STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47990 Based on observation, staff and resident interview, record review, and policy review, the facility failed to ensure residents were treated in a respectful and dignified manner by staff. This affected two (#26 and #27) and had the potential to affect ten other unnamed residents who were in attendance at a smoke break. Additionally, the facility also failed to ensure indwelling urinary catheter drainage bags were covered in a dignified manner. This affected two (#68, and #41) of two residents observed for catheter care. The faciliy census was 58. Findings include: 1. Observation on 10/01/24 at 2:54 P.M., during an attempted interview with Resident #28, inaudible voices were heard coming from the resident's room after knocking on the door. Upon opening the door slightly, both Resident #28 and her roommate were not observed to be in the room. Loud voices were heard, and it appeared a television was on in the room. Upon additional inspection, the window in the room was wide open and overlooked the courtyard where there was multiple residents smoking in the presence of one staff member. The staff member was standing with her back towards the window. The staff member was clearly and loudly yelling I have worked 78 hours this week, not this pay period, this week. She took her left index finger, raised an outstretched arm, and loudly yelled don't play with me, I will end this break as she waved her outstretched left arm and pointed index finger from side-to-side as she stated each word. Unnamed residents were seated, smoking, and facing the staff member and said nothing in response. The surveyor immediately proceeded to the facility's courtyard and approached the staff member, Certified Nursing Assistant (CNA) #289. Interview on 10/01/24 at 2:56 P.M., with CNA #289 confirmed she did work 78 hours in the past week at the facility, which she confirmed was voluntary after she had missed a few days while being out sick. CNA #289 stated she had been yelling, but was not yelling at the residents directly, rather she was just trying to vent to the residents. CNA #289 stated she was angry and had just been counseled by the Director of Nursing (DON) a few moments earlier after she was on her phone and not watching the residents during the beginning of this smoke break. CNA #289 stated she was frustrated at the situation, but verified her yelling and venting to residents was not a dignified, respectful or professionally appropriate interaction. Twelve residents were outside in the courtyard at the time of the observation. (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 - Some	A follow up interview on 10/01/24 at 3:01 P.M., with Resident #27, who was outside and witnessed CNA #289's verbal outburst, reported she liked CNA #289, but felt uncomfortable with her yelling and stated she wasn't sure what all that was about. A follow up interview on 10/01/24 at 3:04 P.M., with Resident #26, who was outside and witnessed CNA #289's verbal outburst, revealed she hated when people yell. Resident #26 stated she had been minding her own business, was walking around the courtyard and the yelling had startled her. An interview on 10/02/24 at 2:34 P.M., with the Administrator and DON discussed professional standards of conduct. The DON confirmed she had addressed CNA #289 the prior afternoon, 10/01/24, during a smoke break as she had been on her phone and was not appropriately supervising the 300-hallway's scheduled smoke break. The Administrator and DON were informed of CNA #289's interactions with residents during the scheduled smoke break on 10/01/24, and verified yelling at residents, for any reason, and venting to residents would not be considered an appropriate, respectful, or dignified interaction. 2. Review of the medical record for Resident #68 revealed an admitted [DATE]. Medical diagnoses included neuromuscular dysfunction of the bladder, urinary retention, and a history of a cerebral infarction. Review of Resident #68's Minimum Data Set (MDS) annual assessment, dated 07/07/24, revealed the resident had intact cognition. The resident was identified to have an indwelling urinary catheter and was dependent on staff for toileting. Review of Resident #68's care plan, dated 06/14/23, revealed the resident has an alteration in elimination related to an indwelling Foley (urinary) catheter related to neuropathic bladder and retention of urine. Listed interventions included to change Foley catheter per physician's orders, provide Foley catheter care every shift, and to keep Foley catheter bag below the level of the bladder. Review of Resident #68's physician's orders revealed an order dated 05/31/24 for a 24-french sized suprapubic catheter (urinary catheter inserted through a surgically-created opening in the lower abdomen), cleanse the site with soap and water every shift and cover with a dry dressing. Resident #68 additionally had an order dated 05/31/24 to cover the urinary drainage bag every shift for privacy. Observation on 09/30/24 at 11:50 A.M., revealed Resident #68 in bed, his urinary catheter drainage bag was hanging on the side of the left side of the bed, and contained approximately 600 milliliters (ml) of yellow urine, visible from the doorway to the room. A subsequent observation on 10/02/24 at 7:56 A.M., revealed Resident #68 in bed with his urinary catheter drainage bag remained uncovered with approximately 300 ml of yellow urine visible in the bag. Interview on 10/02/24 at 7:56 A.M., with Certified Nursing Assistant (CNA) #323 verified Resident #68's urinary catheter drainage bag was uncovered. CNA #323 confirmed the urinary drainage bags were supposed to be covered and she was unsure why Resident #68's was not. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/03/24 at 9:42 A.M., revealed Resident #68 in bed with his eyes closed. His urinary drainage bag was uncovered and hanging on the edge of the left side of the bed with approximately 400 ml of yellow urine visible in the bag. Interview on 10/03/24 at 9:54 A.M., with CNA #323 and CNA #319 confirmed the uncovered urinary drainage bag. Interview and observations on 10/08/24 at 9:32 A.M., with Resident #68 revealed he was awake, alert and in bed. Resident #68's urinary drainage bag was covered. Resident #68 confirmed a few days prior a staff member provided him a sling for his urinary drainage bag. Resident #68 stated it was nice to not have his urine bag on display for everyone to see. 49793 3. Review of Resident #41's medical record revealed an admitted [DATE]. Medical diagnoses included type II diabetes mellitus with hyperglycemia, above right knee amputation, chronic obstructive pulmonary disease (COPD), below left knee amputation, obstructive uropathy and reflux uropathy. Review of Resident #41's quarterly Minimum Data Set (MDS) assessment, dated 09/10/24, revealed the resident had no cognitive impairment with a BIMS score of 15. Resident #41 was coded to have a indwelling urinary catheter. Review of Resident #41's physician order, dated 05/31/24, revealed an order for a Foley (indwelling urinary) catheter due to a diagnosis of obstructive uropathy. The physician's order included foley catheter 18 french (fr),15 cubic centimeter (cc) balloon draining to gravity, report any change issues or concerns with drainage to physician every shift, change foley monthly on the 16th of the month. 18 fr Coude Foley 15 cc into balloon every night shift starting on the 15th and ending on the 16th every month, catheter tubing secured with leg band/statlock; alternate leg daily, in the morning for catheter care, and cover for urinary drainage bag every shift for privacy and dignity. Review of Resident #41's care plan, revised on 09/25/24, revealed Resident #41 required an indwelling urinary catheter. Interventions listed in the care plan included to cover the drainage bag to promote dignity. Observation on 09/30/24 at 11:26 A.M., and on 10/01/24 at 8:52 A.M., revealed Resident #41 lying in bed. Resident #41's urinary drainage bag was hanging on the bed uncovered, with yellow urine visible in the drainage bag. 10/01/24 01:27 PM resident seated in wheelchair with Foley bag uncovered sitting on foot rest of wheelchair while sitting in hallway with Resident #41 holding conversation with another resident. Interview on 10/01/24 at 1:27 P.M., with Licensed Practical Nurse (LPN) #327 verified the urinary drainage bag was uncovered. LPN #327 stated the drainage bag should be covered, and normally the facility used drainage bags with attached vinyl coverings. Resident #41 stated to LPN #327 that the catheter bag cover is located on the side of the wheelchair, and the aide just didn't place it in there like they do all of the time. The staff just place it on his foot rest. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Resident #41 on 10/03/24 1:10 P.M., stated he does care if the Foley bag is covered. Resident #41 stated he liked that it is in the cover because he is usually out in the hallway and activity room where there are other people. Resident #41 stated he doesn't want to have the Foley bag catch in the wheel of his wheelchair and have it pulled out. Resident #41 stated the staff usually keep it under my blanket and on my foot rest of the chair and not in the cover, because when they hang it on the side, it will get tangled up in the wheel. He stated it does bother him that it is uncovered and the one aide stated today, the reason that it is in the cover bag is because the state is in the building. Resident #41 stated he can't remember the name of the girl (aide). Interview on 10/03/24 at 2:46 P.M., with Director of Nursing (DON) revealed the nursing staff have been trained in the rights and dignity/customer service and the foley catheters are at all times to be covered for the dignity of the residents. Review of the undated policy titled Dignity, revealed demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered. Review of the undated policy titled Foley Catheter Care, revealed the nursing staff will provide foley catheter care per physician's order and as needed, which includes placing foley catheter drainage bag inside of a privacy bag to maintain the resident's rights and dignity. This deficiency represents non-compliance investigated under OH00158190.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on medical record review, staff interview, review of the Certification and Licensure System (CALS) and review of facility policy, the facility failed to report a resident elopement to the state agency. This affected one resident (#69) of three residents reviewed for elopement risk. The facility census was 86. Findings include: Review of the medical record for Resident #69 revealed he was admitted on [DATE] and discharged on [DATE]. Diagnoses included paranoid schizophrenia, schizoaffective disorder of bipolar type, Torsades de Pointes (a type of atypical heart rhythm), chronic obstructive pulmonary disease, and adult failure to thrive. The resident resided on the secured unit. Review of the Brief Interview of Mental Status (BIMS), dated 09/16/24, revealed Resident #69 had intact cognition. Review of the elopement evaluation dated 06/25/24 revealed the resident was at moderate elopement risk, on 06/05/24 elopement risk was moderate elopement risk and on 03/04/24 elopement risk was high elopement risk. Review of the plan of care dated 11/30/21 revealed Resident #69 needed a secured unit related to agitation, fixed delusions, paranoia and exit seeking. Review of the care plan dated 02/11/24 for elopement/wandering related to exit-seeking behaviors included interventions to follow facility elopement procedures, monitor and report changes in behaviors and resident resides on a secure unit. Review of the progress note dated 09/15/24 at 10:44 P.M., written by Licensed Practical Nurse (LPN) #294, revealed Resident #69 returned to facility at this time. The resident was alert and oriented to four spheres. Resident #69 shows no signs and symptoms of distress. Full head to toe skin assessment performed finding one abrasion to the right forearm. Resident placed on one-on-one supervision until transport to ER (emergency room). On 09/16/24 at 12:34 A.M., Resident #69 was sent to the hospital for evaluation and treatment related to elopement. Interview on 09/30/24 at 10:00 A.M. with LPN #304 revealed she was the nurse working unit three when Resident #69 eloped on 09/15/24. At 4:40 P.M. she had medication for him and was unable to locate the resident and realized he was missing. LPN #304 stated she notified the Director of Nursing (DON) at 5:50 P. M. that Resident #69 was missing. Review of CALS from 09/15/24 through 09/30/24 revealed no evidence the facility reported Resident #69's elopement from the facility on 09/15/24 to the state agency. Interview on 09/30/24 at 10:30 A.M. with the Administrator confirmed she did not report the elopement to the state agency because she did not feel it met the criteria for reporting. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Abuse Prohibition, dated September 2020, revealed all alleged violations concerning abuse, neglect, misappropriation of property and injuries of unknown origin are reported immediately to the Administrator/Designee. Allegations that involve abuse or result in serious bodily injury will be reported to the Ohio Department of Health as soon as possible, but no more than two hours after the alleged incident is discovered. Reporting of all allegations not involving abuse or serious bodily injuries must not exceed 24 hours. This deficiency represents noncompliance investigated under Master Complaint Number OH00158810.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 36650 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interviews, review of the facility investigation, review of law enforcement reports, review of fire department reports, review of body camera footage, law enforcement interviews, and review of policy for the secure unit, the facility failed to provide adequate supervision to ensure a resident at risk for elopement and residing on a secured unit did not elope from the facility. This resulted in Immediate Jeopardy and placed the resident at risk for potential serious life-threatening harm and/or injuries when Resident #69 left the facility without staff knowledge, was missing for over five hours before staff identified him as missing and was subsequently found 11 hours later at a residence 20 miles from the facility in a different county. This affected one (#69) of three residents (#24, #63 and #69) reviewed for risk of elopement. The facility census was 86. On 10/01/24 at 10:22 A.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 09/15/24 when Resident #69 was picked up by a local police officer at 11:15 A.M. walking on an interstate near the facility. The police officer transported the resident to a location 20 miles from the facility. The facility was unaware the resident was not in the building until Register Nurse (RN) #304 could not locate the resident at 4:40 P.M. Resident #69 was found by a deputy sheriff 20 miles away in another county at approximately 10:30 P.M., at the resident's prior residence, sitting in a lawn chair in the front yard with emesis on his clothing. The Immediate Jeopardy was removed on 09/16/24 and the deficiency was corrected on 09/27/24 when the facility completed the following corrective actions: On 09/15/24 at 5:45 P.M., the DON notified the local police department Resident #69 was missing. A search was initiated with staff in vehicles and on foot searching surrounding areas. On 09/15/24, a Root Cause Analysis was completed by the Administrator, DON, Regional Director of Operation (RDO) #500 and Regional Quality Assurance Nurse (RQAN) #410. A plan of correction was started for the failure of direct care staff on the behavior unit to follow policy and procedure for supervision with outside time. On 09/15/24 at 6:02 P.M., the DON initiated a Count In/Count Out form for all residents exiting to the courtyard for supervised smoke breaks. The DON notified the physician, guardian, and residents' sister with guardian approval, Resident #69 was missing. On 09/15/24 at 6:30 P.M., the DON/designee began audits for the completion of the Count In/Count Out form for resident smoke breaks. These audits will be completed four times a week, times four weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/15/24 at approximately 9:00 P.M., the DON began education to all staff regarding elopement, notification, resident supervision during outside times, and the abuse policy. The education was completed on 09/16/24 at 9:00 P.M. On 09/15/24 at 11:00 P.M., Resident #69 arrived back to the facility, returned to the secured unit, and was placed on one-on-one supervision. Licensed Practical Nurse (LPN) #294 completed a head-to-toe assessment of the resident with no major injuries found. Resident #69 was sent to the emergency room (ER) for evaluation and treatment related to the elopement. On 09/15/24 at 11:33 P.M., LPN #301 and LPN #351 began to assess all residents for elopement risk with care plans updated. All assessments were completed on 09/16/24 by approximately 5:00 A.M. On 9/16/24 at 9:00 A.M., the Quality Assurance Performance Improvement (QAPI) committee met to review the elopement and develop a plan. On 9/16/24 at 11:00 A.M., the DON updated the Elopement book. On 09/16/24 at 3:00 P.M., Maintenance Director #299 completed an elopement drill. On 09/16/24, daily audits were completed by Maintenance Director #299 and/or the 300 Unit nurse of the south and north gates in the courtyard to ensure they were locked. These audits continued through 09/27/24. On 09/17/24, Resident #69 was discharged to a sister facility with increased supervision levels. On 09/27/24, Maintenance Director #299 installed sensory alarms on the south and north gates in the courtyard. A motion detector was placed outside of the north gate. On 09/27/24, Maintenance Director #299/designee began audits three times a day until further notice to ensure the south and north gates are latched with alarms and motion detector in working order. On 09/27/24, Maintenance Director #299 educated all staff on checking the gates to ensure they were latched with alarms and motion detector in working order at every smoke break and documenting the check. On 10/08/24, the medical records for two additional residents (#24 and#63) identified as having an elopement risk, were reviewed. There were no identified concerns regarding elopements. Findings Include: Review of the medical record for Resident #69 revealed he was admitted on [DATE] and discharged on [DATE]. Diagnoses included paranoid schizophrenia, schizoaffective disorder of bipolar type, Torsades de Pointes (a type of atypical heart rhythm), chronic obstructive pulmonary disease, and adult failure to thrive. The resident resided on the secured unit. Review of the Brief Interview of Mental Status (BIMS), dated 09/16/24, revealed Resident #69 had intact cognition. Review of the elopement evaluation dated 06/25/24 revealed the resident was at moderate elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the plan of care dated 02/17/21 revealed Resident #69 was at risk for injury related to smoking. Interventions revealed to provide supervision at all times when smoking. A care plan dated 11/30/21 identified the need for a secured unit related to agitation, fixed delusions paranoia and exit seeking. Review of the care plan dated 02/11/24 for elopement/wandering related to exit-seeking behaviors included interventions to follow facility elopement procedures, monitor and report changes in behaviors, and resident resides on a secure unit. Review of the progress note dated 09/15/24 at 10:44 P.M., written by LPN #294, revealed Resident #69 returned to facility at this time. The resident was alert and oriented to four spheres. Resident #69 shows no signs and symptoms of distress. Full head to toe skin assessment performed finding one abrasion to the right forearm. Resident placed on one-on-one supervision until transport to ER. On 09/16/24 at 12:34 A.M., Resident #69 was sent to the hospital for evaluation and treatment related to elopement. Documentation at 4:00 A.M. revealed Resident #69 returned from the ER. At 3:48 P.M a BIMS was completed with Resident #69 scoring a 14, which identified intact cognition. On 09/17/24 at 1:30 P.M., Resident #69 was transferred to a sister facility. Review of the facility investigation revealed an interview statement dated 09/15/24 at 2:50 P.M. by State tested Nurse Aide (STNA) #380. The statement revealed she took residents, including Resident #69, out to smoke at 2:40 P.M. She did not realize Resident #69 did not come back in with the rest of the residents. When the nurse was passing medications, she realized Resident #69 was not in the facility and staff started searching for him around 4:45 P.M. Review of the facility investigation revealed an interview statement dated 09/15/24 by RN #304. RN #304 revealed at 4:45 P.M. she went to take Resident #69 his medication. Resident #69 was not in his room and his food tray was on the bedside table. She asked STNA #380 and STNA #288 if Resident #69 was in the facility. They stated he was in the facility and was at the last smoke time (2:30 P.M.) RN #304 and both STNAs started looking for Resident #69, searching the unit and throughout the building. RN #304 noted they alerted the manager on duty and the local police department. RN #304 added she had seen Resident #69 at 2:40 P.M. She had the cigarettes locked up in the medication room and she had to get cigarettes for staff to give to residents. Review of the interview statement dated 09/15/24 for STNA #288 revealed smokers went out at 2:40 P.M. and STNA #380 took the smokers out. Around 4:25 P.M., the meal trays arrived and STNA #288 and STNA #380 passed the trays. STNA #288 stated she had fed two residents and STNA #380 had taken the tray cart down the hall. RN #304 could not find Resident #69 to give him his medication. They started looking in all resident rooms and bathrooms and could not find him. They went to the doors at the end of the hallway and looked out. The gate was unlocked and wide open. They noticed Resident #69's dinner tray had not been touched. RN #304 notified management they could not find Resident #69. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the interview statement dated 09/15/24 by LPN #301 revealed Resident #69 arrived back to the facility via a sheriff's vehicle. Resident #69 was paranoid at baseline and believed he was under arrest and reluctant to get out of the vehicle. LPN #301 stated she was able to get him to come out of the vehicle. While walking into the facility Resident #69 stated he had Quite an adventure and his legs were tired. Deputy #400 stated the resident had thrown up in the back seat. There was evidence of emesis on Resident #69's shirt and jeans. She asked Resident #69 how he got to the neighboring county, and he stated a nice person at the church gave him a ride. Resident #69 stated he got sick because the church feeds you good, but you never know how long the food was sitting out. Resident stated when he was gone, he did smoke some marijuana he got from a guy from the church. When assisting resident with removing his soiled sweatshirt there was a small abrasion noted to right arm/wrist area. Resident #69 stated he had fallen while walking but had no complaints of pain or any other visible injuries at that time. Review of the facility investigation revealed an interview was conducted with Resident #15 on 09/15/24 at 11:55 P.M. by LPN #301 and Social Service Designee #309. Resident #15 stated he was laying on the bench and he saw Resident #69 hop the fence. Resident #69 didn't say where he was going. Review of the facility investigation revealed an interview was conducted with Resident #23 on 09/16/24 by Activity Director #354. Resident #23 revealed the day before she had seen the back door to the unit was open and more specifically the gate by the back door was open. Review of the facility investigation revealed an interview was conducted with Resident #27 on 09/16/24 by Activity Director #354. Resident #27 revealed the day before she had seen Resident #69 right after lunch before smoke break. She stated after lunch the outside gate by the back of the unit door was open. Interview on 09/30/24 at 10:00 A.M. with RN #304 revealed she was the nurse working Unit Three when Resident #69 eloped. RN #304 stated the last time Resident #69 was seen by staff was at 2:30 P.M. smoke break on 09/15/24, when STNA #380 took the residents who smoked outside. RN #304 stated she had not seen Resident #69 all afternoon. At 4:40 P.M. she had medication for him and when she was looking for him, she realized he was missing. RN #304 stated staff started looking for Resident #69 and at 5:30 P.M. she notified the DON Resident #69 was missing. RN #304 stated the police found him in a neighboring county at an old address. Interview on 09/30/24 at 10:24 A.M. with the DON revealed Resident #69 went out to smoke, got left outside and he eloped. The last time he was seen was 09/15/24 around 2:40 P.M. The DON stated at 4:40 P.M. RN #304 went to give him medication and he was missing. The DON stated she was not notified until 5:33 P.M. and then she notified the Administrator. The DON stated Resident #69 was an elopement risk, had talked about leaving the facility, and he was very delusional. The DON stated the police were notified of Resident #69's elopement and a search began. Resident #69 was found at 10:30 P.M., at his old address, sitting on a bench with a Mountain Dew. When Resident #69 returned to the facility with the deputy, the resident stated he had the time of his life while he was gone. He stated he was in a neighbor's yard while he was gone. The DON stated STNA #380 took Resident #69 out for a smoke, and he slipped out the back gate. The DON stated he had not had any previous elopements. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 09/30/24 at 10:30 A.M. with the Administrator revealed Resident #69 went out for a smoke break at 2:30 P.M. on 09/15/24 with staff and did not come back into the facility. Resident #69 left the facility through a gate in the courtyard. She was notified at approximately 5:45 P.M. and a full search was started. Resident #69 was found in a neighboring county, about 20 miles away from the facility. The Administrator stated a full investigation was started immediately. Review of the local township fire department incident report dated 09/15/24 at 6:32 P.M. revealed the fire department was notified Resident #69 had eloped. They arrived at the facility at 6:42 P.M. and were cleared at 10:50 P.M. The narrative documented they were dispatched for missing male from the facility. The fire department assisted the police with searching for Resident #69 with two [NAME] and a K-9 Unit. Resident #69 was located at 11:15 P.M. at 5618 Cleveland Rd East (U.S. Route 6) in the neighboring county. Review of the local county sheriff department office incident report dated 09/15/24 at 7:01 P.M. revealed the local police and fire department were made aware at approximately 5:43 P.M. Resident #69 was missing from the facility. Deputy #400 was directed to go to 5618 U.S. Route 6 as a place of interest where Resident #69 could be. Resident #69 was located at that address sitting in a lawn chair with vomit on his lap. Resident #69 stated he was at the address to meet his girlfriend who allegedly was enroute from another town. Resident #69 eventually allowed Deputy #400 to transport him back to the nursing home. While enroute to the nursing home Deputy #400 asked Resident #69 how he got to the address with the resident stating a female police officer assisted with transporting him. Upon arriving to the facility Resident #69 was transferred to the care of the nursing staff. Later Deputy #400 went through call logs and discovered Officer #401 was out with Resident #69 earlier in the day, at approximately 11:20 A.M., when she was called for a welfare check at U.S. Route 250 and [NAME] Rd. Dispatch informed Deputy #400 that Officer #401 showed enroute to 5618 U.S. Route 6 with Resident #69 in the vehicle. Review of Deputy #400's body camera footage revealed on 09/15/24 at 10:30 P.M. Resident #69 was found at 5618 U.S. Route 6 sitting in a lawn chair with vomit on his clothes. Resident #69 identified himself and stated he had eaten at a church and that made him sick, and he vomited. Resident #69 stated he was waiting for his girlfriend who was coming from another town. Deputy #400 was able to get Resident #69 in his vehicle to return to the facility. In the police cruiser Resident #69 stated a lady sheriff gave him a ride to this county. Interview on 10/01/24 at 11:03 A.M. with Deputy #400 revealed Resident #69 was sitting in front of an apartment building in a lawn chair. He had emesis on his lap and on the ground. Resident #69 knew his name and where he was. Resident #69 stated he received a ride from a female police officer when he was on U.S. Route 250 and [NAME] Rd. Deputy #400 stated he returned him to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the local police department Investigative Report titled Courtesy Ride revealed on 09/15/24 at 11:15 A.M. Police Officer #401 received an anonymous caller requesting a welfare check for a man wearing a blue hoodie walking on U.S. 250 near [NAME] Road. The anonymous caller explained the man appeared to be stumbling and believed he fell down at one point as she passed him. As Police Officer #401 approached the man she did not see him stumble or fall and he was walking slowly. The man identified himself giving the name of Resident #69. He stated he was walking to a nearby town. Police Officer #401 did not want to leave him. The man asked if she could take him home and the residential address in the system showed as 5618 Cleveland Road in [NAME]. The officer explained she could not go too far out of her jurisdiction, but she would take him as far as she could. Resident #69 appeared alert and oriented. The report indicated Resident #69 was dropped off on Cleveland Road West, near Center Street, in [NAME]. Review of the local police department Investigative Report titled Follow-up Investigation, signed by the Chief #402 on 09/17/24 at 7:55 A.M. revealed on 09/15/24 they received a call at 5:43 P.M. about a missing resident at the local nursing facility. It was later determined on 09/15/24 around 11:15 A.M. Police Officer #401 responded to U.S. 250 to provide a courtesy ride to a person later determined to be Resident #69. The charge nurse, RN #304's, written statement indicated the resident was seen at 2:40 P.M. as she had cigarettes locked in the medication room and she had to get cigarettes for resident smoke break. STNA #380's written statement indicated she took Resident #69 out to smoke at 2:40 P.M. and she didn't realize he did not come back in with them. It is now known the two employees could not have had eyes on Resident #69 at this time due to him being in the [NAME] area, dropped off by Police Officer #401. Resident #69 left the facility sometime before 11:15 A.M. and was gone for approximately twelve hours. The DON described a portion of their policy and procedure was to physically check residents every two hours. She admitted this was not done and described the failures that day as systemic. Review of the facility policy titled The Secured Unit at CHS [NAME], dated 4/15/22, revealed rounds are to be done every hour to visually observe residents. This deficiency represents non-compliance identified during the investigation of Master Complaint Number OH00158810 and Complaint Number OH00158195.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, staff interview, resident interview, review of Controlled Drug Receipt/Record/Disposition Form, and policy review, the facility failed to ensure medications to relieve pain were obtained in a timely manner for administration. This resulted in Actual Harm to Resident #05 when her physician-ordered supply of a narcotic analgesic, Oxycodone, was exhausted on 09/14/24 at 4:00 A.M. and the facility did not timely obtain a new written prescription from the ordering provider. This delay in obtaining a new prescription led to Resident #05 not receiving the medication for 91 hours which led to the resident experiencing chronic pain horrible, rated her pain at a 10/10, indicating the worst possible pain, and ultimately requiring an emergency department visit on the afternoon of 09/17/24 to obtain a dose of Oxycodone and a short-term written prescription. This affected one (Resident #05) of three residents reviewed for pain management. The facility census was 86. Findings include: Review of the medical record for Resident #05 revealed an admitted [DATE]. Medical diagnoses included chronic pain, hereditary and idiopathic neuropathy, radiculopathy, and spinal stenosis. Review of the Minimum Data Set (MDS) assessment, dated 07/29/24, revealed Resident #05 to be cognitively intact. Resident #05 required physical assistance with activities of daily living (ADLs) and was dependent on mobility. Resident #05 was coded as having frequent pain, rated 06/10 on the assessment. She was recorded as having received scheduled pain medications and as needed (PRN) pain medication during the seven-day lookback period. The resident was not recorded as having received any non-pharmacological interventions to manage pain. Review of Resident #05's care plan, revised on 07/19/24, revealed the resident was at risk for an alteration in comfort related to a hip fracture, neuropathy, spinal stenosis, radiculopathy, bilateral congenital hip deformities, osteoarthritis, and gout. Listed interventions included to administer medications as ordered to manage pain, reposition for comfort, provide rest periods as needed, therapy referral as needed, and use pain scale as reported by resident. Review of Resident #05's pre-admission hospital records dated 07/15/24-07/17/24, revealed the discharge instructions listed the resident's care was to be managed by Skilled Nursing Facility (SNF) providers. Resident #05's hospital face sheet listed Outside Provider #101 as the resident's primary care provider in the community. Review of Resident #05's visit note from Outside Provider #101's office revealed the resident saw Nurse Practitioner (NP) #115 on 09/04/24. The visit note stated the reason for the visit was listed as a chief complaint of referral, with the resident having presented to the office for a face-to-face visit to get a motorized scooter and a referral to pain management. The note listed the resident had arthralgias (joint pain) and back pain, identifying pain in her legs, lower back, hands, knees, and right shoulder, with the pain rated as a 10 on a scale of 0-10 The visit note indicated an order was placed for an ambulatory referral to pain management. Listed diagnoses associated with the office visit included neuropathy, congenital hip dysplasia, facet arthritis of the lumbosacral region, chronic pain syndrome, closed fracture of multiple bones of the right lower leg, bilateral foot drop, and generalized weakness. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #05's physician's orders revealed an order dated 08/05/24 for gabapentin (a medication used to aid in controlling nerve-related pain) 800 milligrams (mg) four times daily. Resident #05 also had an order dated 09/05/24 for Oxycodone 10 mg, one tablet by mouth every eight hours as needed for pain. This order was discontinued on 09/14/24. Review of Resident #05's progress notes from September 2024 revealed a note dated 09/04/24 indicating the resident went to an appointment with Outside Provider #101 and clarification was needed for a medication order. A note dated 09/05/24 noted a nurse found new orders from Resident #05's doctor from appointment to give Oxycodone 10 mg tablet with gabapentin at 6:00 A.M., 12:00 P.M., 6:00 P.M., and 12:00 A.M. Subsequent notes on 09/05/24 at 12:39 P.M. and 2:19 P.M., on 09/06/24 at 2:02 P.M., and on 09/09/24 at 11:44 A.M., revealed attempts to contact Outside Provider #101 for clarification on medication order. A note dated 09/09/24 at 3:11 P.M. revealed the facility received a fax prescription from Outside Provider's office, but the script needed clarified. A subsequent note timed 3:27 P.M. revealed a nurse spoke with a representative with Outside Provider #101's office and the office was faxing orders to the facility. A note dated 09/10/24 at 3:12 P.M. revealed a nurse called and left a message to clarify an order received via fax. There were no further notations of attempts to clarify Resident #05's pain medication order or written prescription until a note dated 09/14/24 at 3:52 A.M., when a note revealed the resident was given the last dose of her PRN Oxycodone. A staff nurse called the pharmacy and there was no new written script on file. The note indicated a controlled substance page was listed in the doctor's binder but was unsigned. The on-call provider does not refill narcotics and the information will be passed onto the next shift. Review of Resident #05's Controlled Drug Receipt/Record/Disposition Form, revealed the resident's last dose of Oxycodone was signed out of the controlled drug storage on 09/14/24 at 4:00 A.M. Review of the Medication Administration Record (MAR) for September 2024 revealed Resident #05's routine gabapentin was administered as ordered. Resident #05's PRN Oxycodone was administered two to three times daily from 09/05/24 through 09/13/24. Only one dose of Oxycodone was administered on 09/14/24, at 3:55 A.M. There was no recorded Oxycodone administered to Resident #05 on 09/15/24, 09/16/24, or 09/17/24. Oxycodone 10 mg was recorded as administered to Resident #05 on 09/18/24 at 12:00 A.M. Subsequent review of progress notes from 09/14/24 through 09/16/24 revealed no documented attempts to contact Resident #05's Outside Provider #101, Medical Director #200, or an on-call provider to address Resident #05's pain medication. There was no note reflecting the as-needed Oxycodone had been ordered to be discontinued by a physician. Review of Resident #05's Occupational Therapy Evaluation and Plan of Care, dated 09/16/24, revealed the resident was noted to have pain that interfered and/or limited her functional activity, pain that interferes with sleep, and noted that nursing was to address pain. Review of a progress note dated 09/17/24 at 1:58 P.M. revealed the Director of Nursing (DON) documented she spoke with Outside Provider #101's office regarding the pain medication prescription for Resident #05. The office representative stated Outside Provider #101 was under the impression at the last visit that Resident #05 was under the facility care for pain medication orders and the DON clarified that was not the case. Office representative stated Outside Provider #101 will manage the resident's pain and will send a script as soon as possible. The DON informed the office the facility would not be writing scripts for Resident #05's pain medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 09/17/24 at 3:06 P.M. revealed Resident #05 requested to go to a local hospital's emergency room (ER) for pain. Resident #05 was aware the pain medication prescription was on the way but still wanted to go. The note included no assessment of Resident #05's pain describing the pain rating, and location or characteristics of her pain. A subsequent note revealed the resident later returned from the ER with a new three-day Oxycodone prescription which was faxed to pharmacy upon her return. Review of the Emergency Department records, dated 09/17/24, revealed Resident #05 presented to the ER from the nursing home for a medication refill. Resident #05 had been receiving Oxycodone from her primary care provider (PCP) for chronic pain for quite some time. The note indicated no provider was currently writing her pain medication prescriptions and Resident #05 was sent to the ER so she could be medicated and have her prescription refilled. Resident #05 reported she had been out of her Oxycodone for the last five days and complained of diffuse pain, chronic in nature. Resident #05 rated her pain at a 10 on a numeric 0-10 scale, indicating 10 as the worst possible pain. The notes indicated she received a dose of Oxycodone 10 mg one tablet while in the ER and was discharged back to the facility with an order for a three-day supply of Oxycodone. The note indicated the facility needed to coordinate with Resident #05's PCP and figure out how she would be getting her medications refilled from here on out. Review of a physician order dated 09/17/24 for Oxycodone 10 mg one tablet every eight hours routine for three days. A subsequent order dated 09/19/24 continued the Oxycodone 10 mg one tablet routinely three times daily for an additional three days, through 09/21/24. An order dated 09/22/24 listed Oxycodone 10 mg one tablet three times daily routine for chronic pain for a duration of 30 days Review of Resident #05's subsequent Controlled Drug Receipt/Record/Disposition Form revealed a card of Oxycodone was listed as filled by the pharmacy on 09/17/24, and the first dose from the new supply was administered to Resident #05 at the facility on 09/17/24 at 11:00 P.M. An interview on 10/01/24 at 2:22 P.M. with Resident #05 revealed she has chronic and neuropathic pain in her bilateral legs, feet, hands, and knees. She stated the facility ran out of her pain medication multiple times, but around 09/17/24, she had to go to the ER to get her pain addressed after she had not received her Oxycodone for multiple days. Resident #05 stated she had asked to go to the ER multiple times and cried because she was in horrible pain. The resident stated the longer she goes without pain medications, the longer it takes to get back the pain back under control. Resident #05 stated she had taken Oxycodone for year for chronic pain and at the time she was finally transported to theER on [DATE] she rated her pain at a 10/10, indicating the worst possible pain. A subsequent interview with Resident #05 on 10/02/24 at 2:58 P.M. revealed her chronic pain was under control at that time as she had received her medication. Resident #05 stated she received a dose of her Oxycodone today and the medication only helps ensure her pain does not get to an excruciating level. Resident #05 stated she is never pain free as she lives with chronic pain all throughout her body and had done so for years. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview on 10/03/24 at 10:48 A.M. with the DON revealed she was familiar with Resident #05 and the pain management concern, as the local Ombudsman had asked her for information regarding this resident. The DON stated Outside Provider #101 was Resident #05's PCP in the community, was the one managing her pain, and continued to prescribe Resident #05's pain while a resident of the facility. The DON confirmed Resident #05 had gone to an outside appointment on 09/04/24 and returned with orders to continue with the pain medication Oxycodone and to it with gabapentin. The DON stated the office did not send a new handwritten script as required by the facility's pharmacy to fill the medication order. Nurses attempted to phone Outside Provider #101's office without success. On 09/17/24, Resident #05 did want to go to the ER as the resident stated she was in excruciating pain, even though the script for the pain medication was on the way. Resident #05 went to the ER, they gave her a dose of Oxycodone, and she returned to the facility with a few days' supply of Oxycodone. The DON stated the facility still did not receive the fax scripts, so she drove the Outside Provider #101's office to obtain the written script herself, and scheduled Resident #05 future appointments with the provider to avoid any future unnecessary delay. The DON who confirmed the resident went from 09/14/24 at approximately 4:00 A.M. to 09/17/24 at 11:00 P.M. with no Oxycodone available or administered to Resident #05. The DON confirmed there was no note indicating any provider had discontinued Resident #05's Oxycodone orders. The DON also confirmed there were no recorded attempts to contact Medical Director #200 as nursing staff know he would not write for Resident #05's pain medication. The DON verified there was a delay in obtaining clarification and a written prescription to obtain Resident #05's pain medication. Interviews conducted on 10/07/24 between 1:21 P.M. and 1:35 P.M. with Licensed Practical Nurse (LPN) #331 and LPN #295 confirmed Resident #05 had chronic and ongoing pain that was difficult to manage. Both reported they had diligently worked to call and phone Outside Provider #101 to get the required script. Both reported they had not contacted the facility providers, as Outside Provider #101 was the one prescribing Resident #05's medication. LPN #295 stated Resident #05 was dependent on staff for care and mobility and reported the resident's legs frequently got twisted up when moving, she had really bad neuropathy, and limb contractures. Review of the undated policy titled Pain Management defined pain as an individual resident's unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is highly subjective and it can be difficult to obtain objective markers. The licensed nurse will gather the following information as it applies to the resident while they are performing the pain assessment: history of pain and past treatment regimen, characteristics of pain (including intensity, descriptors, pattern, location, frequency, timing, and duration), impact of pain on day-to-day activities, strategies to reduce pain, additional symptoms that may come about with pain such as nausea or anxiety, review of current medical conditions and medications, and a discussion of the resident's goals for pain management. If the resident is assessed to be experiencing pain, the nurse will explore pharmacological and non-pharmacological interventions. The documentation in the clinical record must reflect the ongoing communication between the prescribe and the staff for the most optimal use and management of pain medications. This deficiency represents non-compliance investigated under Complaint Number OH00158190.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on record review, staff interview and policy review the facility failed to ensure medications were given as ordered. This affected one (#291) of three residents reviewed for medication administration. The census was 86. Findings included: Review of the medical record for Resident #291 revealed an admitted [DATE]. Diagnoses included alcoholic cirrhosis of liver, suicidal ideations and major depression. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #291 had intact cognition. Review of the telephone order dated 09/24/24 from Nurse Practitioner (NP) #421 to start Prozac (antidepressant) 10 milligrams (mg) by mouth daily for anxiety and depression and to follow up with psychiatric services for depression. Review of the physician telephone order from medical doctor (MD) #200 dated 09/24/24 revealed Prozac 40 mg by mouth daily signed by nurse on 09/30/24. Review of the Medication Administration Report (MAR) for September 2024 revealed Prozac 10 mg was given on 09/26/24 and discontinued on 09/29/24. Prozac 40 mg was started on 09/30/24. Interview on 10/03/24 at 9:48 A.M., with Resident #291 stated he did go without his Prozac for 6 days. Resident #291 stated Prozac had been increased by the MD #200 and it was not started for six days. He had to keep asking the nurse about the medication and then finally she found the order on a clipboard behind the nurse's station, Licensed Practical Nurse (LPN) #327 finally put the order in, and the medications was increased. Interview on 10/08/24 at 9:29 A.M., with Director of Nursing (DON) verified Resident #291 had the order for the increase of Prozac a week earlier then when the medication was not given. Interview on 10/08/24 at 10:44 A.M., with LPN #327 stated Resident #291 got an order from the nurse practitioner for Prozac 10 mg and to follow-up with psychiatric service for depression. Resident #291 seen the psychiatrist MD #200 later in the day and the Prozac was increased to 40 mg. LPN #327 verified Resident #291 did not receive Prozac 10 mg until 09/26/24 and then started Prozac 40 mg on 09/30/24. LPN #327 stated Resident #291 was questioning her on why he was not receiving Prozac 40 mg since it was increased on 09/24/24. LPN #327 stated she started looking for the order and found it on a clipboard on 09/30/24 and that is when she put the order in. Review of the policy titled, Medication Administration, General Guidelines, dated 2007 revealed medications are administered as prescribed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on staff interview, record review, and policy review, the facility failed to ensure timely laboratory testing to monitor therapeutic drug levels for psychotropic medications was completed as ordered. This affected one (#29) of three residents reviewed for mood and behavior. The facility census was 86. Findings include: Review of Resident #29's medical record revealed an admitted [DATE]. Medical diagnoses included schizophrenia, drug-induced parkinsonism, and lack of coordination. Review of Resident #29's Minimum Data Set (MDS) quarterly assessment, dated 07/04/24 revealed the resident had intact cognition. Resident #29 was recorded as having hallucinations but no other behaviors or rejection of care. Review of Resident #29's care plan, dated 01/04/21, revealed the resident was at risk for side effects related to psychotropic medications. Listed interventions included to administer medications as ordered and to administer and monitor laboratory tests as ordered and as needed and report results to the physician and/or nurse practitioner. Review of Resident #29's physician's orders included an order dated 04/06/22 for Lithium Carbonate 300 milligrams (mg), give 1 tablet by mouth in the morning. Resident #29 also had an order dated 01/19/21 for Divalproex Sodium 500 mg, give two tablets (to total 1000 mg) once daily at bedtime. Both medications were listed to treat schizophrenia. Review of Resident #29's laboratory orders revealed an order dated 04/08/21 to check Lithium level every two months. Resident #29 also had an order dated 12/30/23 to check labs, including a Depakote (valproic acid) level, every three months. Review of Resident #29's laboratory results from October 2023 to October 2024 revealed the resident had a lithium and valproic acid level (to monitor the therapeutic level of Depakote or divalproex in the bloodstream) drawn on 03/07/24. The reported lithium level was 0.3 millimoles/liter (mmol/L), with the report indicating the resulted value was low, with normal range between 0.6 and 1.3 mmol/L. Resident #29's valproic acid level was 78 micrograms (mcg)/milliliter (ml), within normal range. The report was initialed by Nurse Practitioner (NP) #510 with a note which stated send to psych. Resident #29 also had a lithium level drawn on 09/11/24, with a result of 0.3 mmol/L, indicating low. Review of Resident #29's progress notes revealed no indication the 03/07/24 or 09/11/24 laboratory results had been reported to the psychiatric provider. (continued on next page)

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	366067	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's Psychiatry Progress Notes, authored by Psychiatric Nurse Practitioner (Psych NP) #555, dated 03/19/24, 05/14/24, 06/11/24, 07/09/24, 08/06/24, and 10/01/24, all included laboratory results from a visit dated 08/24/23. The notes dated 06/11/24, 07/09/24, and 10/01/24 indicated there were no recent laboratory results available for review. Interview on 10/03/24 at 9:57 A.M., with Licensed Practical Nurse (LPN) #331 revealed she was unsure of the process for how laboratory testing is done. LPN #331 stated she just knows the laboratory technicians come to the facility in the early morning hours while night shift is still here, and lab only comes between Tuesday and Friday. If she obtains a laboratory order from a provider, she inputs the order into the electronic medical record, and then it is passed on verbally to the next shift. LPN #331 stated she was unsure how the laboratory technicians would know what laboratory testing needs done each day unless they check with the nurse upon arrival. Interview on 10/03/24 at 2:59 P.M., with Assistant Director of Nursing (ADON) Infection Preventionist (IP) #351 revealed when providers write orders for laboratory or radiology testing, the nurse who takes the order is responsible for transcribing the order into the resident's electronic medical record, and inputting the order into the laboratory's online portal. ADON IP #351 reported all nurses have credentials to input orders into the laboratory online portal. Resident #29's laboratory results for the last year were reviewed, and ADON IP #351 confirmed multiple laboratory testing had gotten missed for Resident #29's therapeutic drug level monitoring. A follow up interview on 10/08/24 at 1:18 P.M., with ADON IP #351 provided a copy of Resident #29's valproic acid and lithium level which were drawn earlier on 10/08/24. The report listed the valproic acid level as 108, indicating above the therapeutic range of 50-100 mcg/ml, and the lithium level was 0.3 mmol/L, a continued low result. ADON IP #351 stated the results had not yet been reported to the provider but would be soon. Review of the undated policy titled, Lab Draws, revealed the nurse will review lab orders written by physicians and clarify orders as needed. The nurse accepting the order will enter the ordered lab into the lab computer to communicate the order draw requirements with the lab. The nurse will transcribe the ordered lab onto the treatment record, making certain to include the names of the ordered labs, as well as the date that the lab is to be drawn. Lab results will be reported to the physician and/or nurse practitioner per policy.

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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** 47990 Based on observation, resident and staff interview, and record review, the facility failed to provide a resident with physician-ordered adaptive equipment for meals. This affected one (#05) of four residents reviewed for nutrition. The facility identified 14 residents who required adaptive equipment at meals. The facility census was 86. Findings include: Review of the medical record for Resident #05 revealed an admitted [DATE]. Medical diagnoses included muscle weakness, lack of coordination, hereditary and idiopathic neuropathy, hypothyroidism, and anemia. Review of Resident #05's minimum data set (MDS) admission assessment, dated 07/2/24, revealed the resident had intact cognition. Resident #05 required set-up/clean-up assistance with eating. Review of Resident #05's care plan, dated 08/26/24, revealed the resident had the potential for alteration in nutrition and hydration related to hypothyroidism, depression, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, vitamin D deficiency, and anemia. Resident #05 was listed to be at risk for malnutrition. Listed interventions included to assist with meals as needed and to provide adaptive equipment as ordered. Review of Resident #05's physician's orders listed an order dated 07/22/24 for a handled cup for liquids per resident and family request. Interview on 10/01/24 at 2:30 P.M., with Resident #05 revealed she had trouble grasping cups and glasses of liquids. A styrofoam cup with no lid, filled with water, was noted on the overbed table in front of her. Resident #05 stated her right hand cannot close all the way, and her left hand does not open all the way, and it is difficult to get herself a drink with the open cups. Observation on 10/03/24 at 8:40 A.M., revealed Resident #05 in bed. Her meal tray was next to the bed with her breakfast. There was no handled cup on the resident's tray or anywhere visible in the resident's room. A subsequent observation and interview on 10/07/24 at 11:48 A.M., revealed Resident #05 seated upright in her wheelchair feeding herself. The resident had only one drink on her tray, a small 4-ounce carton of a chocolate nutritional supplement that was in an unopened carton. Resident #05 stated she could not open the carton, but that she did not want the nutritional supplement as she was tired of the chocolate flavor. Resident #05 stated she had not received any other drinks, nor had anyone offered to get her any additional drinks. There was no handled cup present on the resident's tray or anywhere visible in the room, only a styrofoam cup with no lid, filled with water. Resident #05 stated it was hard to get a drink out of the styrofoam cup, sometimes she spilled things, but she tried to do the best she could. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/07/24 at 12:10 P.M., with Certified Nursing Assistant (CNA) #292 stated Resident #05 did not like the handled cup, but she would offer the cup to the resident. CNA #292 approached Resident #05 and asked if she would like something to drink in the handled cup, Resident #05 stated she would like some orange juice and stated the handled cup definitely helps her be able to get a drink on her own. CNA #292 stated the cup usually comes from the kitchen on the meal trays that arrive to the unit, and the resident does not typically keep a handled cup in her room for water or hydration in between meals. Interview on 10/08/24 at 11:22 A.M., with the Director of Nursing (DON) revealed the facility does not have an order on providing adaptive equipment but the facility would follow written physician's orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on staff interview, record review, review of infection control logs and review of facility policy, the facility failed to ensure complete and accurate medical records. This affected three (#23, #76, and #53) of 24 resident reviewed for accurate medical records. The facility census was 86. Findings include: 1. Review of the medical record for Resident #23 revealed an admitted [DATE]. Medical diagnoses included paranoid schizophrenia, depression, and asthma. Resident #23 had a guardian. Review of the facility's infection control log for [DATE] revealed Resident #23 tested positive for COVID-19 during routine weekly testing on [DATE]. Review of Resident #23's progress notes for [DATE] revealed a note dated [DATE] at 3:21 P.M., indicating the resident was in the common area observing a group trivia activity, but was not actively participating. The resident denied having any health concerns. Further review of Resident #23's medical record from from [DATE] through [DATE] revealed no evidence the resident's positive COVID-19 test result had been documented in the medical record and no evidence the resident's guardian or provider had been notified. 2. Review of the medical record for Resident #76 revealed an admitted [DATE]. Medical diagnoses included traumatic brain injury, schizophrenia and delusional disorder. Resident #76 had a guardian. Review of the facility's infection control log for [DATE] revealed Resident #76 tested positive for COVID-19 during routine weekly testing on [DATE]. Review of Resident #76's medical record from [DATE] through [DATE] revealed no evidence the resident's positive COVID-19 test results had been documented in the medical record and no evidence the resident's guardian or provider had been notified. 3. Review of the closed medical record for Resident #53 revealed an admitted [DATE]. Medical diagnoses included dementia, chronic atrial fibrillation and muscle weakness. Resident #53 expired at the facility under hospice care on [DATE]. Resident #53 had a guardian. Review of the facility's infection control log for [DATE] revealed Resident #53 tested positive for COVID-19 during routine weekly testing on [DATE]. Review of Resident #53's medical record from [DATE] through [DATE] revealed no evidence the resident's positive COVID-19 test result had been documented in the medical record and no evidence the resident's guardian or provider had been notified. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 1:03 P.M., with Assistant Director of Nursing (ADON) Infection Preventionist (IP) #351 confirmed there was no documentation in Resident #23, Resident #76, or Resident #53's medical record reflecting their positive COVID-19 test results and no notification to the physician or guardian/responsible party. Review of the undated policy titled, Status Change in Resident Condition - Notification, revealed the licensed nurse will record in the resident's medical record any changes in the resident's medical condition or status.