STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365859	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Merriman	209 Merriman Rd Akron, OH 44303

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review and review of facility policy, the facility did not ensure Resident #5 had properly sized clothing to maintain his right to dignity. This affected one resident (Resident #5) out of 21 residents reviewed for dignity. The facility census was 53. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including schizophrenia, anemia, pain in left knee, muscle weakness, essential hypertension, history of falling, and other abnormalities of gait and mobility. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/03/25, revealed Resident #5 was cognitively intact, hallucinated and had delusions, had not rejected care, could walk independently with a walker, and required setup or clean up assistance for upper and lower body dressing and for putting on footwear. Observation on 01/21/25 at 11:11 A.M. revealed Resident #5 was in his room in full view of the hallway. The resident's gray sweatpants were so large on him he had to hold them up with his hand and every time he let go of the sweatpants, the pants would fall to his ankles exposing his legs and white disposable brief. Interview with Resident #5 at the time of observation revealed the resident was alert but unable to answer questions, as his focus of the interview was making statements he was a king . Observation on 01/21/25 at 12:11 P.M. revealed as Resident #5 was standing at the end of his bed and was writing on a piece of paper on his overbed table in his room, his gray sweatpants were around his ankles with his legs and white disposable brief exposed and in full view of the hallway outside his room. Observation on 01/22/25 at 8:51 A.M. revealed Resident #5 was observed to be holding up his sweatpants as he walked down the hallway with his walker. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/22/25 at 9:00 A.M. revealed Resident #5's sweatpants were down to his ankles with his white disposable brief in full sight of other residents and staff in the outside smoking area as he smoked a cigarette. At the time of observation, Occupational Therapy Assistant #346 confirmed Resident #5's pants were down to his ankles with his legs and brief exposed in the outside smoking area as four residents were going outside to smoke and proceeded to alert staff so he could be brought inside. Interview on 01/22/25 at 9:06 A.M. with Certified Nursing Assistant (CNA) #335 confirmed Resident #5's pants were too large on him and would often fall to his ankles exposing his brief in open view of the hallway. Interview on 01/22/25 at 10:59 A.M. with Assistant Director of Nursing #377 confirmed Resident #5's pants were really large, but he had no guardian or family to provide clothes for him. She stated the facility had tried to find him better fitting clothing but could not give a reason why the facility hadn't found more appropriately fitting pants and went on to state having appropriately sized clothes for residents was above her. Interview on 01/23/25 at 9:27 A.M. with CNA #323 confirmed Resident #5 was wearing pants too big for him and would fall down exposing his lower body. CNA #323 stated she would go to laundry and find pants that would fit him. Review of facility policy Resident Rights, revised December 2016, revealed the resident had the right to a dignified existence.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36650 Based on observation, interview and review of facility policy the facility did not maintain clean bathing and shower rooms for all residents excluding 20 residents (Resident #2, # 3 #7, #8, #9, #12, #15, #17, #19, #21, #22, #23, #24, #25, #26, #28, #32, #33, #35 and #46) the facility identified as not using the bathing and shower rooms. The facility census was 53. Findings include: Observation on 01/21/25 at 10:42 A.M. of the facility bathing room used for all residents who preferred and/or needed bathing revealed the toilet in the bathing room had no water in the toilet and had feces in the bowl. There was no signage on the toilet saying it was not to be used. The floor was dirty and there was dirt built up around the edges of the floor. Observation on 01/21/25 at 10:50 A.M. of the facility shower room used for all residents who could shower revealed there were missing tiles on the floor of the shower area, and the shower was leaking with a black substance on the wall of the shower. The grout along the bottom of the shower was black/brown in color. Used gloves were on the floor, a dirty towel was sitting on an old cloth chair and there was a gritty dirt build-up on the floor behind the door. Interview on 01/21/25 at 10:53 A.M. with Housekeeper (HK) #340 verified and observed all concerns of the bathing room and shower room. HK #340 verified both the shower room and bathing room were in use for residents to use for baths and showers. Review of the facility policy, Bathrooms, dated 04/2006 revealed bathrooms shall be maintained in a clean and sanitary manner and shall be cleaned on a daily basis. Review of the facility policy, Floor, dated 12/2009 revealed floors shall be maintained in a clean, safe and sanitary manner.

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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 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** 46195 Based on record review, and interviews the facility failed to develop person-centered care plans to identify triggers of Post Traumatic Stress Disorder (PTSD) for Resident #10 and Resident #29. This affected two residents (#10 and #29) of 21 residents reviewed for care plans. The facility identified three residents (#10, #29, and #37) with PTSD. The facility census was 53. Findings include: 1. Review of the medical record for Resident #29 revealed an admitted [DATE]. Pertinent diagnoses included post traumatic stress disorder, anxiety disorder, depression, and bipolar disorder. Review of Trauma Life Events Checklist, dated 07/28/23, revealed Resident #29 had a transportation accident and witnessed a transportation accident, had a serious accident at work, home or during recreational activity, had been physically assaulted and witnessed physical assault, had been assaulted with a weapon and witnessed assault with a weapon, had been sexually assaulted, had experienced other unwanted or uncomfortable sexual experiences, had been held in captivity, had witnessed a sudden accidental death, had witnessed serious injury, harm, or death to someone else, and had witnessed other very stressful events or experiences. Review of Resident #29's care plan, dated 11/21/24, revealed the resident had a history of trauma/PTSD since he was a survivor of crimes. Interventions included: attain the highest practicable physical, mental and psychosocial well-being to assure resident's safety; assist resident and family with access to psychiatry and psychosocial services; identify triggers for trauma; provide care in treating past trauma with coordination of resident's attending physician and/or psychiatric services. There were no specific triggers listed in the care plan. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 12/17/24, revealed Resident #29 was cognitively intact. Interview on 01/21/25 at 12:05 P.M. with Resident #29 revealed large crowds was a trigger for him and if he was in a crowd of people it would cause him anxiety related to PTSD. Resident #29 stated since he had been at the facility he stayed to himself in his room to avoid being triggered. Interview on 01/22/25 at 11:41 A.M. with Certified Nursing Assistant (CNA) #400 revealed she didn't know crowds were a trigger for Resident #29. Interview on 01/22/25 at 11:43 A.M. with Registered Nurse #328 revealed she was aware there were residents with PTSD, but she was unaware if Resident #29 had any triggers. Interview on 01/22/25 at 3:22 P.M. with Activity Aide #383 revealed she was not aware Resident #29 would be triggered by crowds. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 3:48 P.M. with Social Services Director (SSD) #351 revealed she didn't think she had the ability to ask for triggers for residents with PTSD, and she was unaware of any triggers for Resident #29. SSD #351 verified there were no triggers identified on Resident #29's care plan for PTSD. 2. Review of the medical record for Resident #10 revealed an admitted [DATE]. Pertinent diagnoses included post traumatic stress disorder (PTSD), insomnia, depression, chronic pain syndrome, and abnormalities of gait and mobility. Review of Resident #10's care plan, which was initiated on 07/31/24, revealed no care plan for PTSD and no identified triggers. Review of the quarterly MDS 3.0 assessment, dated 10/30/24, revealed Resident #10 was cognitively intact, and for seven to 11 days during the assessment reference period the resident had little interest or pleasure in doing things, had trouble falling or staying asleep or sleeping too much; had trouble concentrating on things such as reading the newspaper or watching television; moved or spoke slowly that other people had noticed or the opposite being fidgety or restless that you have been moving around more than usual. Review of a 12/23/24 psychiatry note in Resident #10's medical record revealed he had been referred to their services for depression. Resident #10 had a PTSD diagnosis, and he endorsed symptoms of flashbacks and nightmares. The resident reported being hit by a motor vehicle causing him to have multiple surgeries and being in a coma for about nine months. The note indicated there had been no mention of this incident per chart review. Plan was for staff to monitor and report to the psychiatrist for worsening signs/symptoms of PTSD. Interview with Resident #10 on 01/21/25 at 12:05 P.M. confirmed he had a diagnosis of PTSD from getting hit by a car. He stated his triggers were big groups of people and when he was spoken to in an aggressive or disrespectful manner. Interview on 01/22/25 at 11:41 A.M. with Certified Nursing Assistant (CNA) #400 revealed she didn't know the triggers for Resident #10. Interview on 01/22/25 at 11:43 A.M. with Registered Nurse #328 revealed she was aware there were residents with a PTSD, but she did not know the triggers for Resident #10. Interview on 01/22/25 at 3:22 P.M. with Activity Aide #383 revealed she was not aware of triggers for Resident #10. Interview on 01/22/25 at 3:48 P.M. with SSD #351 revealed she didn't think she had the ability to ask for triggers for residents with PTSD and was unaware of any triggers for Resident #10. Review of Resident #10 care plan and interview on 01/22/25 at 4:58 P.M. with SSD #351 confirmed there was no care plan for PTSD and no triggers on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Trauma-informed Care in Nursing Facilities education material, dated 10/25/24 with staff signatures, revealed the facility would realize the widespread impact of trauma and understand potential paths for recovery, recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system and would actively seek to resist re-traumatization. Review of facility policy Trauma Informed Care, revised March 2019, revealed nursing staff would be trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization and trauma care would be culturally sensitive and person centered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observations, record review, and interview the facility failed to ensure Resident #21 wore a hand splint according to physician order. This affected one resident (Resident #21) of one resident reviewed for splint devices. The facility identified three residents (#6, #12 and #21) with orders for hand splints. The facility census was 53. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included chronic pain, hemiplegia and hemiparesis following cerebral infarction (stroke), and anxiety disorder. Review of Resident #21's occupational therapy evaluation and plan of treatment, dated 07/08/24, revealed the resident had been referred to therapy due to increased assist and worsening left upper extremity tone, especially in his hand, and the resident had a functional limitation present due to a contracture. Review of Resident #21's physician orders revealed an order dated 08/16/24 for left resting hand splint to be on in A.M. and removed in P.M. Check skin prior to and after application. Inform CNP(certified nurse practitioner)/MD (doctor of medicine) of refusals every shift. Review of Resident #21's occupational discharge summary, dated 09/05/24, revealed Resident #21 received occupational therapy from 07/08/24 to 09/05/24 and by discharge on 09/05/24 the resident was wearing the splint for eight hours without signs or discomfort and prognosis was excellent to maintain current level of care with consistent staff support. The discharge recommendation was to continue use of left resting hand splint. Review of the care plan, dated 08/16/24, revealed Resident #21 had an alteration in musculoskeletal status related to impairment to the left side. Interventions included left resident hand splint to be on in A.M. and removed P.M. Check skin prior to and after application, Inform CNP/MD of refusals. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 11/13/24, revealed Resident #21 was moderately impaired cognitively and had impairment on one side of functional limitation in range of motion for upper extremity, and had no rejection of care. Further review of progress notes from 07/24/24 to 01/21/25 in Resident #21's medical record revealed no documentation of the resident refusing to wear his splint. Review of the task section in Resident #21's medical record for the past 30 days revealed no evidence the splint was applied as ordered on 12/30/24, 12/31/24, 01/01/25, 01/02/25, 01/03/25, 01/04/25, 01/05/25, 01/06/25, 01/08/25 and 01/09/25. The task documentation revealed the last time staff marked Resident #21 wore his splint was on 01/12/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/21/25 at 10:58 A.M. revealed the resident had a contracted left hand and was not wearing a splint. Interview with Resident #21 at time of observation revealed he had a splint but didn't know where it was, and the last time he wore his splint was a couple weeks ago. Observation on 01/22/25 at 8:48 A.M. revealed Resident #21 was not wearing a splint to his contracted left hand. Interview on 01/22/25 at 9:09 A.M. with Certified Nursing Assistant (CNA) #335 stated he (Resident #21) wears a thing for his hand. I don't know why he is not wearing it, and therapy would know why he isn't wearing it. Interview on 01/22/25 at 11:29 A.M. with Director of Therapy #375 and Occupational Therapist #313 both confirmed Resident #21 wasn't wearing his splint and didn't know why. They stated he needed to wear the split for contracture prevention and if he didn't wear it, he had the potential for his contracture to get worse. Interview on 01/22/25 at 11:46 A.M. with CNA #400 revealed she thought he was supposed to wear a splint but was not sure if he had one. Observation of Resident #21's room with CNA #400 at the time of interview revealed Resident #21's splint was sitting on top of his dresser, which was next to the door. Interview on 01/23/25 at 2:20 P.M. with the Director of Nursing (DON) confirmed Resident #21's medical record under the task section indicated the last time it was documented the splint had been applied was on 01/12/25. The DON stated the aides were supposed to document when they applied the splint, and if nothing was marked, the splint had not been applied. Review of facility policy Adaptive Equipment, revised January 2024, revealed the use of adaptive equipment, which included splints, would be carried out or supervised by members of the nursing staff to assist residents with attaining or maintaining their highest level of physical well-being.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure Resident #5 and Resident #29 were free from potential accident hazards related to smoking. This affected two residents (#5 and #29) of four residents reviewed for accidents/hazards. The facility identified 29 residents (#4, #5, #6, #10, #11, #13, #15, #16, #17, #18, #21, #23, #29, #31, #32, #34, #38, #40, #41, #43, #44, #45, #46, #48, #49, #50, #51, #56, #156) as smokers. The facility census was 53. Findings include: 1. Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including schizophrenia, generalized muscle weakness and need for assistance with personal care. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #5 had intact cognition with hallucinations and delusions but no behavioral symptoms or rejection of care. He was independent with mobility using a walker. Review of the care plan for Resident #5 dated 01/17/25 revealed he was a smoker and was at risk for injury related to smoking. Interventions included educate on risks of smoking and offer cessation assistance, smoking apron to be worn when smoking, smoking assessment quarterly and as needed and supervise smoking. Further review of the medical record for Resident #5 revealed a Smoking and Safety assessment dated [DATE] and completed by Assistant Director of Nursing (ADON) #377. The assessment revealed the resident smoked cigarettes and was deemed to be a safe independent smoker. Review of the incident/accident log dated 10/01/24 to 01/22/25 revealed Resident #5 had not had any documented burns or other accidents related to smoking. Further review of the medical record also revealed the resident had not been treated for any burns or other accidents related to smoking during this time period. Observation on 01/22/25 at 8:51 A.M. and 9:06 A.M. revealed Resident #5 was smoking a cigarette in the outside smoking area. When Resident #5 was done smoking his cigarette his threw his cigarette butt toward the building which landed on the ground. Resident #5 was not wearing a smoking apron and the pants he was wearing had nine burn holes in the pants. At the time of observation, Licensed Practical Nurse (LPN) #336 was present and confirmed the burn holes in Resident #5's pants. LPN #336 stated Resident #5 was supposed to wear a smoking apron and confirmed he hadn't been wearing one at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 9:10 A.M. with Certified Nursing Assistant (CNA) #335 revealed almost all Resident #5's clothes had burn holes in them. Observation of Resident #5's clothes in his wardrobe with CNA #335 revealed black sweat pants with 30 burn holes on the front, five t-shirts/shirts with one to 23 burn holes on each item, a gray and black jacket with 16 burn holes on the front and a pair of gray shorts with six burn holes on the front of the pants. The size of the burn holes n the clothing ranged from pencil-eraser sized to quarter coin size. At the time of observation, CNA #335 confirmed the condition of the clothing with the burn holes present. Interview on 01/22/25 at 10:59 A.M. with ADON #377 revealed she had completed Resident #5's smoking assessment on 01/21/25 in response to concerns raised by the State agency Life Safety Code surveyor on 01/21/25 pertaining to safe smoking by another resident in the facility. ADON #377 stated she did not thoroughly inspect Resident #5's clothing to see if there were any burn holes and that should have been done because that was one of the questions on the assessment to determine if he was safe to smoke independently. ADON #337 stated if she had noticed burn holes on his clothing the resident would be encouraged to wear a smoking apron and the interdisciplinary team would discuss if a smoking apron was sufficient or if the resident would need to be a supervised smoker. ADON #337 revealed there were currently no residents she was aware of who wore a smoking apron at this time. She stated throwing a lit cigarette butt to the ground was not an appropriate way to extinguish the cigarette which was another risk factor on the smoking assessment indicating unsafe smoking. She stated the resident should be able to extinguish the cigarette appropriately and throw it in the receptacle for cigarette butts. 2. Review of medical record for Resident #29 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, bipolar disorder, chronic pain, chronic combined systolic (congestive) and diastolic heart failure, essential hypertension , tobacco use, anxiety disorder, and other psychoactive substance abuse. Review of the care plan dated 06/01/23 revealed Resident #29 was a smoker but it was noted on 12/17/24 smoking cessation was in place. Interventions included the resident would comply with facility smoking policy and the resident verbalized safe smoking practices. Review of Resident #29's physician's orders revealed an order dated 09/28/23 for oxygen three liters per minute as needed for respiratory support. Review of quarterly Minimum Data Set (MDS) 3.0 assessment, dated 12/17/24, revealed Resident #29 was cognitively intact and was on oxygen during the assessment reference period. Review of progress notes dated 12/25/24 through 01/20/25 revealed no documented incidents of the resident smoking in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/21/25 at 9:45 A.M. with Director of Maintenance (DM) #370 revealed an odor of smoke in the hallway near Resident #29's room. Further investigation found the odor to be emanating from Resident #29's room. Upon entering Resident #29's room with DM #370, the resident was observed sitting in a recliner located between the bed and doorway. A blue plastic lighter, a thin metal pipe approximately eight inches long with burnt soot on the end, two toothpick size pieces of wood with soot on the ends, a small metal clip with soot on it fastened to a metal handle and a yellow vape device with Pulse THC were observed sitting on a rolling table beside Resident #29's recliner. Further observation noted a red sign on Resident #29's doorway to indicate no smoking oxygen in use in the room of Resident #29. Resident #29 had an oxygen mask on his face at the time of the observation but was not smoking. DM #370 verified the above findings at the time of the observation. A progress note entry dated 01/21/25 revealed suspected smoking violation. Cup with water and cigarette butts observed in room. Oxygen in room not being used. Resident educated on smoking policy and changed to supervised smoking. Placed on increased supervision. Will reassess in 72 hours. Resident alert and oriented and able to verbalize understanding of smoking policy. Administrator will issue 30 day discharge notice for any subsequent infraction. Interview on 01/21/25 at 9:49 A.M. with Resident #29 revealed he was a smoker. Additionally, when asked about smoking in his room Resident #29 admitted he had previously smoked in his room but stated he was not smoking at the time when the observations were made. A review of the facility's smoking policy revealed the facility allowed residents to smoke in the designated smoking area located in a small courtyard near the east side of the building. Further review of the policy revealed if deemed competent they were responsible for acquiring and maintaining their own smoking materials including lighters, but the policy did not include provisions for residents who were smokers, used oxygen and the elimination sources of ignition in the areas of those residents.

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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 observations, interviews, record review, facility policy review , and review of manufacturer's user guide, the facility failed to ensure Resident #21's head strap for the BiPAP (bilevel positive airway pressure) machine was clean and sanitary and failed to ensure Resident #34's oxygen tubing was dated. This affected two residents (#21 and #34) out of two residents reviewed for respiratory care. The facility census was 53. Findings include: 1. Review of medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) and cancer lesion. Review of physician orders for Resident #21 revealed an order dated 08/27/23 to replace BiPAP mask, headgear/straps and tubing every night shift every three months. Review of quarterly Minimum Data Set (MDS) 3.0 assessment, dated 11/13/24, revealed Resident #21 was moderately impaired cognitively, exhibited no behaviors or rejection of care, and was on a noninvasive mechanical ventilator. Review of Resident #21's care plan revealed a care plan for COPD with interventions including use of a BiPAP machine at bedtime with full face mask to be applied at hour of sleep (HS) and as needed. Observation on 01/22/25 at 8:49 A.M. of Resident #21's head straps for his BiPAP machine revealed the head straps connected to the face mask and the straps were dirty and saturated with what appeared to be blood stains. Resident #21 had a growth, red in color and approximately the size of a golf ball around his left temple area. Interview with Resident #21 stated he had a growth on the side of his head which would bleed at times causing blood to get on the straps of his BiPAP machine. Observation on 01/23/25 at 9:19 A.M. revealed the head straps for his BiPAP machine remained dirty and saturated with what appeared to be blood stains. At the time of observation, Resident #21 stated the red color on his mask straps was from blood from the growth on the side of his head which he would sometimes pick, causing the area to bleed. He stated the straps had been replaced a couple weeks ago. Observation on 01/23/25 at 10:43 A.M. of Resident #21 with Registered Nurse #328 confirmed the straps were dirty with what appeared to be blood. At the time of observation, RN #328 stated that's disgusting, and the straps should have been replaced with new straps. Interview on 01/23/25 at 1:24 P.M. with the Director of Nursing (DON) confirmed a bloody head strap should have been replaced or washed. Review of facility policy CPAP/BiPAP Support,revised April 2023, revealed the policy didn't address the cleanliness of the head straps. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of manufacturer user guide, undated, revealed it is important that you regularly clean the device. 51072 2. Review of the medical record revealed Resident #34 was admitted on [DATE] with a primary diagnosis of COPD. Review of physician orders for Resident #34 dated 11/20/24 revealed an order for oxygen at two to four liters via nasal cannula continuous to maintain oxygen saturation greater than or equal to 92 percent as needed for shortness of breath and change oxygen tubing every week, one time a day every Sunday. Observation on 01/21/25 at 10:52 AM revealed Resident #34 sitting on the edge of his rollator with a portable oxygen canister over the handle of the rollator. The tubing to the portable oxygen canister was not labeled with a date of when it was last changed and the oxygen flow rate was set to four liters. To the left of the resident next to his bed was an oxygen concentrator running at four liters which was connected to nasal cannula tubing (tubing that goes into the nose to administer oxygen) and not connected to the resident at the time of the observation. The oxygen tubing was not labeled with a date of when it was last changed. Resident #34 stated he used the oxygen concentrator when in the room and when he would leave the room he would use his portable oxygen. An interview on 01/21/25 at 11:15 AM with Registered Nurse (RN) #500 revealed she was not sure about the oxygen policy or when to change the oxygen tubing. She stated every facility was different and she could not recall from memory when to change the tubing. RN #500 verified the tubing should be labeled with a date of when it was last changed. Observation on 01/21/25 at 2:00 PM of Resident #34 with the DON verified the oxygen tubing was not labeled on Resident #34. The DON stated it was the policy to label and date oxygen tubing. The DON revealed the procedure was to change the tubing every 72 hours. The DON stated the staff needed a refresher on the oxygen administration policy and procedures so she would conduct an inservice on that policy. Review of facility policy labeled, Oxygen Administration dated 04/01/23 revealed under the policy Explanation and Compliance Guidelines it stated: to change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on observation, interview and record review the facility failed to ensure all insulin medications were accurately labeled to ensure safe administration of medications. This affected three residents (Resident #3, #15 and 36) of nine residents reviewed for medication storage. The census was 53. Findings include: 1. Review of the medical record for Resident #3 revealed admitted [DATE]. Diagnoses included type two diabetes mellitus and depression. Review of the physician orders for January 2025 revealed Humalog (insulin) Kwik Pen 100 units per milliliter (unit/ml) eight units subcutaneous (SQ), three times a day and per sliding scale. Order for Toujeo Solostar (long-acting insulin) 40 units at bedtime. 2. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus. Review of the physician orders for January 2025 revealed Fiasp pen 100 unit/ml to give per sliding scale. 3. Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus and depression. Review of the physician orders for January 2025 revealed Fiasp (insulin) SQ per sliding scale. Toujeo Solostar (long-acting insulin) 40 units at bedtime. Observation on 01/22/25 at 9:49 A.M. of medication cart #2 revealed Humalog Kwik Pen 100 unit/ml for Resident #3 opened and not dated when it was opened, Fiasp pen 100 unit/ml opened and not dated when it was opened for Resident #36, Fiasp pen 100 unit/ml for Resident #15 was opened and not dated and two Toujeo 300 unit/ml pens not dated when opened and the labels with resident names were not on the insulin pens. Interview on 01/22/25 at 9:55 A.M. with Register Nurse (RN) #325 verified all insulin's are to be dated when they are opened and all medications are to have the resident name on them. RN #325 verified Resident #3, #15 and #36's insulin's were not dated when they were opened to ensure they were not outdated and that two Toujeo insulin pens did not have a label for which resident medications and how to take it, also they were not dated. Review of the facility policy, Storage of Medications, dated 04/2007 revealed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy guideline for insulin storage revealed Humalog, Fiasp and Torjeo are to be refrigerated until they are used. After insulins were opened, they have to be dated with open date and disregarded after 28 days.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 39969 Based on observation, interviews, and record review the facility failed to ensure there was sufficient dietary staff for timely meal service. This had the potential to affect all residents who received meals from the kitchen. The facility did not identify any residents who did not eat by mouth. The facility census was 53. Findings include: Review of the mealtimes provided by the facility revealed breakfast at 8:00 A.M., lunch at 12:00 P.M., and dinner at 5:00 P.M. Observations during the initial tour of the kitchen on 01/21/25 from 9:45 A.M. to 10:11 A.M. revealed three staff plating breakfast trays for resident meal service. Interview on 01/21/25 between 10:11 A.M. and 10:16 A.M. with Dietary [NAME] (DC) #376, DC #309 and Dietary Aide (DA) #372 revealed the kitchen was short staffed and this affected meals not being served from the kitchen in a timely manner. DC #376 verified today's breakfast was late, as it should have went out at 8:00 A.M., lunch would then be late too, and late meals happened due to not enough staffing in the kitchen. Interviews on 01/21/25 between 10:10 A.M. and 3:59 P.M. with Residents #11, #19, #16, #29, and #56 stated the meals were always late. Interview on 01/21/25 at 10:35 A.M. with Resident #45 stated he still had not received breakfast yet and breakfast was at 8:00 A.M. Observation on 01/21/25 at 12:58 P.M. of the nursing unit and dining areas revealed no meal carts. Interview at this with Certified Nurse Aides (CNA) #323 stated lunch had not been brought down yet. Interview on 01/23/25 at 8:35 A.M. with Dietary Manager (DM) #303 stated she had heard complaints from residents regarding late meals and that it was related to insufficient dietary staffing. DM #303 stated she had recently hired three new staff for the 6:00 A.M. to 2:00 P.M. shift that covers breakfast and lunch. DM #303 stated the new staff were to start orientation on 01/28/25.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39969 Based on observation, interview, and record review the facility failed to ensure the correct serving size of mechanical soft meat was served to Resident #5, #14, #25, #32, #35 and #156. This affected six residents (#5, #14, #25, #32, #35, and #156) of seven residents (#5, #9, #14, #25, #32, #35, and #156) the facility identified as receiving a mechanical soft diet excluding Resident #9 who had a physician order for mechanical soft diet with pureed meats only. The facility census was 53. Findings include: Review of the menu revealed for 01/22/25 lunch meal included Salisbury steak, mashed potatoes, and lima beans. Review of the menu/diet spreadsheet revealed for the mechanical soft diet the ground Salisbury steak serving utensil was a #6 scoop (5.33 ounces). Review of the diet type report dated 01/22/25 revealed Residents #5, #14, #25, #32, #35, and #156 had physician orders for the mechanical soft diet. Observation on 01/22/25 between 11:52 A.M. and 1:02 P.M. of lunch tray line service revealed Dietary [NAME] (DC) #361 serving the mechanical soft (ground) Salisbury steak using an ivory colored handle scoop. Interview on 01/22/25 at 1:04 P.M. with Dietary Manager (DM) #303 verified the ivory handled scoop was a #10 scoop providing 3.20 ounces and the #6 scoop providing 5.33 ounces should had been used per the diet spreadsheet for the mechanical soft (ground) Salisbury steak.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, record review and interview the facility did not ensure Resident #9 received pureed food to meet individual needs. This affected one resident (Resident #9) of five residents reviewed for food/nutrition. The facility identified one resident (#9) as receiving pureed food texture. The facility census was 53. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including severe protein-calorie malnutrition, dementia without behavioral disturbance, and oropharyngeal phase dysphagia (difficulty swallowing between the mouth and esophagus). Review of the physician orders for Resident #9 dated January 2025 revealed active orders for a regular diet, mechanical soft with puree meats texture, regular-thin consistency, large portions, and snacks three times a day after meals with a start date of 05/24/23. Observation on 01/22/25 at 1:27 P.M. of Resident #9's lunch meal revealed Resident #9 was served mechanical soft (ground with gravy) Salisbury steak. There was no pureed meat. The meal ticket on Resident #9's lunch tray revealed he was to be served mechanical soft, large portions with puree meat only. Interview on 01/22/25 at 1:27 P.M. during the above observation with Dietary Manager (DM) #303 verified Resident #9 was served mechanical soft meat but should have received pureed meat. DM #303 stated she was in the process of checking diet orders against the meal tickets to ensure they were updated but had not gotten to Resident #9's yet so she was unclear of Resident #9's diet order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39969 Based on observations, interview, and record review, the facility failed to ensure food was stored, prepared and served under sanitary conditions. This had the potential to affect all 53 residents receiving meals from the kitchen, as the facility identified no residents who did not eat by mouth The facility census was 53. Findings include: Observations during the initial tour of the kitchen on 01/21/25 from 9:45 A.M. to 10:11 A.M. revealed the following sanitation concerns: The floor of the small storage room where pots, pans and various kitchware for resident meal servce was stored was dirty with dirt stains and debris under the storage racks. The stove had a heavy build-up of stains and food debris. The prep table across from the stove had moderate food debris and stains on it. The robotcoup (blender used to mechanically alter food) had various dried food debris and stains all over it. The large, black plug in fan next to the robotcoup had a moderate amount of dust on the fan blades and blade cover. The floor where the steamer and plate warmer were located had a moderate amount of dirt stains, crumbs and debris. The small silver counter/stand the mixer sat on had various food crumbs and stains. Walk-in cooler #1 floor had various debris, a cracked egg with dried yolk, an old onion and various debris under the racks. The rack on the left had a medium silver pan of green beans covered with saran wrap not labeled or dated. Next to it was another medium sized pan covered with saran wrap with parchment paper inside and an unknown food item that was also not labeled and dated. Walk-in freezer #1 and #2 both had various food, crumbs, and debris throughout floor. Underneath the rack across from walk-in freezer had a slice of bread and debris. The dry storage area had several boxes greater than 15 boxes including sugar, cans of pop, condiments, and other food items stored directly on the floor. On top of the ice machine were several dried, sticky red and tan stains. There was a pile of several dirty towels on the three compartment sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observed next to the steam table was a cart that had on the top shelf plates, and the middle and bottom shelves had several insulated bottoms for the plates. There were various crumbs/food debris, and stains all over the cart. The bottom shelf of the steam table had various food debris and crumbs. The floor where the dish machine was had dirt stains and various debris, there was a large brown, plastic container that had standing water under the dish machine. Observed on top of the dish machine was a large whitish dried substance and various debris. Interview on 01/21/25 between 10:11 A.M. and 10:16 A.M. with Dietary [NAME] (DC) #376 verified the identified findings and stated the kitchen was short staffed so cleaning was not getting done as it should. Reviewed policy Food Receiving and Storage, revised October 2017 revealed food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste, disposable pipes and vents. All foods stored in the refrigerator or freezer will be covered, labeled, and dated. Reviewed policy Sanitation, revised October 2008 revealed the food service area shall be maintained in a clean and sanitary manner.