STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366238	A. Building B. Wing	05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Towers Post-Acute	1500 Sherman Avenue Cincinnati, OH 45212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 20298 Based on review of Resident Council Meeting notes, resident interview, review of response forms, and staff interview, the facility failed to provide specific and appropriate resolution to resident concerns expressed during the meetings. The had the potential to affect 12 residents (#63, #41, #70, #54, #122, #30, #34, #60, #44, #23, #35 and #41) who attended the meetings in 2021. The facility census was 75 residents. Findings include: Review of the Resident Council meetings conducted in 2021 and response forms revealed: -On 01/20/21 resident #63 requested more activities. Residents #41 and #70 had concerns about the food quality and variety. There was no evidence of a response to address the resident's concerns. -On 2/18/21 resident #122 had complaints about her meals, wanted more activity crafts and did not like the way staff talked to her. Resident #34 had some missing clothing in the laundry and would like some different snacks. Resident #30 had clothing missing in the laundry. The response to this meeting revealed menu ideas were brainstormed and labeling ideas for clothing was discussed with no specific resolution to the resident's concerns or any follow up. -On 03/29/21 an unnamed resident had a concern about a dirty bathroom. Unnamed residents had concerns about aides ignoring them. The Council Response form following the meeting revealed the concerns were taken to the department to resolve. There was a note that staff ensured residents were treated with respect and dignity or it would be reported to Administration. There was no specific resolutions the the resident's concerns or any follow up. -On 04/27/21 an unnamed resident requested different snacks. Residents wanted to know how to obtain their money. There was no response form to address the resident's concerns. -On 05/04/21 an unnamed resident had concerns about activity frequency and snack options. The Council Response form revealed the activity director would provide appropriative activities and dietary was notified of snack options. There was no specific resolutions to the resident's concerns or any follow up noted. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the resident group meeting conducted on 05/20/21 at 11:03 A.M. with residents (#63, #41, #70, #54, #122, #30, #34, #60, #44, #23, #35 and #41) revealed Resident #63 had requested back in the January 2021 meeting to have more activities he enjoyed such as arts and crafts, outings and virtual bowling. The resident revealed no response had been received from facility staff regarding his request. Interview with the Administrator In Training (AIT) #200 on 05/24/21 at 9:30 A.M. verified there was no evidence of specific resolution or follow up to the resident concerns expressed during the 2021 meetings. AIT #200 stated he was not aware of the residents who had concerns about how staff were treating and talking to them from the 02/18/21 and 03/29/21 meetings. Activity Director #81 was called on the phone and could not name the residents who had concerns about how staff were treating and talking to them from the 02/18/21 and 03/29/21 meetings.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 03276 Based on review of the facility's surety bond, review of the resident personal fund trust account balance, and staff interview, the facility failed to ensure the amount of the resident funds surety bond was sufficient to assure the security of the amount of the resident's funds deposited with the facility. This had the potential to affect all 54 residents (#35, #59, #03, #17, #21, #45, #48, #53, #05, #54, #47, #04, #38, #32, #44, #46, #50, #06, #27, #63, #57, #40, #25, #60, #26, #58, #61, #10, #41, #09, #30, #19, #16, #62, #68, #28, #64, #07, #322, #18, #66, #55, #42, #67, #29, #69, #33, #11, #13, #20, #08, #71, #31, and #02) who had authorized the facility to manage their personal funds. The facility census was 75. Findings include: Review of Resident personal funds with Business Office Manager (BOM) #75 on 05/24/21 at 11:26 A.M. revealed there was a solitary trust account for both the residents of the nursing facility and the adjoining licensed residential care facility. The total amount of the resident funds being managed as of 05/18/21 was $241,214.57. Review of the facility's resident funds surety bond effective 09/01/19 revealed the surety bond was in the sum of $170,000.00. At the time of the review of Resident funds, BOM #75 affirmed the facility's current resident fund surety bond was for an amount that was not sufficient to cover the current resident funds trust account.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03276 Based on medical record review, staff interview, and facility policy review, the facility failed to ensure when a resident formulated an advanced directive it was accurately recorded in all locations of the medical record to ensure the resident's wishes would be followed as directed in the event of an emergency. This affected one resident (#68) of one reviewed for Advanced Directives. The facility census was 75. Findings include: Medical record review revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including schizophrenia, diabetes mellitus type 1, anxiety disorder, anemia, neuropathy, and obesity. Review of Resident #68's five day Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. Review of Resident #68's current physician orders in the electronic health record (EHR) revealed an order for the resident to be Full code. Review of the hard paper record for Resident #68 revealed no evidence of the designation of the resident's code status on the front of the record, or under the advanced directive tab. Interview with the Director of Nursing (DON), and the Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN) #27 on 05/19/21 at 3:02 P.M. revealed each resident's advanced directive was to be part of the physician's orders, and the advanced directive was supposed to be in both the EHR and the hard paper record kept on the units. On 05/19/21 at 3:29 P.M. Resident #68's hard paper record was observed with Social Services Designee (SSD) #101. SSD #101 affirmed the resident's code status was not evident on the outside or inside of the record. Review of the facility policy and procedure titled :Advance Directives revised on 12/2016 revealed advanced directives would be respected in accordance with state law and information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. This is an example of continued non-compliance from the Complaint survey of 05/03/21.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 03276 Based on observation, staff interview, resident interview, and review of facility policy, the facility failed to provide each resident with housekeeping and/or maintenance services necessary to maintain a sanitary and orderly environment to ensure protection of one resident's personal belongings from loss. This affected 12 residents (#7, #68, #59, #30, #27, #28, #67, #29, #47, #14, #71, and #32) of 12 residents reviewed for environment. The facility census was 75. Findings include: 1. A tour of the first floor of the facility was conducted with Maintenance Director (MD) #08 on 05/19/21 at 11:13 A.M. While touring the first floor the following was observed: a) In the private room occupied by Resident #7 revealed a substantial accumulation of dust, dirt, paper and plastic debris on the floor behind and to the left and right of the head of the resident's bed. There were what appeared to be numerous dried on splashes of liquid debris on the walls to the left and right of the resident's television, and on the wall where the window was. The frame and padding of the resident's recliner/wheel chair was soiled with an accumulation of dried on liquids spills, dust and debris. 2. In the room occupied by resident #68 the wall where the window was, to the left of the resident's bed, was damaged. There was an approximately eight inch by 11 inch area where the paint and top surface of the wall had been scraped off. Chunks of chalky dry wall was crumbling and falling out of the wall. There also was a three inch by eight inch area where the top layer of paint and dry wall had been scraped off the wall. The top of the resident's chest of drawers around the top of was chipped and exposing the rough particle board below. 3. In the room occupied by Residents #59 and #30, there was a eight inch by four inch square cut out of the wall above the toilet in their bathroom. Above the opening was a large screw sticking out of the wall. The pipes behind the wall were visible. MD #08 shared there was an access panel that was supposed to be covering the opening. 4. In the room occupied by Residents #27 and #28 there was an approximately five inch by eight inch hole in the dry wall behind the door to the room. Chunks of dry wall were crumbling out of the wall. MD #08 stated the hole had been repaired once, and it must have been caused by staff, as neither resident in the room were likely able to have caused the hole. 5. Observation of the corridor across from the first floor nursing station and activity/television room revealed areas the cove base was missing off the base of the walls, exposing the stripped top layer of dry wall where the cove base had been. 6. In the large first floor activity/television room there were two large tan colored vinyl, high back arm chairs. The seat cushions of both chairs were damaged with splits and tears, which would not allow for the chairs to be thoroughly cleaned and sanitized. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with MD #08 affirmed the above observations at the time of the tour. 7. A tour of the second floor of the facility was conducted on 05/19/21 at 11:35 A.M. with Licensed Practical Nurse (LPN) #83 and revealed the following: a) There was an approximately 14 inch by 20 inch glass panel missing from the vision panels in the lower half of the corridor wall near the door to the nursing station. There was a piece of cardboard filling the hole left by the glass. LPN #83 stated the glass panel/window had been missing for months. b) Resident #67 was in his wheel chair eating in the unit dining room. His wheel chair was heavily soiled with an accumulation of dried on food/liquid debris and dirt. The top, back of the back rest of the wheel chair was ripped. c) In the room occupied by Residents #29 and #47, there was an accumulation of what appeared to be dried on food and liquids spills on the wall where the window was located. In the bathroom, within the room, there were tiles missing and tiles falling off the bottom of the wall to the left of the toilet. d) Resident #14 was observed sitting in the corridor in her wheel chair. The wheel chair was heavily soiled with an accumulation of food and debris. e) In the room occupied by Resident #64 the resident's bed frame was soiled with a heavy accumulation of dried on black debris and food/liquids debris and spills. The mattress the resident was lying on was exposed and also observed with food debris and liquid spills. There was a large orange/brown colored water stain on the ceiling above the resident's bed. f) In the room occupied by #71 and #32 there was a cracked double duplex outlet cover next to Resident #71's bed. The outlet cover was broken and exposing the junction box below. There was dried on tan/brown splashes all long the wall adjacent to the resident's beds. The head rest of Resident #71's wheel chair was ripped, and the frame of the chair was soiled and in need of cleaning. g) In the open common area in front of the nursing station/office there was a black vinyl chair with a bent frame, and the seat cover was damaged with pieces of vinyl missing. LPN #83 affirmed the aforementioned observations and the needed cleaning and repairs while touring with the surveyor. This deficiency substantiates Complaint Number OH00113236 and OH111512.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40471 Based on medical record reviews, staff interview, resident interview, and facility policy review, the facility failed to provide bed hold notices for residents sent to the hospital. This affected five residents (#6, #7, #75, #122, and #322) of seven reviewed for bed hold notifications. The facility census was 75. Findings include: 1. Medical record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, tracheostomy, and anoxic brain damage. The record revealed Resident #6 was transferred to the hospital on 01/15/21 and 04/30/21. There was no evidence the resident or resident's representative was given a bed hold notice on either date of being transferred to the hospital. 2. Medical record review revealed Resident #322 was admitted to the facility originally on 12/01/17, with diagnoses including Covid-19, Chronic Obstructive Pulmonary Disease (COPD), end stage renal disease, stage 5, and heart failure. Further review of Resident #322's medical record revealed the resident was transferred to the hospital on 07/17/20, 09/16/20, 01/02/21, 01/20/21, and 02/04/21. There was no evidence the resident or the resident's representative was given a bed hold notice. Interview on 05/20/21 at 1:16 P.M. with Registered Nurse (RN) #96 revealed prior to 05/20/20 the facility was not providing bed hold notices. 03276 3. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, intracranial injury, and quadriplegia. Further review of Resident #7's medical record revealed the resident was sent out to the hospital on 04/03/21 for an evaluation regarding tracheostomy issues. There was no evidence the facility provided the resident, or the resident's family/representative with the required information related to the bed hold policy, bed hold days remaining, or information regarding return to the facility. Interview on 05/20/21 at 1:16 P.M. with RN #96 revealed the facility had not been sending out bed hold notice information with/to the resident or their family/representative when they were transferred to the hospital. 4. Medical record review revealed Resident #75 was admitted to the facility on [DATE] with diagnoses including cerebrovascular disease, bipolar disorder, and diabetes mellitus type 2. The resident was discharged to the hospital on 11/04/20 and did not return. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of of the resident nursing progress notes dated 11/04/20 revealed the resident was lethargic and hard to arouse. The resident was sent to the hospital for an evaluation. There was no evidence the resident, or resident's family/representative was provided with the required information related to the bed hold policy, bed hold days remaining, or information regarding return to the facility. Interview on 05/20/21 at 1:16 P.M. with RN #96 revealed the facility had not been sending out bed hold notice information with/to the resident or their family/representative when they were transferred to the hospital. 5. Medical record review revealed Resident #122 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] after being hospitalized . The resident's diagnoses included chronic obstructive pulmonary disease, and depressive episodes. The resident was responsible for herself. Review of the resident's nursing progress note dated 03/15/21 at 2:41 P.M. revealed the resident was sent to the hospital due to hypoxia. There was no evidence the resident was provided with the required information related to the bed hold policy, bed hold days remaining, or information regarding return to the facility. Interview on 05/20/21 at 1:16 P.M. with RN #96 revealed the facility had not been sending out bed hold notice information with/to the resident or their family/representative when they were transferred to the hospital. Review of facility policy titled Bed-Holds and Returns revised 03/2017, revealed prior to transfers and therapeutics leaves, residents or resident representatives would be inform in writing of the bed-hold and return policy. The procedure specified that prior to transfer, written information would be given to the resident and the resident's representative that explained in detail: the rights and limitations of the resident regarding bed-holds; the reserve bed payment policy as indicated by the state plan (medicaid residents); the facility per diem rate required to hold a bed (non-Medicaid residents) or to hold a bed beyond the state bed-hold period (Medicaid residents); and the details of the transfer

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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** 03276 Based on medical record review, observation, staff and resident interview, the facility failed to develop and/or implement a comprehensive plan of care for each resident for assessed problems/needs relating to urinary incontinence, activities of daily living (ADLs), contractures, and the need to reside on a secured unit. This affected three residents (#68, #7, #29) of 31 reviewed for care plans. The facility census was 75. Findings include: 1. Medical record review revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including schizophrenia, diabetes mellitus type 1, anxiety disorder, anemia, neuropathy, and obesity. Review of Resident #68's admission incontinent assessment completed on 02/22/21 revealed the resident as being incontinence of urine at night time only, both urge and stress mixed incontinence, and that the resident had some incontinence and wore a pull up brief at night. Review Resident #68's care area assessment (CAA) dated 03/04/21 revealed the resident as being incontinent of bowel and bladder and needing assistance with all toileting and personal hygiene and to proceed with care planning for urinary incontinence. Review of Resident #68's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident required the limited assistance of one staff person for bed mobility, transfer, walking in her room, dressing, personal hygiene, and toileting. The resident was assessed as being only occasionally incontinent of urine. Review of Resident #68's current comprehensive plan of care for urinary incontinence revealed a problem need of stress, functional, mixed bladder incontinence initiated on 02/23/21. There was no goal for the plan of care, and the only interventions was as follows: The resident uses disposable briefs. Change (no frequency specified) and as needed, and incontinent products at night only. In addition, review of Resident #68's assessed care need of needing assistance with ADLs due to increased altered mental status due to diagnoses of schizophrenia, recent hospitalization and muscle weakness was identified in the care plan. However, there was no goals for the resident, and the only intervention listed was transfer the resident with the assist of one. Review Resident #68's State tested Nursing Assistant's (STNAs) tracking of urinary incontinence in the electronic health record (EHR) revealed 30 days prior to, and including 05/19/21, the resident had documented episodes of incontinence on all but four days; 04/25/21, 04/28/21, 05/06/21, and 05/10/21. Observation of Resident #68 on 05/19/21 at 9:37 A.M. revealed the resident was in her room dressed in street clothing. The resident and the room smelled of urine. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with STNA #51 on 05/18/21 at 4:49 P.M. revealed she was familiar with Resident #68 and routinely cared for her. STNA #51 affirmed the resident smelled of urine, and the resident would lay in bed or sit in her chair and wet. She revealed the resident would sometimes not let you assist in cleaning her up and would get angry when you attempted to help her. 2. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, intracranial injury, quadriplegia, spastic hemiplegia affecting left dominant side, contracture left hand, and major depressive disorder. Review of Resident #7's physician's orders dated 06/20/18 revealed the resident to wear a left elbow extension splint for three to five hours in the evening as tolerated every night shift, and an order dated 06/20/18 revised on 04/25/19 for the resident to wear a left resting hand splint (RHS) for three to five hours in the morning. Review of an annual MDS assessment for Resident #7 dated 02/11/21 revealed the resident was totally dependent on staff for all ADLs. He was assessed as having functional limitations in both his left and right upper and lower extremities. Review of Resident #7's current comprehensive plan of care revealed failed to reveal any mention of the schedule for use of the resident's RHS or elbow extender, or for any refusals to wear the elbow extender/ brace. Observation of the resident on 05/17/21 at 3:44 P.M. revealed the resident appeared to have a contracture of the wrist/hand/fingers of the left hand, and was not wearing any splint or device to his left hand or elbow. During an interview with Resident #7 on 05/17/21 at 5:13 P.M., the resident was able to nod in the affirmative that he had a splint for his hand, and nodded in the negative that it was applied daily. The resident was not wearing a RHS or elbow extender at that time. Interview with STNA #95, on 05/18/21 at 9:36 A.M., revealed Resident #7 did not wear any splints or braces. Interview with STNA #51 on 05/18/21 at 4:30 P.M., and 4:52 P.M., revealed per her observations it had been months/years since Resident #7 wore the RHS/elbow extender due to refusals. Interview with LPN #91 on 05/18/21 at 4:35 P.M. affirmed Resident #7 did have RHS and an elbow extender for his left hand and left elbow, however he would not leave them on. LPN #91 stated the resident would only leave them on for about 10 minutes if you could get them on. She explained he was able to removed the RHS with his right hand. Interview with the Assistant Director of Nursing (ADON) Licensed Practical Nurse (LPN) #27 and the Director of Nursing (DON) on 05/24/21 at 11:15 A.M. affirmed there was no plan of care developed specific to the resident's contractures which addressed the use of the elbow extender and RHS, or for the resident's refusals to use the devices. She shared the splint was mentioned under the care plan for skin, but was not specific to the resident's contractures. 20298 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Medical record review for Resident #29 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar, anxiety and communication deficit. It was noted the resident resided on a secure unit. Review of Resident #29's progress note dated 04/20/20 at 6:45 P.M. revealed the resident had an isolated elopement incident with no injury while he was receiving care on the COVID 19 unit. He was transferred to the secured unit on 05/04/20 to reduce the elopement risk. Review of Resident #29's current care plan revealed the resident was an elopement risk, was exit seeking and talked about leaving. There was no mention the resident resided on a secured unit since 05/04/20. Interview on 05/24/21 at 10:37 A.M. with LPN #27 verified the resident's care plan did not mention he resided on a secured unit.

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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** 03276 Based on medical record review, observation, and staff interview, the facility failed to ensure a resident with a limited range of motion received appropriate treatment and services, including splinting, to improve and/or prevent further decline in range of motion (ROM). This affected one resident (#7) of one reviewed for ROM. The facility census was 75. Findings include: Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, intracranial injury, quadriplegia, spastic hemiplegia affecting left dominant side, contracture left hand, and muscle wasting. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had moderately impaired cognitive skills. He was non verbal, however able to make his basic needs known via gestures/nodding. The resident was totally dependent on staff for all activities of daily living. He was assessed as having functional limitations in both his left and right upper and lower extremities. Review of Resident #7's physician's orders revealed an order dated 06/20/18 for the resident to wear a left elbow extension splint for three to five hours in the evening, as tolerated, every night shift. An order dated 06/20/18, revised on 04/25/19 revealed an order for the resident to wear a left resting hand splint (RHS) for three to five hours in the morning. Observation of Resident #7 on 05/17/21 at 3:44 P.M. revealed the resident appeared to have a contracture of the wrist/hand/fingers of the left hand, and was not wearing any splint or device to his left hand or elbow. During an interview with Resident #7 on 05/17/21 at 5:13 P.M., the resident was able to nod in the affirmative that he had a splint for his hand, and nodded in the negative that it was applied daily. The resident was not wearing a RHS or elbow extender at that time. During an interview with Resident #7 on 05/18/21 at 9:33 A.M. the resident nodded in the negative when asked if staff had applied his elbow splint during the evening the night before. The resident was not wearing a RHS or elbow extender at that time. During interview with State tested Nursing Assistant (STNA) #95, on 05/18/21 at 9:36 A.M., revealed Resident #7 did not wear any splints or braces. Interview with Therapy Program Manager, Certified Occupational Therapy Assistant (COTA) #97 on 05/18/21 at 11:15 A.M. revealed she was not aware of Resident #7 having any splints/braces to his upper or lower extremities. She revealed she had never observed the resident wearing splints. Interview with STNA #51 on 05/18/21 at 4:30 P.M., and 4:52 P.M., revealed per her observations it had been months/years since Resident #7 wore the RHS/elbow extender due to refusals. STNA #51 stated the resident did not like them and was able to take them off with his right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #91 on 05/18/21 at 4:35 P.M. affirmed Resident #7 did have a RHS and an elbow extender for his left hand and left elbow, however he would not leave them on. She revealed he was able to removed the RHS with his right hand. On 05/18/21 at 4:58 P.M. LPN #91 found Resident #7's left elbow extender which was found in his closet. The LPN was unable to find the left RHS. Review of Resident #7's Treatment Administration Record (TAR) for May 2021 revealed nurses were checking off on the TAR the resident was wearing the left elbow extender daily during the night shift of duty with no refusals noted. The TAR also reflected the left RHS was applied per order daily through the day shift of 05/18/21. Follow-up interview with LPN #91 on 05/20/21 at 2:28 P.M. affirmed the use of the splints for Resident #7 had been being marked off on the TAR documenting they had been applied as ordered. However, affirmed the resident's RHS still had not been located.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 20298 Based on review of the personnel files and staff interview, the facility failed to provide annual performance evaluations and 12 hours of inservice education for two State tested Nursing Assistants (STNAs) of four reviewed. The facility census was 75. Findings include: Review of the personnel file for STNA #3 who was hired on 01/20/16 and STNA #17 hired 12/18/13 revealed there was no evidence of an annual evaluation since 01/14/19. Additionally, the STNAs had no evidence of inservice training or education since 01/01/20. Interview with Administrator In Training (AIT) #200 on 05/24/21 at 4:45 P.M. verified STNA #3 and #17 had no evidence of an annual evaluation since 01/14/19. The AIT further verified there was no record STNAs completed inservice training to meet the 12 hour annual requirement since 01/01/20.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03276 Based on medical record review, observation, and staff interview, the facility failed to ensure a resident received the necessary behavioral health care and services to maintain their highest practicable mental and psychosocial well being. This affected one resident (#68) of one reviewed for behavioral health. The facility census was 75. Findings include: Medical record review revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including schizophrenia, diabetes mellitus type 1, anxiety disorder, anemia, and neuropathy. The resident had resided in the adjoining Residential Care Facility (RCF) prior to being admitted to the facility. Review of an initial psychiatry visit for Resident #68 dated 11/24/20, while she was a resident of the RCF, revealed the psychiatrist who visited with the resident documented the resident had fixed non bizarre delusional beliefs concerning her marriage to a doctor who runs the facility. The psychiatrist diagnosed the resident with delusional disorder, and recommended to continue current medications and to follow-up with the resident in four to six weeks. Review of Resident #68's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and had no behaviors. Review of Resident #68's current physician's orders revealed an order for 300 milligrams (mg) of Quetiapine Fumarate daily for schizophrenia, and 50 mg of Trazadone at bedtime for depression. The physician also ordered on 02/23/21 for psychiatric/psychological care as needed. Review of Resident #68's interdisciplinary progress notes dated 04/22/21 revealed an entry by Social Services Designee (SSD). SSD #101 documented she spoke with the resident about ongoing behavior towards staff and her roommate. She noted the resident had been using racial slurs and being disrespectful. SSD #101 documented she informed the resident the behavior would not be tolerated by the facility, and the resident needed to respect staff and other residents. She noted the resident reported understanding of the conversation and apologized to her current roommate. SSD #101 documented she would follow-up with staff to ensure the resident's behavior did not continue. Review of Resident #68's nursing progress notes dated 05/06/21 at 10:26 P.M. by Licensed Practical Nurse (LPN) #26 revealed the resident was cursing at staff. Review Resident #68's nursing progress notes dated 05/07/21 at 1:57 A.M. by LPN #26 revealed the resident was refusing to allow staff to provide personal care and assist the resident to bed. LPN #26 documented the resident was calling staff names, like idiot, and yelling so she was left to calm down. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt to interview Resident #68 was made on 05/18/21 at 10:45 A.M. The resident appeared angry when questioned, was impatient, and did not want to be interviewed. The room smelled strongly of urine. Interview with State tested Nurse Aide (STNA) #51 on 05/18/21 at 4:49 P.M. revealed she was familiar with Resident #68 and routinely care for her. STNA #51 affirmed the resident smelled of urine. She stated when you offered to assist in changing her and cleaning her up she could sometimes get very mean and racist. The STNA revealed she had reported the resident's behaviors to the nurse. STNA #51 revealed when the resident was first admitted to the facility she was nice as could be, however since then her behaviors have gotten worse. Interview with SSD #101 on 05/19/21 at 3:17 P.M. affirmed she had a conversation Resident #68 regarding her being disrespectful to her roommate and staff, and did not think there was any reason at that time to make a referral for psychiatric/psychological services. She stated she was informed by staff the resident's behavior was just a matter of being disrespectful. Interview with LPN #83, on 05/24/21, at 2:28 P.M. revealed Resident #68 did have behaviors of screaming out. She revealed the resident would get agitated when she had a roommate and staff were assisting the roommate and not her. The LPN revealed just this morning the resident was delusional, stating to STNA #95 that her husband left her for STNA #95. LPN #83 confirmed the resident was not on the list to see the psychiatrist. LPN #83, and LPN #33 who was present at the time of the interview, both confirmed the resident's behaviors had been about gone about three months. Interview with LPN #33 on 05/21/21, at 2:36 P.M., revealed she had also cared for Resident #68 when she lived in the adjoining RCF. She revealed the resident had these type of behaviors when living in the RCF, prior to admission to the nursing facility. LPN #33 stated the resident often had delusional thoughts about relationships.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35770 Based on medical record review, review of Pharmacy Consultation Reports, and staff interview, the facility failed to act upon pharmacy recommendations for the gradual dose reduction (GDR) and discontinuation of anxiety medications. This affected three residents (#16, #32, and #42) of five reviewed for unnecessary medications. The facility census was 75. Findings include: 1. Medical record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including acute kidney failure, altered mental status, dementia, anxiety, and and psychosis. Review of Resident #16's physician orders dated 07/08/20 revealed an order for Ativan 0.5 milligrams (mg) every 12 hours as needed, for severe agitation related to unspecified dementia with behavioral disturbance. Review of repeated Pharmacy Consultation Report dated 07/15/20, 09/02/20, 11/27/20, 02/18/21, and 04/14/21, revealed to please discontinue as needed Ativan. If medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. There was no evidence in the medical record the recommendations were acted on by the physician. 2. Medical record review revealed Resident #32 was admitted on to the facility on [DATE] with diagnoses including Alzheimer's disease, dysphagia, and psychosis. Review of Resident #32's physician order dated 04/10/19 revealed to administer Perphenazine (anti-psychotic) 2 mg daily. Review of repeated Pharmacy Consultation Reports dated 05/12/20, 12/16/20, 03/18/21, revealed Resident #32 had received Perphenazine 2 mg daily for psychosis since 04/19. Resident #32 was noted to be hospice, however to please attempt a GDR while concurrently monitoring for re-emergence of target behaviors and/or withdrawal symptoms. There was no evidence the pharmacy recommendations were acted on by the physician. 3. Medical record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including diabetes, Alzheimer's, polyneuropathy, hypertension, hyperlipidemia, irritable bowel syndrome, nonmedicinal substance allergy status, and depression. Review of physician order dated 02/27/20 for Resident #42 revealed an order for Abilify (anti-psychotic) 2.5 mg daily, then the Abilify was increased on 03/06/20 to 5 mg of Ability daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #42's repeated Pharmacy Consultation Report dated 09/17/20, 02/18/21, 04/14/20 revealed Resident #42 had received Abilify 5 mg daily for major depressive disorder since 03/20. For the initial attempt at GDR, please reduce Ability to 4 mg daily while monitoring for re-emergence of target behaviors and/or withdrawal symptoms. Please respond promptly to assure facility compliance with Federal regulations. There was no evidence the repeated pharmacy recommendations were acted on by the physician. Interview on 05/20/21 at 1:35 P.M. with Registered Nurse (RN) #96 verified the above findings. RN #96 verified there was no evidence the pharmacy recommendations were acted on.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03276 Based on observation, medical record review, staff interview, review of facility policy, and review of Centers for Disease Control (CDC) guidelines, the facility failed to ensure newly admitted residents were quarantined when indicated and proper precautions implemented, as well as not ensuring personal protective equipment (PPE) was readily available. Additionally, the facility failed to ensure residents were encouraged to remain socially distant during activities and smoking to prevent the potential spread of Covid-19. This had the potential to affect all 75 residents of the facility. Findings include: 1. Review of the medical record revealed Resident #125 was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, paranoid schizophrenia, schizoaffective disorder, and major depressive disorder. Review of immunization records for Resident #125 failed to reveal if the resident had received the Covid-19 vaccine. Review of Resident #125's physician's orders revealed no evidence the need to quarantine/isolate until 05/17/21. On 05/17/21 the resident's physician order revealed the resident be placed in prophylactic isolation for 14 days to monitor for Covid-19 due to being a recent admission, and the isolation period to end on 05/26/21. Observation of Resident #125 on 05/19/21 at 9:30 A.M. revealed the resident was following a group of residents on the first floor who smoked out the exit door to the smoking area. Initially the resident was not wearing a mask, then an Activity Assistant (AA) #22 instructed the resident to keep his mask on until he got outside to smoke. The resident was observed smoking outside with the other residents. Observation of Resident #125 on 05/19/21 at 2:47 P.M. revealed the resident was sitting in his wheel chair in the corridor across from the first floor nursing station. The resident had a mask positioned completely under his chin, it was not covering his mouth or nose. Interview with the Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN) #27 on 05/19/21 at 2:51 P.M. revealed new admissions were to undergo a prophylactic 14 day quarantine for Covid-19. LPN #27 further reported if a quarantined resident wanted to smoke the facility would encourage smoking cessation, and try to keep the resident in their room. Registered Nurse (RN) #29 and the Director of Nursing (DON) who were both present at the time of the interview revealed in the past nursing staff have taken the quarantined residents out a different door and let them smoke independently of the regular smoking group. The DON verified at this time the procedure would be to offer a patch for smoking cessation, or take the resident to smoke separately from other residents. Observation on 05/19/21 at 3:28 P.M. revealed Resident #125 was sitting in his wheel chair outside of his room in the corridor. The resident had mask positioned under his chin, and not covering his mouth or nose. At the time of the observation, Social Services Designee (SSD) #101 verified the resident was out of his room, and not properly wearing a mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with LPN #91 on 05/19/21 at 5:05 P.M. revealed she was not aware of any written procedure to follow for resident's in a 14 day quarantine for Covid-19. She stated staff just knew they were to try to keep them in their rooms as much as possible. Observation of staff distributing meal trays during the evening meal on 05/19/21 at 5:12 P.M. revealed RN #40 walking into and out of the room occupied by Resident #125 and his roommate Resident #124, who were both in quarantine to deliver Resident #124's meal tray. RN #40 had not donned any PPE, other than the surgical mask she was wearing. She gave the resident his tray, sanitized her hands, then re-entered the room without any PPE shortly afterwards to deliver a cup of juice to Resident #124. The nurse used hand sanitizer when exiting the room each time. However, she had not donned any PPE when entering the room on either occasion. RN #40 verified the above findings at the time of the observation. 40471 2. Medical record review revealed Resident #323 was admitted to the facility on [DATE]. Diagnoses included pleural effusion, atrial fibrillation, adult failure to thrive, and malignant neoplasm of unspecified part of bronchus or lung. Review of the physician's order revealed an order written 05/17/21 for prophylactic isolation for 14 days to monitor for Covid-19 due to recent admission. Isolation period was to end on 05/28/21. Observation on 05/17/21 at 10:00 A.M. revealed Resident #323 was noted to have a sign on the door that stated to see the nurse prior to entering, no isolation cart was noted outside the resident's room nor inside the door. There was no sign to indicate the necessary use for PPE. LPN #20 verified the presence of the the sign, verified the resident was in quarantine for admission, and verified there was no isolation cart in the hallway with PPE to use. 3. Medical record review revealed Resident #324 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia. Review of the physician's orders dated 05/20/21 revealed Resident #324 was to be placed in prophylactic isolation until 05/26/21. Observation on 05/17/21 at 10:00 A.M. revealed Resident #324 was noted to have a sign on the door that stated to see the nurse prior to entering, no isolation cart was noted outside the resident's room nor inside the door. There was no sign to indicate the necessary use for PPE. LPN #20 verified the presence of the the sign, verified the resident was in quarantine for admission, and verified there was no isolation cart in the hallway with PPE to use. 4. Medical record review revealed Resident #326 was admitted to the facility on [DATE] with the diagnosis of quadriplegia. Review of physician's orders dated 05/20/21 revealed an order for the resident to be in prophylactic isolation for 14 days to monitor for Covid-19 due to recent admission. Isolation period to end on 05/25/21. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/17/21 at 10:00 A.M. revealed Resident #326 was noted to have a sign on the door that stated to see the nurse prior to entering, no isolation cart was noted outside the resident's room nor inside the door. There was no sign to indicate the necessary use for PPE. LPN #20 verified the presence of the the sign, verified the resident was in quarantine for admission, and verified there was no isolation cart in the hallway with PPE to use. Review of the policy titled Coronavirus disease (Covid-19) - Infection Prevention and Control Measures, dated 04/2020, revealed For a resident whose Covid 19 status is unknown or a new admission - a. Staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator. And c. 1. In general, all other new admissions and readmissions should be placed in a 14-day quarantine. 20298 5. Observation on 05/17/21 at 03:16 P.M. revealed AA #22 was playing cards at a table with a surgical mask pulled down below her chin. Sitting around the same table playing cards with no masks were Residents #12, #14, #58 and #46 two to three feet apart from each other. At the time of the observation AA #22 verified her mask did not cover her mouth and nose, and the above residents were not wearing masks. 6. Observation on 05/20/21 at approximately 4:30 P.M. of residents smoking revealed 15 residents (#03, #04, #13, #16, #19, #21, #25, #45, #47, #50, #53, #55, #58, #64, and #67)smoking without social distancing. At the time of the observation State tested Nursing Assistant (STNA) #17 verified the residents in the smoking area were not socially distanced at least six feet apart. Review of an online resource from the Center for Disease Control (CDC) at https://www.cdc.gov/coronavirus/2019-nCo revealed any person entering a room with a resident on contact/droplet isolation should clean their hands, don gloves/gowns, and make sure their eyes, nose and mouth were fully covered with a mask BEFORE entering the room. Quarantine was used to keep residents who were potentially exposed to COVID-19 away from others. Quarantine prevented the spread of COVID 19 that can occur before a person realized they were ill or infected with the virus without feeling symptoms. Residents in quarantine should stay in their rooms, separate themselves at least six feet from others and wear a mask as much as possible. The CDC information posted in the facility revealed the mask completely covered the nose and face. To prevent the spread of COVID 19 residents must be socially distanced at least six feet apart. Review of the facility policy titled Coronavirus Disease (COVID 19) Infection Prevention dated 04/20 revealed under 2c that appropriate use of personal protective equipment (PPE) was strictly required for standard precautions. This deficiency substantiates allegations contained in Complaint Control Numbers OH00112394, OH00112035, OH00111767 and OH00111512.