/24 timed 3:44 P.M. revealed Resident #43 approached the nurse and stated her right hand hurt. Upon assessment, the dorsal part of the right hand was edematous. Resident #43 was transferred to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #43's progress note dated 10/06/24 timed 1:26 A.M. revealed Resident #43 returned from the hospital around 10:52 P.M. Review of Resident #43's progress note dated 10/10/24 timed 2:36 P.M. revealed Resident #43 sustained a fall on 10/05/24 and was diagnosed with a right fifth metacarpal and right fifth proximal phalanx fracture. Interview on 12/03/24 at 1:15 P.M. with Regional Registered Nurse #467 confirmed Resident #43 was not provided a bed-hold notice upon transfer to the hospital which identified the bed-hold policy with bed-hold days and included the policy for returning to the facility with the reserve bed payment policy. Review of the Bed Hold Letter Policy revised 09/26/20 revealed it was the policy of the facility to track Medicaid bed hold days and notify the appropriate parties via Medicaid Bed Hold Letter. 3. Review of Resident #47's medical record revealed the resident was admitted on [DATE] with diagnoses including multiple sclerosis, vascular dementia and bipolar disorder. Further review of the medical record revealed Resident #47's insurance payor source was Medicaid. The medical record did not reveal evidence Resident #47 or the resident representative were provided a bed hold notice upon Resident #47's discharge to the emergency roiagnom on [DATE]. Review of Resident #47's Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #47's progress note dated 09/15/24 timed 4:08 P.M. revealed Resident #47 and another resident were fighting over an orange dehydration unit and Resident #47 fell to the floor with the dehydration unit. Review of Resident #47's progress note dated 09/15/24 timed 8:00 P.M. revealed Resident #47 had a bruise to the left shoulder which was tender to the touch. Resident #47 was discharged to the emergency room . Review of Resident #47's progress note dated 09/17/24 timed 2:58 P.M. revealed Resident #47 sustained a fall on 09/15/24 and was diagnosed with a dislocation of the left shoulder with no surgical intervention. Review of Resident #47's progress note dated 09/20/24 timed 7:33 A.M. revealed Resident #47 returned from the hospital. Interview on 12/03/24 at 1:15 P.M. with Regional Registered Nurse #467 confirmed Resident #47 was not provided a bed-hold notice upon transfer which identified the bed-hold policy with bed-hold days and included the policy for returning to the facility with the reserve bed payment policy. Review of the Bed Hold Letter Policy revised 09/26/20 revealed it was the policy of the facility to track Medicaid bed hold days and notify the appropriate parties via Medicaid Bed Hold Letter.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review and staff interview the facility failed to notify the appropriate state agency (The Ohio Department of Mental Health) of a significant change in a resident's mental health condition as required. This affected one resident (#106) of one resident reviewed for preadmission screening and resident review (PASARR). The facility census was 148. Findings include: Review of the medical record for Resident #106 revealed an admitted [DATE] with a diagnosis of dementia. Further review of the resident's diagnosis list revealed diagnoses including bipolar disorder, current episode depressed, mild or moderate severity dated 05/21/23, bipolar disorder, current episode mixed, moderate dated 05/23/23, schizoaffective disorder dated 07/26/23, and paranoid schizophrenia dated 10/24/23. Further review of a Notice of PASARR level II outcome dated 04/21/22 revealed Resident #106 was ruled out from further PASARR review related to dementia, Alzheimer's or other neurocognitive disorder. There were no other PASARR reviews after this date. Interviews on 12/03/24 at 1:50 P.M. and at 2:26 P.M. with the Administrator revealed they checked the Healthcare Electronic Notification System ([NAME]) and there were no other PASARRs other than the one from 2022. The Administrator stated they submitted a PASARR today (12/03/24) to include the diagnoses from 2023.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review, interview, and review of the facility policy and procedure, the facility failed to ensure individualized care plans were developed and accurate for three residents (#40, #92, and #133) of 29 sampled residents whose care plans were reviewed. The facility census was 148. Findings include: 1. Review of the medical record for Resident #133 revealed an admitted [DATE]. Diagnoses included post-traumatic stress disorder (PTSD), end stage renal disease, dependence on renal dialysis, and schizophrenia. Further review of Resident #92's medical record on 12/03/24 at 8:56 A.M. revealed no care plan related to PTSD. On 12/04/24 the facility provided a copy of Resident #133's plan of care. Review of this plan of care revealed it was created on 12/04/24 and indicated Resident #92 had a diagnosis of PTSD. The care plan indicated Resident #40 (another resident) has or had potential for intrusive thought, flashbacks, avoidance behaviors, negative changes in mood and cognition. The care plan indicated Will follow up with psych/behavior management as needed. Interview on 12/04/24 at 1:57 P.M. with Minimum Data Set (MDS) Registered Nurse (MDSRN) #356 revealed it was brought to her attention that Resident #133 did not have a care for PTSD, so she ran a report and added a PTSD care plan to those residents who did not. MDSRN #356 verified she created the care plan for Resident #133 today (12/04/24) and that it included Resident #40. MDSRN #356 stated she had created a template from Resident #40's care plan and copied and pasted it to Resident #133's care plan and that was why Resident #40's name was in the PTSD care plan for Resident #133. 2. Review of the medical record for Resident #92 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, major depressive disorder, and personal history of other venous thrombosis and embolism. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92 had intact cognition and received an antidepressant, antipsychotic, and anticoagulant. The assessment indicated Resident #92 received an antipsychotic on routine basis. Review of the physician orders for December 2024 revealed active orders for risperidone (antipsychotic) tablet two milligrams (mg) by mouth at bedtime; Seroquel (antipsychotic) tablet 50 mg by mouth at bedtime; trazodone (antidepressant) tablet 50 mg by mouth at bedtime; and Eliquis (anticoagulant) tablet five mg by mouth twice a day. Interview on 12/04/24 at 3:28 P.M. with Regional Nurse #467 verified there were no care plans for Resident #92's use of psychotropic or anticoagulant medication. 45442 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included but were not limited to bipolar disorder, suicidal ideations, altered mental status, schizoaffective disorder, panic disorder and post-traumatic stress disorder (06/29/23). Review of Resident #40's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #40 had mild cognitive impairment and required supervision for eating, oral hygiene, toileting hygiene and rolling 150 feet in her wheelchair. Resident #40 required moderate assistance for dressing and personal hygiene and maximum assistance from staff for bathing. Review of Resident #40's care plan revealed it was last reviewed on 11/04/24 and revealed no evidence of a care plan or interventions for post-traumatic stress disorder (PTSD). Interview on 12/04/24 at 9:28 A.M. with Social Services #317 confirmed there was no PTSD care plan for Resident #40. Interview on 12/04/24 at 9:46 A.M. with Regional Nurse #467 confirmed there was no care plan addressing PTSD despite Resident #40 having a diagnosis of PTSD since 06/29/23. Review of the facility's Comprehensive Care Planning Policy with a revision date of 03/02/21, revealed the facility must develop a comprehensive Person-Centered Care Plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review, interview, and policy review, the facility failed to ensure Resident #44's care plans were updated to reflect the resident's behaviors and interventions which required the resident to sleep on a flat yoga mat on the floor with no furniture in the room. The facility also failed to ensure Residents #13 and #29's care conferences were conducted at least quarterly. This affected three (Residents #13, #29 and #44) of four residents reviewed for care plans. Findings include: 1. Review of Resident #29's medical record revealed the resident was admitted on [DATE] with diagnoses including paranoid personality disorder and schizophrenia. Further review of the medical record revealed Resident #29 had a legal guardian who was the emergency contact and responsible for the resident's finances. Review of Resident #29's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 exhibited severe cognitive impairment. Review of Resident #29's Care Conference Report form dated 05/06/24 revealed the interdisciplinary team (IDT) was present for the care conference at 11:00 A.M. and the legal guardian was not present after three notifications. Interview on 12/03/24 at 9:08 A.M. with Resident #29's legal guardian revealed she had not been invited to a care conference in greater than three months. Interview on 12/03/24 at 1:15 P.M. with Licensed Social Worker (LSW) #373 confirmed care conferences for Resident #29 were not conducted quarterly. 2. Review of Resident #44's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, bipolar disorder, antisocial disorder and generalized anxiety. Review of Resident #44's annual MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate impairment in cognitive skills for daily decision making. Review of Resident #44's Violent Behavior Care Plan dated 04/12/24 revealed interventions including follow up with psychiatric services, if agitation/aggression behaviors, leave in a safe situation and return in five to ten minutes, encourage to participate in care and activities of choice. Review of Resident #44's Behaviors Care Plan dated 10/23/24 revealed behaviors such as pacing, aggressiveness, hallucinations, and delusions. The care plan had interventions including refer to psychiatrist or psychologist, provide support and reassurance, offer choices to feel more independent, observe for and report to provider behavior issues, monitor/record mood, if resident disruptive, remove from situation and attempt to calm down; identify what helps calm resident; explain all care and procedures before assisting, ensure a safe environment, encourage activity and attempt to redirect. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/03/24 at 1:15 P.M. with Regional Registered Nurse #467 confirmed Resident #44's care plans were not updated to reflect interventions for the resident's behaviors including removing the furniture in the resident's room to prevent the resident from throwing the furniture out of the windows and providing the resident a thin blue yoga mat to sleep on per the resident's preference. 45442 3. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included but were not limited to epileptic seizures, dysphagia, flaccid hemiplegia affecting right dominant side, bipolar disorder, dementia and paranoid schizophrenia. Further review of the medical record did not reveal any documentation of a care conference being held within the past twelve months. Review of Resident #13's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had moderate cognitive impairment and was dependent upon staff for all activities of daily living (ADLs). Phone interview on 12/02/24 at 1:58 P.M. with Resident #13's guardian revealed she was unsure when the last care conference was held as she had not been contacted to attend. Interview on 12/04/24 at 9:46 A.M. with Regional Registered Nurse #467, the Director of Nursing and Assistant Director of Nursing revealed they were unable to provide evidence of a care conference being held for Resident #13 in the past 12 months. Regional Registered Nurse #467 stated the facility identified the concern in October 2024 but had not held a care conference since identifying the concern. Review of the facility's Comprehensive Care Planning Policy with a revision date of 03/02/21 revealed an interdisciplinary plan of care would be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. The facility was to develop a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessments. A resident care plan conference was to be scheduled at least weekly. Residents scheduled for the resident care conference included new admissions whose MDS was completed within the previous seven days, residents who returned from the hospital in the past week, residents with a significant condition change and MDS was completed in the past week, and residents with 90-day review assessments or an annual full assessment completed within the previous seven days.

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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** 45442 Based on medical record review, bathing/showering documentation review, facility policy review and interview, the facility failed to ensure bathing/showering was completed as required for one Resident #110 who required total assistance with activities of daily living. This affected one (#110) of one resident reviewed for bathing. The facility census was 148. Findings include: Review of the medical record for Resident #110 revealed an admitted [DATE]. Diagnoses included but were not limited to acute respiratory failure, chronic obstructive pulmonary disease, and atrial fibrillation. Review of Resident #110's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #110 had intact cognition and was dependent for all activities of daily living (ADLs) including bathing. Review of Resident #110's care plan last reviewed on 11/18/24 revealed Resident #110 had a self-care deficit and required total assistance with ADLs. The care plan did not include specific information related to bathing type preference or frequency for bathing. Interview on 12/02/24 at 10:32 A.M. with Resident #110 revealed he had not been offered a shower in two months, he was sometimes offered a bed bath but not consistently. Review of the undated facility shower rotation sheet for the second floor (the floor Resident #110 resided) revealed Resident #110 was to receive a shower or bed bath on Wednesdays and Saturdays. Review of Resident #110's shower sheets for the past 90 days revealed four shower sheets dated 08/14/24, 08/21/24, 12/02/24 and one which was undated. Interview on 12/04/24 at 1:05 P.M. with the Director of Nursing revealed she was unable to provide any other shower sheets for Resident #110 for the past 90 days and he should have been bathed twice weekly. Review of the facility's Resident Bath Showering Scheduling Policy with a revision date of 09/09/22 revealed each resident would be scheduled to receive bathing a minimum of two times per week unless they preferred less frequent baths. When the bath or shower was complete, the nursing assistant was to document the activity on the shower sheet or the electronic medical record.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 34297 Based on observation, record review and interview, the facility failed to ensure residents who resided on the fifth floor were provided activities as scheduled. This affected 34 residents (Residents #2, #4, #9, #14, #18, #19, #21, #22, #23, #24, #26, #27, #29, #31, #34, #38, #41, #43, #44, #46, #58, #61, #65, #68, #78, #79, #90, #91, #93, #97, #102, #107, #119 and #123) who resided on the fifth floor secured unit. The facility census was 148. Findings include: Observation on 12/02/24 at 2:01 P.M. revealed Activity Director (AD) #459 counting money for residents on the fifth floor. Residents were observed in their rooms and in the common area. The television was on and music was playing in the common area. No formal activities were observation the fifth floor in the afternoon. Interview on 12/03/24 at 11:45 A.M. with AD #459 revealed she was the only activity staff member working on 12/02/24 and the afternoon/evening activities were not completed as scheduled for the fifth floor residents including the 2:00 P.M. Hydration Hour, 3:00 P.M. Griddle Goodies and 6:00 P.M. Table Games. AD #459 stated she had recently terminated an activity staff. The current activity staff consisted of AD #459, one activity staff member who worked during the week and one activity staff who worked the weekend. Review of the Activity Calendar for 12/02/24 revealed activities including 10:00 A.M. coffee cafe, 11:00 A.M. What's in the news?, 11:30 A.M. Hidden Picture Puzzles; 1:00 P.M. room/virtual visits, 2:00 P.M. Hydration Hour, 3:00 P.M. Griddle Goodies and 6:00 P.M. Table Games. Review of the facility census revealed 34 residents resided on the fifth floor secured unit including Residents #2, #4, #9, #14, #18, #19, #21, #22, #23, #24, #26, #27, #29, #31, #34, #38, #41, #43, #44, #46, #58, #61, #65, #68, #78, #79, #90, #91, #93, #97, #102, #107, #119 and #123. Review of the Life Enrichment Programming Policy revised 05/04/23 revealed an ongoing resident-centered Life Enrichment Program, based on comprehensive assessments and care plans, would be provided. The program would be designed to meet the interests and abilities of each resident including their physical, mental, emotional, social, spiritual, psychosocial and leisure needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to ensure assessment and monitoring of a wound to Resident #79's left great toe. This affected one (Resident #79) of four residents reviewed for wounds. Findings include: Review of Resident #79's medical record revealed the resident was admitted on [DATE] with diagnoses including Huntington's disease, acute respiratory failure with hypoxia and muscle weakness. Review of Resident #79's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment. Review of Resident #79's physician orders revealed an order dated 10/22/24 to cleanse the great toe of the left foot with normal saline, pat dry, apply an abdominal dressing and wrap with a gauze roll until healed once daily on night shift. Further review of Resident #79's medical record revealed no evidence of monitoring or assessment of Resident 79's left great toe wound. Observation of Resident #79 on 12/02/24 at 11:50 A.M. with Licensed Practical Nurse (LPN) #364 revealed no evidence Resident #79 had a dressing on the inner aspect of the left great toe. Interview on 12/03/24 at 9:55 A.M. with Interim LPN Wound Nurse #308 revealed the staff did not tell her that Resident #79 had a wound on the inner aspect of the great toe and wound assessments and monitoring were not completed. Interview on 12/04/24 at 12:24 P.M. with Wound Nurse Practitioner (NP) #468 revealed Resident #79's left great toe wound was an abrasion and their first evaluation of the wound was on this date (12/04/24). Review of the Skin and Wound Care Best Practices policy revised 11/05/24 revealed the facility would provide evidence based preventative skin care and wound treatment to prevent unavoidable skin complications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview and record review the facility failed to ensure pre and post dialysis communication was completed. This affected two residents (#100 and #133) of two residents reviewed for dialysis. The facility census was 148. Findings include: 1. Review of Resident #100's medical records revealed an admitted [DATE]. Diagnoses included end stage renal disease and acute kidney failure. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 had intact cognition. Review of the care plan dated 11/18/24 revealed Resident #100 required dialysis. Review of physician orders for December 2024 revealed an order to complete Resident #100's dialysis observation tool prior to dialysis and print and send with resident to dialysis. Interview on 12/04/24 at 8:05 A.M. with Licensed Practical Nurse (LPN) #425 revealed dialysis communication was to be completed prior to residents leaving for dialysis and was to be sent with the residents. Review of dialysis communication forms for Resident #100 on 12/04/24 at 2:37 P.M. with Regional Registered Nurse (RRN) #467 revealed communication forms had not been completed with each dialysis treatment as required. Review of the facility policy titled Hemodialysis revised 08/24/23 revealed the policy indicated to document pre-assessments on the dialysis communication tool including vital signs, pre-treatment weight, medications administered before treatment and any additional alerts or information. The policy further indicated to print the tool and send with the residents. The Post dialysis processes included received report from the dialysis provider and post dialysis information was to include vital signs, post treatment weights and any new orders. 39969 2. Review of the medical record for Resident #133 revealed an admitted [DATE]. Diagnoses included post-traumatic stress disorder, end stage renal disease, dependence on renal dialysis, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #133 had intact cognition, behaviors that included delusions and hallucinations, physical behaviors, verbal behaviors, and rejection of care that occurred daily. The assessment also indicated the resident was dependent on staff for transfers and received dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders for December 2024 revealed and active order for dialysis on Mondays, Wednesdays, and Fridays at the dialysis center. Review of a 30 day look back of the dialysis communication tools revealed communication tools dated 11/06/24, 11/11/24, 11/18/24, and 12/02/24 sent to dialysis but nothing was documented under the section to be completed by dialysis staff. There was no dialysis communication tools for the days the resident attended dialysis on 11/15/24, 1/22/24, and 11/27/24. Resident #133 refused to go to dialysis on 11/04/24, 11/08/24, 11/13/24, 11/20/24, and 11/29/24. Interview on 12/05/24 at 10:04 A.M. with Regional Nurse #467 verified dialysis did not send back the communication completed with the dialysis center information and that there were days that the communication tool was not sent at all outside of the days Resident #133 refused to go. Review of the Hemodialysis Care Policy, revised 08/24/23 revealed licensed staff with demonstrated competence would care for residents who required hemodialysis (via onsite third party providers or who traveled to an outpatient setting). Communication between the dialysis provider and facility staff would occur before and after hemodialysis treatment and as needed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45442 Based on record review, interview and review of monthly pharmacy recommendations, the facility failed to ensure pharmacy recommendations were addressed by the physician timely. This affected four residents (Residents #10, #19, #75, and #92) of five residents reviewed for medication regimen reviews. The facility census was 148. Findings include: 1. Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included but were not limited to diabetes mellitus, paranoid schizophrenia, gastroesophageal reflux disease, convulsions, restlessness and agitation, and post traumatic stress disorder. Review of the 10/30/24 significant change Minimum Data Set (MDS) 3.0 assessment for Resident #10 revealed he was cognitively intact, and was receiving insulin, antipsychotics, anticonvulsant, and antidepressants. Resident #10 was noted to have delusions and rejection of care. The last gradual dose reduction (GDR) for antipsychotics was attempted on 09/24/13 and the last time a GDR was indicated as contraindicated was 04/22/24. Review of the pharmacy consultation report for Resident #10 dated 12/18/23 revealed Resident #10 received Seroquel extended release 800 milligram (mg) per day, trazadone 50 mg at night and divalproex 1000 mg at night. The recommendation indicated to consider a GDR or provide documentation to support if a GDR was clinically contraindicated. The form did not have a physician response. Review of pharmacy consultation reports for Resident #10 dated 12/18/23 and 03/15/24 revealed the most recent hemoglobin A1c (measures average blood sugar levels over the past three months) was nine percent. The recommendation indicated to consider increasing Metformin to 1000 mg twice daily. The form did not have a physician response. Review of pharmacy consultation report for Resident #10 dated 05/22/24 revealed the most recent hemoglobin A1c was 8.4 percent. The recommendation indicated to consider increasing Metformin to 1000 mg twice daily. The form did not have a physician response. Review of pharmacy consultation reports for Resident #10 dated 04/22/24 and 06/17/24 revealed the resident received divalproex sodium extended release (ER) but did not have a trough concentration documented in the medical record within the past six months. The recommendation indicated to monitor a valproic acid trough concentration on the next convenient lab day and every six months. Review of the medical record revealed no evidence of the valproic acid trough being completed as recommended. Review of pharmacy consultation report for Resident #10 dated 06/17/24 and 08/20/24 revealed the resident received omeprazole 40 mg once daily. The recommendation indicated to consider a trial reduction to 20 mg daily. The form did not have a physician response. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's active physician orders revealed orders dated 09/11/24 for divalproex (anticonvulsant) 500 milligrams (mg) one tablet, Seroquel (antipsychotic) 400 mg two tablets at bedtime, trazadone (antidepressant) 50 mg one tablet at bedtime, Metformin (antiheperglycemic) 750 mg extended-release twice daily, and omeprazole (reduces amount of acid stomach makes) 40 mg delayed release once daily. Review of a physician order dated 09/22/24 revealed an order for benztropine (anti-tremor) 0.5 mg twice daily. Interview on 12/04/24 at 2:21 P.M. with Regional Registered Nurse #467 revealed the facility was unable to provide evidence that the above pharmacy recommendations were addressed within 30 days as required. Regional Registered Nurse #467 also confirmed the labs for valproic acid were not completed as recommended on 04/22/24 and 06/17/24. Follow up interview on 12/05/24 at 11:30 A.M. with Regional Registered Nurse #467 confirmed there were no diagnoses listed for benztropine, Metformin, omeprazole, Seroquel and trazadone for Resident #10. 2. Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included but were not limited to morbid obesity, hepatic encephalopathy, cirrhosis of the liver, esophageal varices with bleeding and depression. Review of the 09/30/24 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #75 revealed the resident was cognitively intact. Resident #75 was noted to have received antipsychotics, antidepressants, anticoagulant and a diuretic. The Last gradual dose reduction was noted to be 02/05/24 and the last noted contraindicated gradual dose reduction was noted on 04/11/24. Review of physician orders dated 01/28/24 for Resident #75 revealed an order for Eliquis five milligram (mg) (blood thinner) one tablet by mouth two times daily for hypertension. Review of the pharmacy consultation reports for Resident #75 dated 02/25/24, 04/12/24, 06/16/24, and 08/15/24 revealed the following irregularities were noted on the electronic medication administration record /prescriber order sheets: Diagnosis inappropriate (Medication): Eliquis diagnosis listed in the electronic medication administration record as hypertension. Eliquis is an anticoagulant. The recommendations indicated to please clarify or correct these items. The form did not have a physician response. Interview on 12/04/24 at 2:21 P.M. with Regional Registered Nurse #467 revealed the facility was unable to provide evidence the above identified pharmacy recommendations were addressed within 30 days as required. 39969 3. Review of the medical record for Resident #92 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, major depressive disorder, and personal history of other venous thrombosis and embolism. Review of the physician orders for December 2024 revealed active orders for Seroquel (antipsychotic) tablet 50 milligrams (mg) by mouth at bedtime. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the consultation report from the pharmacist dated 09/17/24 revealed a recommendation for an initial attempt at a gradual dose reduction (GDR). The recommendation indicated to consider reducing Seroquel to 25 milligram (mg) at bedtime or to provide a rationale as to why a GDR was contraindicated. The report was marked declined, signed by the physician, and dated 09/19/24. There was no documentation on the report regarding the rationale for declining the recommendation. Further review of Resident #92's medical record revealed there was no documentation as to the rationale for declining the GDR for the Seroquel. Interview on 12/05/24 at 8:56 A.M. with Regional Registered Nurse #467 verified there was no documented rationale from the physician for declining the GDR recommendation for the Seroquel. 34297 4. Review of Resident #19's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, bipolar disorder and generalized anxiety. Review of Resident #19's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem. Review of Resident #19's physician orders revealed an order dated 02/17/23 (discontinued 01/29/24) for Meloxicam 7.5 milligrams (mg) give one tablet one time a day for inflammation of the right leg. Review of Resident #19's Pharmacy Consultation Report form dated 12/16/23 indicated the resident was started on Meloxicam 7.5 mg daily on 02/17/23. The recommendation indicated to please discontinue the Meloxicam and consider initiating an alternative analgesic. The form did not have a physician response. Review of Resident #19's physician orders revealed an order dated 01/29/24 (discontinued 09/24/24) for Meloxicam 7.5 mg one tablet by mouth one time a day for inflammation of the right leg. Review of Resident #19's Pharmacy Consultation Report form dated 02/29/24 revealed the resident was started on Meloxicam 7.5 mg daily on 02/17/23. The recommendation indicated to please discontinue Meloxicam and consider initiating an alternative analgesic. The form did not have a physician response. Review of Resident #19's Pharmacy Consultation Report dated 06/17/24 indicated the resident was started on Meloxicam 7.5 mg daily on 02/17/23. The recommendation indicated to discontinue the Meloxicam and consider initiating an alternative analgesic. The physician response to the recommendation indicated to check a basic metabolic panel (BMP) blood level with the next lab draw. Interview on 12/04/24 at 9:31 A.M. with Regional Registered Nurse #467 confirmed Resident #19's pharmacy recommendations were not acted upon in a timely manner. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Regiment Review policy revised 06/01/24 revealed the consultant pharmacist would document medication record reviews (MRRs) and would make recommendations based on the information made available in the residents' health record. The consultant pharmacist would provide required recipients of residents' MRRs on the MRR report to the Director of Nursing and/or the attending physician, and to the Medical Director.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure Resident #19's as-needed antipsychotic medications were limited to fourteen days until the physician evaluated the resident, and non-pharmacological interventions were attempted prior to administering as-needed antipsychotic medications. This affected one (Resident #19) of five residents reviewed for medication administration. Findings include: 1. Review of Resident #19's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, bipolar disorder and generalized anxiety. Review of Resident #19's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem and received antipsychotic medications. Review of Resident #19's physician orders revealed an order dated 11/11/24 for olanzapine (antipsychotic) 2. 5 mg intramuscularly (IM) every six hours as needed for agitation. There was no stop date on the order. Review of Resident #19's Pharmacy Consultation Report dated 11/15/24 revealed the resident was ordered olanzapine antipsychotic medications without a stop date. The physician response dated 11/26/24 indicated to initiate the stop date to 14 days (stop date 11/26/24). Review of Resident #19's medication administration records from 11/04/24 to 12/04/24 revealed no evidence the resident received the olanzapine IM during this time frame. Interview on 12/04/24 at 9:44 A.M. with Regional Registered Nurse (RN) #467 confirmed Resident #19's IM olanzapine did not have an appropriate stop date. 2. Review of Resident #19's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, bipolar disorder and generalized anxiety. Review of Resident #19's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem and received antipsychotics. Review of Resident #19's physician orders revealed an order dated 11/27/24 (discontinued 12/09/24) for olanzapine 2.5 mg give one tablet by mouth every six hours as needed. Review of Resident #19's medication administration records revealed the resident was administered the olanzapine antipsychotic on 11/27/24 at 1:26 P.M., 11/27/24 at 8:04 P.M. and 11/28/24 at 9:19 P.M. The medical record did not have evidence non-pharmacological interventions were implemented prior to administering the antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/04/24 at 9:31 A.M. with Regional Registered Nurse #467 confirmed Resident #19's medical record did not have evidence non-pharmacological interventions were implemented prior to administering Resident #19's as needed antipsychotic medication. Review of the Psychoactive Medication Policy revised 05/10/24 revealed all residents receiving psychoactive medications would have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for a gradual dose reduction of psychoactive medications monitored and documented.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 39969 Based on observation, record review, and interview the facility failed to ensure the coordination of services to make certain residents received the correct diets. This affected two residents (#19 and #29) of seven residents (#19, #29, #31, #100, #119, #134, and #143) reviewed for nutrition. The facility census was 148. Findings include: Observation of lunch on 12/02/24 at 12:50 P.M. revealed Resident #29's meal ticket indicated regular double protein diet and listed beef stew, mixed vegetables, biscuit, margarine, tropical fruit cup, whole milk, and beverage of choice. Observation of Resident #29's meal revealed no double protein. Medical record review revealed Resident #29 was to receive double protein with meals. Interview on 12/02/24 at 12:55 P.M. with Agency Certified Nurse Aide (CNA) #500 confirmed Resident #29 did not have double protein for his meal. Observation of lunch on 12/03/24 at 12:30 P.M. revealed Resident #19's meal ticket indicated regular, renal diet and listed cheese pizza, salad garden with dressing, fortified potatoes, chocolate chip cookie, two percent milk, hot chocolate, margarine, beverage of choice, salt, pepper, and sugar. Observation of Resident #19's meal revealed she received noodles, a plain hamburger, and milk. Medical record review revealed Resident #19 was to receive fortified potatoes and was not ordered a renal diet. Interview on 12/03/24 at 12:33 P.M. with CNA #347 verified the observation of Resident #29's lunch meal.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review, interview, and policy review the facility failed to ensure Resident #95 was provided education and offered the influenza and pneumococcal vaccines. This affected one (Resident #95) of five residents reviewed for immunizations. Findings include: Review of Resident #95's medical record revealed the resident was admitted on [DATE] with diagnoses including essential hypertension, other chronic pain and history of falling. Review of Resident #95's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Further review of Resident #95's medical record did not reveal evidence the resident was offered or educated on the influenza and pneumococcal vaccines. Interview on 12/05/24 at 11:03 A.M. with Registered Nurse Infection Preventionist #320 and Regional Registered Nurse #467 confirmed Resident #95 was not offered or educated on the influenza or pneumococcal vaccines. Review of the Influenza Vaccine Policy (Resident) revised 08/19/20 revealed all residents would be offered an influenza vaccine beginning in October of each year, unless medically contraindicated or the resident had already been vaccinated. The facility would provide the most recent vaccine information statement from the Centers for Disease Control and Prevention and an opportunity to ask any questions they may have before consenting to the vaccination. Review of the Pneumococcal Vaccine Policy (Resident) revised 08/19/20 revealed all residents would be offered the pneumococcal vaccine to aid in preventing pneumococcal infections. The facility would provide educational information regarding the significant risks and benefits of the vaccine to the resident and/or residents' representative on admission and prior to administration of the vaccine.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39969 Based on observation and interview the facility failed to ensure the resident environment on the fourth floor was maintained in good repair. This had the potential to affect all 42 residents (#1, #3, #6, #7, #11, #12, #16, #36, #37, #39, #45, #49, #51, #52, #56, #57, #60, #64, #72, #73, #77, #80, #83, #85, #87, #89, #92, #98, #106, #108, #109, #111, #112, #114, #120, #128, #133, #137, #140, #144, #145, and #148) who resided on the fourth floor. The facility census was 148. Findings include: Observation on 12/03/24 at 12:04 P.M. revealed Resident #72 was in bed. The wall the bed was against was caved in and in disrepair. Interview at the time of the observation with Certified Nurse Aide (CNA) #300 verified the observation and stated the damage to the wall was from the bed. CNA #300 asked Resident #72 how long the wall had been that way and the resident responded it was like that when he moved to this room about four months ago. Observation of the shower room on the fourth floor located to the right of the vending machine on 12/03/24 at 1:07 P.M. revealed the back of the sink was not affixed to the wall and slightly leaning forward. Interview on 12/03/24 at 1:13 P.M. with CNA #451 verified the observation and stated all the residents on the unit used the shower room. Observation of Residents #1 and #3's room on 12/03/24 at 1:20 P.M. revealed a missing ceiling tile above the toilet exposing the pipes. The ceiling tile was on the floor near the toilet. Several missing floor tiles were observed around the toilet. There was a large white patch on the wall above the soap dispenser that needed to be painted. Interview at this time with CNAs #300 and #451 verified the observations and they stated that the bathroom had been that way greater than five months During observation of the fourth floor on 12/05/24 from 11:03 A.M. to 11:20 A.M. with Director of Maintenance (DOM) #341 the DOM #341 verified the back side of sink in the shower room was not affixed to the wall and sightly leaning forward. During the observation of Residents #1 and #3's bathroom, DOM #341 stated he was not aware of the missing ceiling or floor tiles but stated he was aware of the patched wall and needed to get paint. DOM #341 stated he was not sure when the hole was patched because there were so many holes they had patched because of the resident population. During the observation of Resident #72's room, DOM #341 stated he was aware of wall next to bed and stated he was not sure when the damage occurred. Additional observation of Resident #72's room with DOM #341 revealed a baseball size hole in wall across from and facing the foot of the bed. DOM #341 stated he was not aware of that hole. Review of the facility census report dated 12/02/24 revealed 42 residents (#1, #3, #6, #7, #11, #12, #16, #36, #37, #39, #45, #49, #51, #52, #56, #57, #60, #64, #72, #73, #77, #80, #83, #85, #87, #89, #92, #98, #106, #108, #109, #111, #112, #114, #120, #128, #133, #137, #140, #144, #145, and #148) resided on the fourth floor.