STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365979	A. Building B. Wing	01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Community at Fairborn	789 Stoneybrook Trail Fairborn, OH 45324

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, staff interview and policy review, the facility failed to notify the resident and the Ombudsman of a transfer or discharge from the facility. This affected two (#79 and #330) out of two residents reviewed for discharge notification from the facility. The facility census was 81. Findings Include: Review of medical record for Resident #79 revealed he was admitted to the facility on [DATE] and discharged to the hospital on 11/15/21. Diagnosis included metabolic encephalopathy, acute neurologic, rhabdomyolysis, pleural effusion, dementia with behavioral disturbance, essential primary hypertension, diabetes mellitus 2, atrial fibrillation, congestive heart failure and history of malignant neoplasm of prostate. Review of the five day admission Minimum Data Set (MDS) assessment, dated 11/15/21 revealed Resident #79's cognition was not assessed. Further review of the MDS assessment for Resident #79 revealed his assistance from staff was not assessed. Review of the Resident #79's nurse's progress notes revealed resident was admitted to the facility on [DATE] and found to be pacing while naked in the hallway at 1:28 A.M. on 11/15/21. Resident #79 was noted to be confused and combative. Resident #79 was discharged to the hospital on 11/15/21 at 8:47 A.M. related to a mental status change. Further review of Resident #79's chart review revealed the facility did not notify his family in writing of his discharge on 11/15/21 and there was no documentation the facility notified the Ombudsman of the residents discharge from the facility. 2. Review of the medical record for Resident #330 revealed an admission of 01/29/21. Diagnosis included dementia with behaviors, adult failure to thrive, depression, venous insufficiency, restlessness, and agitation. Resident #330 was discharged to the hospital on 09/08/21. The quarterly MDS assessment dated [DATE] revealed Resident #330's cognition was not assessed with a Brief Interview Mental Status (BIMS) score. Further review of the MDS assessment revealed Resident #330 required supervision with bed mobility, transfers, eating toilet use and personal hygiene. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #330's nursing progress notes revealed she was discharged to the hospital for assessment due to aggressive behaviors. Further review of Resident #79's chart review revealed the facility did not notify his family in writing of his discharge on 11/15/21 and there was no documentation the facility notified the Ombudsman of the residents discharge from the facility. Interview on 01/06/22 at 09:40 A.M. with the Social Service Director (SSD) #38 revealed the facility is not notifying the Ombudsman or the resident's families of discharges from the facility. SSD #38 stated he was not aware of the need for notification for discharge to the resident's or the Ombudsman. Interview on 01/06/22 at 10:30 A.M. with the Administrator confirmed the facility did not notify residents in writing for discharges from the facility. The Administrator confirmed the facility had not notified the Ombudsman of discharges from the facility. The Administrator stated the facility had been cited during previous surveys for failing to provide this information. The Administrator confirmed the facility failed to notify the resident/resident representative or Ombudsman of Resident #79 or Resident #330's discharge to the hospital. Review of the facility policy titled, Admission/Transfer/Discharge Criteria Policy, dated 11/01/16, revealed resident and/or resident representative will be notified of transfer/discharge and the reasons for the transfer/discharge in writing when applicable. The office of the State Long-Term Care Ombudsman will also receive a copy of the notice when applicable.

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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** 43062 Based on medical record review, staff interview and facility policy review, the facility failed to notify residents of the facility bed hold policy prior to discharge from the facility. This affected two (#77, # 330) out of two residents reviewed for the bed hold policy. Facility census was 81. Findings include: 1. Medical record review for Resident #79 revealed he was admitted to the facility on [DATE] and discharged to the hospital on 11/15/21. Diagnosis included metabolic encephalopathy, acute neurologic, rhabdomyolysis, pleural effusion, dementia with behavioral disturbance, essential primary hypertension, diabetes mellitus 2, atrial fibrillation, congestive heart failure and history of malignant neoplasm of prostate. Review of the five day admission Minimum Data Set (MDS) assessment, dated 11/15/21 revealed Resident #79's cognition was not assessed. Further review of the MDS assessment for Resident #79 revealed his assistance from staff was not assessed. Review of the Resident #79's nurse's progress notes revealed resident was admitted to the facility on [DATE] and found to be pacing while naked in the hallway at 1:28 AM on 11/15/21. Resident #79 was noted to be confused and combative. Resident #79 was discharged to the hospital on 11/15/21 at 8:47 A.M. related to a mental status change. Further record review for Resident #79 revealed there was no evidence the resident or representative was provided the bed hold notice at the time of the hospitalization on [DATE]. 2. Review of the medical record for Resident # 330 revealed an admission of 01/29/21. Diagnosis included dementia with behaviors, adult failure to thrive, depression, venous insufficiency, restlessness, and agitation. The resident was discharged to the hospital on 09/08/21. The quarterly MDS assessment revealed Resident #330 's cognition was not assessed with a Brief Interview Mental Status (BIMS) score. Further review of the MDS assessment revealed Resident #330 required supervision with bed mobility, transfers, eating toilet use and personal hygiene. Review of Resident #330's nursing progress notes revealed she was discharged to the hospital for assessment due to aggressive behaviors on 09/08/21. Further record review for Resident #330 revealed there was no evidence the resident or representative was provided the bed hold notice at the time of the hospitalization on [DATE]. Interview on 01/11/22 at 7:38 A.M. with the Administrator confirmed the facility did not notify Resident #79 or Resident #330 of a bed hold policy at the time of their discharge. (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 the facility policy titled, Admission/Transfer/Discharge Criteria Policy, dated 11/01/16, revealed resident and/or resident representative will be notified in writing of any Bed Hold duration and the reserve bed payment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, staff interview and policy review, the facility failed to ensure a Pre-Admission Screen and Resident Review (PASARR) was in place for Resident #47 and #48. This affected two (#47 and #48) out of two residents reviewed for PASARR status. The facility census was 81. Findings include: 1. Record review revealed Resident #48 was admitted to the facility on [DATE]. Diagnoses included hyperkalemia, heart failure, pressure ulcer of left buttock, essential primary hypertension, hypothyroidism, anxiety disorder, and major depressive disorder. Review of Resident #48 quarterly minimum data sheet (MDS), dated [DATE], revealed resident scored a 13 on her brief interview for mental status (BIMS) indicating she has intact cognition. Further review of the MDS assessment revealed Resident #48 required extensive assistance from facility staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #48 required supervision from staff with eating. However, Resident #48 was totally dependent on staff with bathing. Review of the PASARR determination from the Ohio Department of Mental Health, revealed Resident #48 did not have a PASARR. Further review of Resident #48 revealed her hospital exemption revealed she was approved for a 30 day stay at the facility and it had expired. A further stay beyond 30 days would require a new PASARR. Interview on [DATE] at 10:57 A.M. with Social Service Designee (SSD) #38 verified a PASARR for Resident #48 expired on [DATE] and no valid PASARR was in place for Resident #48's continued stay at the facility. 34291 2. Medical record review for Resident #47 revealed an admitted [DATE]. Diagnoses included epilepsy,bipolar disorder, schizophrenia, hyperlipidemia and anxiety. Review of the quarterly MDS dated [DATE] revealed Resident #47 was cognitively intact. Functional status was extensive assistance for bed mobility, transfers and toilet use. She was a supervision for eating. Review of the PASARR determination from the Ohio Department of Mental Health, revealed Resident #47 did not have a PASARR. Interview on [DATE] at 11:45 A.M. with SSD #38 revealed he didn't have a PASARR from the prior facility for Resident #47 and when he reached out to the prior facility they didn't send him one and he couldn't provide documentation of this. SSD #38 stated he called the Area Agency on Aging and they didn't have one for the resident either since it was so old. SSD #38 stated if he was to make up another one for the resident it would be illegal. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Preadmission, Screening, and Annual Resident Review (PASARR), dated [DATE], revealed the facility will participate in or complete the Level 1 screen for all potential admissions.

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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** 44076 Based on medical record review, staff interview and policy review, the facility failed to develop a comprehensive care plan to address resident care needs including medical skin condition, a resident's medical diagnosis and a resident's smoking. This affected three (#15, #61 and #47) of twenty-three residents reviewed for care plans. The facility census was 81. Findings include: 1. Record review of the medical record for Resident #15 revealed an admitted [DATE]. Admitting diagnosis included atrial fibrillation, acute on chronic congestive heart failure, chronic kidney disease stage four, dementia with behaviors, unspecified psychosis, anxiety, depression and cerebral arthrosclerosis. The quarterly minimum data set (MDS) assessment for Resident #15 dated 10/13/21 revealed a brief interview mental status (BIMS) of three out of 15 indicating severely impaired cognition, no documentation of mental status change, inattention, or altered level of consciousness. There is documentation in section C of the MDS of disorganized thinking, which fluctuates and in section E of other behaviors not directed towards others was documented to have occurred four to six days. Resident #15 required extensive one person assistance with bed mobility, dressing, independent for eating was totally dependent for transfers and toileting. Record review of the care plan for Resident #15 contained no documentation for goals, interventions and objectives related to her dementia diagnosis. Interview on 01/10/22 at 2:16 P.M. with the MDS Coordinator #75 verified dementia was not addressed on the care plan for Resident #15. 2. Record review of medical record for Resident #61 revealed admitted [DATE]. Diagnoses included congestive heart failure, stage four (of four) kidney disease and of Bullous Pemphigoid (a rare skin condition that causes large, fluid-filled blisters). The quarterly MDS assessment for Resident #61 dated 12/21/21 revealed the resident had a BIMS score of 13 out of 15 indicating intact cognition. Resident #61 required extensive one person assist for bed mobility and toileting; extensive two assist for transfers; limited assist for dressing and supervision for eating. Documentation was noted on the skin area of the MDS for open lesions other than ulcers, rashes and cuts with the application of nonsurgical dressings, application of dressings to feet and the application of ointments/medication other than to feet. Record review of the care plan for Resident #61 contained no documentation regarding goals, interventions and objectives for skin care or related to the medical diagnosis of Bullous Pemphigoid (a rare skin condition that causes large, fluid-filled blisters). (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 Resident #61's physician orders revealed an order dated 10/14/21 for a treatment to the bilateral legs/bottom of feet: cleanse open areas with normal saline (NS), pat dry, apply Clobetasol gel to open areas, cover areas with non-adherent pad (start from toes) wrap legs and feet with kerlix and then ACE wraps. There was also an order for weekly skin assessment. Interview on 01/05/22 at 8:15 A.M. with MDS Coordinator #75 verified skin was not addressed on the care plan for Resident #61. MDS Coordinator #75 confirmed Resident #61 had the diagnosis Bullous Pemphigoid which caused the resident to have blistering of the skin. 34291 3. Medical record review for Resident #47 revealed an admitted [DATE]. Diagnoses included epilepsy, bipolar disorder, schizophrenia, hyperlipidemia and anxiety. Review of the quarterly MDS assessment dated [DATE] revealed Resident #47 was cognitively intact. Functional status was extensive assistance for bed mobility, transfers and toilet use. She was a supervision for eating. Review of smoking assessment dated [DATE] revealed Resident #47 was a smoker and could smoke without supervision. Review of care plans for Resident #47 revealed there was no care plan for smoking. Interview with the Director of Nursing (DON) on 01/05/22 at 12:20 P.M. confirmed the care plan wasn't completed for smoking for Resident #47. The DON revealed the prior MDS nurse had not kept up with the care plans. Review of policy entitled Person Centered Care Planning Policy and Procedures dated 11/27/17 revealed Interdisciplinary Team (IDT) will develop and implement a comprehensive care plan in place of the baseline care plan. A comprehensive care plan must be developed within seven days of the comprehensive assessment (unless used as a baseline care plan-then within 48 hours).

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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** 34291 Based on medical record review, observation and staff interview, the facility failed to ensure palm protectors were placed on a resident with limited range of motion per the physician order. This affected one (#21) of two reviewed for range of motion. Facility census was 81. Findings included: Medical record review for Resident #21 revealed an admitted [DATE]. Diagnoses included non-traumatic brain dysfunction, Alzheimer's Disease, aphasic, and paraplegic. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was rarely/never understood. Resident #21's functional status was total dependence for bed mobility, transfers, eating and toilet use. Resident #21 had impairment on one side of her upper extremities. Review of Resident #21's physician orders dated 07/14/21 revealed to don palm protectors in the mornings and doff in the evenings. Review of the electronic charting from 09/01/21 through 01/05/22 revealed there was no charting regarding the palm protectors were being placed on Resident #21. Review of care plan for Resident #21 dated 12/28/21 revealed she had self care deficit related to weakness, decreased mobility and cognitive deficit. Resident #21 has decreased range of motion of upper extremities. Intervention was to wear [NAME] guards at all times except for hygiene and showers. Observation of Resident #21 on 01/05/22 at 10:30 A.M. revealed she didn't have palm protectors on her hands. Further observation in Resident #21's room revealed there was no palm protectors present in the room. Interview with Licensed Practical Nurse (LPN) #30 on 01/05/22 at 10:35 A.M. confirmed Resident #21 did not have on her palm protectors. LPN #30 looked in the room and couldn't find the protectors. LPN #30 said the order was put in wrong in the electronic charting and there was no documentation the palm protectors were being placed on Resident #21 daily.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review and staff interview, the facility failed to ensure the resident's laboratory (lab) work was completed per the physician orders. This affected one (#15) of six residents reviewed for unnecessary medication. The facility census was 81. Findings include: Review of Resident #15's medical record revealed an admitted [DATE] with diagnoses which included dementia, atrial fibrillation, chronic kidney disease, chronic pulmonary edema, chronic respiratory failure, anemia, Barrett's esophagus, hypovolemia and cerebral atherosclerosis. Review of Resident #15's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) of three out of 15 which indicated severe cognitive decline. The MDS revealed the resident required total dependence with two assists for transfers, and total dependence with one assist for toileting. The resident required extensive one-person assistance for bed mobility personal hygiene and dressing. The resident was independent with set-up for eating. Further review of the MDS in section J revealed the resident received medications from the drug classes including antipsychotic, antidepressant, diuretics, anticoagulants, and opioids. Review of Resident #15's plan of care dated 10/21/21 revealed the resident received anticoagulants related to deep vein thrombosis prophylaxis. Interventions included to complete labs as orders. Further review of the resident's plan of care revealed the resident received diuretics and at risk for electrolyte imbalance. Interventions included to report pertinent lab results to the physician. Review of Resident #15's physician orders dated 01/12/21 revealed to obtain a complete metabolic profile (CMP) and a complete blood count (CBC) every night shift every three months starting on the fifth. Review of Resident #15's lab results revealed a basic metabolic profile (BMP), and CBC was completed on 10/29/21. The resident's electronic medical record contained no documentation regarding the CMP or no other CBC results. Interview on 01/10/22 at 3:17 P.M. with the Director of Nursing (DON) confirmed Resident #15 only had the BMP and CBC drawn once on 10/29/21. The DON confirmed a CMP was not completed and the CBC was only completed on 10/29/21. The DON confirmed the physician order had not been followed regarding Resident #15's lab orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, observation, staff and resident interview and policy review, the facility failed to ensure a residents meal was provided per the residents order and meal ticket. This affected one (#26) of three residents reviewed during the lunch observation. The census was 81. Findings included: Medical record review for Resident #26 revealed an admitted [DATE]. Diagnoses included peripheral vascular disease, below the knee amputation, schizophrenia, atrial fibrillation, and diabetes. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 was cognitively intact. Resident #26 functional status was extensive assistance for bed mobility and toilet use, total dependence for transfers, and supervision for eating. Resident #26 was coded for impairment to one side of upper and lower extremities. Review of physician orders dated 11/02/21 revealed Resident #26's revealed the resident diet was regular diet, mechanical soft, with ground meat textured, regular to thin consistency. Review of the lunch meal ticket for Resident #26 revealed he had macaroni and cheese, mashed potatoes, vanilla pudding, ice cream, and milk. Observation of the lunch meal service and interview on 01/03/22 at 11:59 A.M. Revealed resident #26 was delivered his meal and he said to the State tested Nursing Aide (STNA) #107 he was missing his ice cream and his milk. STNA #107 stated he would get the two items from the kitchen for the resident. Interview with STNA #107 on 01/03/22 at 12:37 P.M. revealed the lunch meal service was completed and he confirmed he forgot to get the ice cream and milk for Resident #26. Review of policy entitled Food and Drink revised 12/17/18 revealed the community will provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and special dietary needs, and drinks including water and other liquids to maintain resident hydration, taking into consideration the preferences of each resident.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, observation, staff and resident interview, and policy review, the facility failed to ensure an assistive device was provided to a resident during a meal. This affected one (#26) of three resident's reviewed for adaptive equipment during the annual survey. Facility census was 81. Findings included: Medical record review for Resident #26 revealed an admitted [DATE]. Diagnoses included peripheral vascular disease, below the knee amputation, schizophrenia, atrial fibrillation, and diabetes. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 was cognitively intact. Resident #26 functional status was extensive assistance for bed mobility and toilet use, total dependence for transfers, and supervision for eating. Resident #26 was coded for impairment to one side of upper and lower extremities. Review of Resident #26's physician orders from 09/01/21 through 01/10/22 revealed there was no physician order for adaptive equipment. Review of the meal ticket for Resident #26 on 01/03/22 revealed he was supposed to receive his drinks in a mug with a handle on it. Observation of the lunch meal service and interview on 01/03/22 at 11:59 A.M. revealed Resident #26 was delivered his meal and he had Styrofoam cup of a drink on his tray. Resident #26 stated he was supposed to be served his drinks in mug with a handle on it since he had right-sided paralysis. Resident #26 stated the staff had not been giving him the mug with the handle on it and it was his preference. Interview with the [NAME] #85 on 01/03/22 at 12:40 P.M. confirmed the kitchen had not been placing a mug with a handle on the meal tray for Resident #26 due to the using Styrofoam for meals since the facility had an outbreak 12/24/21 but confirmed this resident didn't reside on the COVID-19 nest. Interview with Dining Services Supervisor (DSS) #96 on 01/10/22 at 3:07 P.M. revealed this was not a physician's order for Resident #26 to use a mug, but a communication form for diet requesting adaptive equipment and it was processed by the dietary staff to ensure the resident received the adaptive equipment with their meal. Review of the policy entitled Adaptive Equipment Policy revised on 05/01/10 revealed a resident requiring adaptive equipment at meals, snacks, or when out of the facility for meals will have the adaptive equipment needed. Residents with an identified need for adaptive equipment while eating will be referred to therapy for evaluation. Therapy will receive an order from the physician for any adaptive equipment needs. Orders for adaptive equipment will be communicated to the Dining Services Department with inclusion of type of equipment needed on the resident's tray slip. The adaptive equipment required for meal will be sent on the resident's meal tray.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34742 Based on medical record review, observation, staff and local health department personnel interview, review of the facility policy, and review of guidelines from the Centers for Disease Control and Prevention (CDC), the facility failed to properly isolate residents placed in transmission-based precautions (TBP) per CDC guidelines for Coronavirus Disease 2019 (COVID-19) infections to potentially prevent the spread of COVID-19. This affected four (#74, #68, #25, and #12) of eight residents reviewed for transmission-based precautions and infection control practices. The facility census was 81. Findings include: 1. Medical record review for Resident #62 revealed admitted [DATE]. Resident #62 was fully vaccinated for COVID-19 and had received a COVID-19 booster vaccine on 11/18/21. Medical diagnosis included chronic diastolic heart failure, hemiplegia and hemiparesis, vascular dementia, chronic obstructive pulmonary disease, and COVID-19. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #62's medical record revealed a document titled Severe Acute Respiratory Syndrome (SARS) COVID-19 by Polymerase Chain Reaction (PCR) dated 12/30/21 which revealed positive test results. Review of Resident #62's plan of care dated 12/03/21 revealed the resident required isolation precautions related to COVID-19 infection. Interventions included ensure resident stayed in room, away from other people, droplet isolation, all treatments, meals, activities, and therapy services to be given in room. Resident #62 was relocated to a room on the designated COVID-19 unit on 01/03/22. Medical record review for Resident #25 revealed admitted [DATE]. Resident #25 was fully vaccinated for COVID-19 and received a COVID-19 booster vaccine 10/13/21. Medical diagnosis included bipolar disorder, chronic kidney disease, history of transient ischemic attach and cerebral infarction without residual deficits and Diabetes Mellitus II. Review of the quarterly MDS dated [DATE] revealed the resident had intact cognition. Review of Resident #25's Coronavirus Testing Result Forms dated 12/29/21 and 01/06/22 revealed BinaxNOW negative test results. Review of the plan of care dated 10/28/21 revealed the resident was at risk for Coronavirus-19 Disease illness. Interventions included encourage to practice good infection control procedures such as hand hygiene, wearing a mask, and social distancing until otherwise instructed. Resident #25 shared a semi-private room with Resident #62 until 01/03/22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Medical record review for Resident #65 revealed admitted [DATE]. Resident #65 was fully vaccinated for COVID-19 and received a COVID-19 booster vaccine on 10/13/21. Medical diagnosis included acute appendicitis with perforation and localized peritonitis, without abscess, cerebral infarction due to unspecified occlusion of left middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, and COVID-19. Review of Resident #65's quarterly MDS dated [DATE] revealed a brief interview mental status (BIMS) score of 99 indicating the resident was unable to complete the interview. Further documentation revealed impaired short-term memory and modified independence for daily decision making. Review of Resident #65's medical record revealed a document titled SARS COVID-19 by PCR dated 12/30/21 which revealed a positive test result. Review of Resident #65's plan of care dated 12/09/21 revealed the resident required isolation precautions related to COVID-19 infection. Interventions included ensure resident stayed in room, away from other people, droplet isolation, all treatments, meals, activities, and therapy services to be given in room. Resident #65 was relocated to a room on the designated COVID-19 unit on 01/04/22. Medical record review for Resident #45 revealed admitted [DATE]. Resident #45 was fully vaccinated for COVID-19 and received a COVID-19 booster vaccine on 10/13/21. Medical diagnosis included hypertensive heart disease, Diabetes Mellitus II, vascular dementia with behavioral disturbance, and transient cerebral ischemic attack. Review of the quarterly MDS dated [DATE] revealed the resident had moderately impaired cognition. Review of Coronavirus Testing Result Form Dated 12/29/21 and 01/06/22 revealed BinaxNOW negative test results. Resident #45 shared a semi-private room with Resident #65 until 01/04/22. 3. Medical record review for Resident #178 revealed admitted [DATE]. Resident #78 was fully vaccinated for COVID-19 on 12/01/21. Medical diagnosis included spontaneous bacterial peritonitis, alcoholic cirrhosis of liver with ascites, moderate protein-calorie malnutrition, and COVID-19. Review of Resident #178's admission MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #178's medical record revealed a document titled SARS COVID-19 by PCR dated 12/31/21 which revealed positive test results. Review of Resident #178's plan of care dated 12/08/21 revealed the resident required care and isolation precautions related to COVID-19 infection. Interventions included ensure the stay in my room, away from other people, droplet isolation, all treatments, meals, activities, and therapy services to be given in room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident #74 revealed admitted [DATE]. Resident #74 was fully vaccinated for COVID-19 on 05/01/21. Medical diagnosis included cellulitis right lower limb, chronic pulmonary obstructive disease, mild-protein calorie malnutrition, and chronic kidney disease stage three. The resident had intact cognition. Review of Resident #74's Coronavirus Testing Results dated 12/30/21 and 01/06/22 revealed BinaxNOW negative test results. Review of Resident #74's plan of care dated 12/13/21 revealed the resident was at risk for COVID-19 illness. Interventions included encourage the resident to continue to practice good infection control procedures such as hand hygiene, wearing a mask, and social distancing until instructed otherwise. Resident #74 was relocated to a semi-private room on 01/03/22. Resident #178 shared a semi-private room with Resident #74 until the room change on 01/03/22. 4. Medical record review for Resident #69 revealed admitted [DATE]. Resident #69 resident was fully vaccinated for COVID-19 on 04/05/21. Medical diagnosis included cerebral infarction, severe-protein calorie malnutrition, dysphagia, malignant neoplasm of stomach, gastrostomy, malignant neoplasm of liver, and COVID-19. Review of Resident #69's admission MDS dated [DATE] revealed a BIMS score of 99 indicating the resident was unable to complete the interview. Further documentation revealed impaired short- and long-term memory problems and moderately impaired daily decision making. Review of Resident #69's medical record revealed a document titled SARS COVID-19 by PCR dated 12/31/21 which revealed positive test results. Review of Resident #69's plan of care dated 12/15/21 revealed the resident required care and isolation precautions related to COVID-19 infection. Interventions included ensure resident stays in his/her room, away from other people, droplet isolation, all treatments, meals, activities, and therapy services to be given in room. Medical record review for Resident #68 revealed admitted [DATE]. Resident #68 was fully vaccinated for COVID-19 on 04/14/21. Medical diagnosis included displaced articular fracture of left femur, subsequent encounter for closed fracture with routine healing, diabetes mellitus type II, and chronic obstructive pulmonary disease (COPD). Review of Resident #68's admission MDS assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #68's Coronavirus Testing results Form dated 12/20/21 and 01/06/22 revealed BinaxNOW negative test results. Review of Resident #68's plan of care dated 12/07/21 revealed the resident was at risk for COVID-19 illness. Interventions included encourage the resident to continue to practice good infection control procedures such as hand hygiene, wearing a mask, and social distancing until instructed otherwise. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #68 was relocated to a semi-private room on 01/03/22. Resident #68 shared a semi-private room with Resident #69 until the room change on 01/03/22. Interview on 01/03/22 at 9:43 A.M. the Administrator and Director of Nursing (DON) revealed the facility had resident's positive for the COVID-19 infection. The Administrator stated the facility had moved Resident #75, fully vaccinated for COVID-19, to a private room in the area designated as the nest because the resident had a positive COVID-19 test and was symptomatic. The Administrator revealed Resident #179, unvaccinated, tested positive for COVID-19 test, and was asymptomatic, was also in a private room. The Administrator further stated corporate office told them to keep the exposed negative residents in the semi-private rooms with the positive residents. The Administrator stated a staff member had tested positive on 12/24/21 and the facility started outbreak testing. The Administrator stated residents on the 100 and 600 halls were tested [DATE]. The Administrator stated residents tested positive on 12/29/21 and on 12/30/21. The Administrator stated residents and families/representatives had been informed of the positive test results by use of one-call, in person conversation, and/or email. The Administrator stated the negative residents had been informed their roommates had tested positive for the virus. The Administrator stated the [NAME] County Public Health Department liaison had been notified by email. Interview on 01/03/22 at 10:46 A.M. the [NAME] County Public Health Department Liaison #9 stated she was not aware that the facility had negative and positive residents in the same room. [NAME] County Public Health Department Liaison #9 stated they always discussed moving positive cases to a private room or with another positive resident. [NAME] County Public Health Department Liaison #9 stated that had always been the practice in the past. [NAME] County Public Health Department Liaison #9 verified the facility had notified the health department of the testing results by email. Interview on 01/03/22 at 11:11 A.M. Registered Nurse (RN) #84, Infection Control Liaison, revealed the facility did not want to move the residents around when they started having residents test positive for COVID-19, since they had already been exposed. RN #84 stated Resident #75 was moved to the designated Nest and was symptomatic. RN #84 stated the roommate had tested negative. Interview on 01/03/22 at 12:04 P.M. the [NAME] County Public Health Department Liaison #9 stated she spoke with the facility Corporate Nurse and Administration. [NAME] County Public Health Department Liaison #9 stated she did not see the guidance as they had reviewed it. [NAME] County Public Health Department Liaison #9 stated she had recommended that the positive residents not share a room with the negative residents. [NAME] County Public Health Department Liaison #9 stated corporate had looked at it from the number of positive residents in the facility and the risk of exposing those with no exposure. [NAME] County Public Health Department Liaison #9 stated the facility stated fully vaccinated and boosted residents did not need to quarantine after exposure. [NAME] County Public Health Department Liaison #9 further stated corporate revealed they understood her interpretation and would follow up with the Administrator. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/03/22 at 12:26 P.M. the Administrator stated the original plan from November 2020 was to designate the therapy room as the Nest. The facility soon realized the space would not accommodate enough residents. He stated six residents tested positive overnight and then three tested positive. The Administrator stated the facility made the determination, with how virulent Omicron was, the movement of residents posed a greater risk of further exposure. The Administrator stated contact tracing had the four negative residents in contact with the four positive residents with no personal protective equipment (PPE) or source control and felt it necessary to leave the residents in the room. The Administrator stated with the current guidance, boosted and vaccinated individuals did not have to be quarantined. The Administrator stated the residents were considered infected 48 hours prior to a positive test. The Administrator further stated, at the rate the residents were turning up positive and with twice weekly testing, rather than try to find open, semi-private beds, they decided to leave the residents in place. The Administrator confirmed four (#25, #45, #74 and #68) residents who were COVID-19 negative and vaccinated for COVID-19 continued residing in the same room with four (#62, #65, #178 and #69) COVID-19 positive residents. Interview on 01/03/22 at 1:00 P.M. the Administrator verified the facility did not notify the [NAME] County Health Department that the negative residents had not been moved from rooms with positive roommates. The Administrator stated he thought he had included that information, but on review, it was not included. Review of emails dated 12/24/21 though 01/03/22 verified the facility did notify the Health Department of positive test results, as well as vaccination status for staff and residents. Observation on 01/03/22 at 1:00 P.M. verified three semi-private rooms on the 100-hall identified with isolation precautions with PPE supply carts outside each of the three rooms. Two (#28 and #41) residents with COVID-19 positive test results resided in one room. The other two rooms each housed one resident with a negative and one resident with a positive COVID-19 test result. The 500-hall had two semi-private rooms with signage and PPE supply carts at the doors. Each of the rooms housed one resident with a negative and one resident with a positive COVID-19 test result. Resident #179, COVID-19 positive, unvaccinated, and asymptomatic, resided in one private room. Resident #75, COVID-19 positive, fully vaccinated, and symptomatic resided in the second private room. Observation on 01/03/22 at 6:40 P.M. staff members gathered cleaning supplies and PPE for resident room changes. Review of Centers for Disease Control and Prevention (CDC) Infection Control for Nursing Homes updated 09/10/21 recommend identifying space in the facility that could be dedicated to monitor and care for residents with confirmed severe acute respiratory syndrome Coronavirus (SARS-CoV-2). The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection. Recommended infection prevention and control (ICP) practices when caring for a resident with suspected or confirmed SARS-CoV-2 infection stated asymptomatic residents who have met the criteria for Transmission-Based Precautions (BBP) (quarantine) based on close contact with someone with severe acute respiratory syndrome Coronavirus (SARS-CoV-2) infection should not be cohorted (the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group or quarantining close contacts of a particular case together as a group). With residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled COVID Positive Residents: Screening and Management, revised date 07/26/21 revealed residents on the COVID Unit who are confirmed to have COVID-19 through testing should not share a room with a symptomatic resident without a positive COVID-19 test. Discontinuation of Transmission-Based Precautions/NEST Unit (Asymptomatic Resident), COVID-19 positive resident who did not have/develop symptoms may leave the COVID Unit and/or transmission-based precautions in accordance with the following: time strategy, ten days since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, observations, staff interview and facility policy review, the facility failed to provide a clean, comfortable, home-like environment. This affected one (#48) out of three residents reviewed for a clean environment. The facility census was 81. Findings include: Record review revealed Resident #48 was admitted to the facility on [DATE]. Diagnoses included hyperkalemia, heart failure, pressure ulcer of left buttock, essential primary hypertension, hypothyroidism, anxiety disorder, and major depressive disorder. Review of Resident #48 quarterly minimum data sheet (MDS), dated [DATE], revealed the resident scored a 13 out of 15 on her brief interview for mental status (BIMS) indicating she has intact cognition. Further review of the MDS assessment revealed Resident #48 required extensive assistance from facility staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #48 required supervision from staff with eating. However, Resident #48 was totally dependent on staff with bathing. Review of Resident #48's current order summary revealed the resident did not require the need for oxygen. Observation on 01/03/22 at 11:53 A.M. revealed Resident #48's room continued to have oxygen concentrator near the bedside of Resident #48. Further observation of Resident #48's room revealed a soiled bedside tabletop. Observations revealed a pile of brown circular substance along the bottom of Resident #48's bedside table along with sticky, splattered stains of unknown substance. On 01/04/22 at 11:09 A.M. an interview with State tested Nurse Aide (STNA) #107 confirmed an oxygen concentrator remained in front of Resident #48's bed. Resident #48's bedside tabletop was soiled. The bottom bar of Resident #48's bedside table contained a brown sticky substance and a circular pile of unknown brown substance. STNA #107 stated he was not aware of what the pile of brown substance was on the soiled bed side table. STNA #107 confirmed Resident #48 utilizes her bedside table as a table for her meals. Observation on 01/04/22 3:24 P.M. revealed Resident #48's room continued to have oxygen concentrator near the bedside of Resident #48. Further review of the Resident #48's room revealed a soiled bedside tabletop. Observations revealed a circular pile of brown substance along the bottom of Resident #48's bedside table along with dried, sticky unknown brown substance. Interview on 01/05/22 at 08:07 A.M. with Licensed Practical Nurse (LPN) #39 confirmed the oxygen concentrator remains in front of the Resident #48's bed. LPN #49 confirmed Resident #48's breakfast tray was on the top of her soiled bedside table. LPN #49 confirmed the splattered sticky substance on the bottom bar of the table and the circular brown pile of unknown substance remains on the bottom of the table. LPN #49 confirmed Resident #48 does not require the need for oxygen and believes the concentrator belongs to Resident #48's roommate. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Residents Rights, dated 01/10/19, revealed the resident has the right to an environment like a home that maximizes your comfort and provides you with assistance to be as independent as possible.