STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. Building B. Wing	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Winchester	36 Lehman Dr Canal Winchester, OH 43110

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 19571 Based on observation, record review and interview the facility failed to ensure residents were treated with respect and dignity. This affected six residents (#11, #35, #45, #53, #87 and #117) of 134 residing in the facility. Findings include: 1. On 10/25/21 at 12:50 P.M. observation of the lunch meal revealed State tested Nursing Assistant (STNA) #445 was observed passing meal trays on Hall A. At 12:50 P.M. Resident #117, who was observed in the dining room was served a meal tray. There were four other residents, Resident #11, #35, #45 and #53 at the table who were not served at that time. STNA #445 then passed more trays on Hall A leaving the dining room to do so. At 1:04 P.M. STNA #445 had Resident #48 come to the dining area and served him his tray and Resident #35 was also served at this time. STNA #445 again left the dining room and passed more trays on the hall A. Resident #11, #45 and #53 watched the other residents eat until 1:06 P.M. when they were finally served their tray. Interview with STNA #445 verified she had not delivered the meal trays to the residents in the dining room and some residents watched other residents eat while they were waiting for their meal as noted above. 2. Review of Resident #117's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia, chronic kidney disease, high blood pressure and anemia. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 09/23/21 revealed the resident's cognition was moderately impaired. Resident #117 was assessed to require extensive assistance from two staff members for bed mobility, transfers, dressing and toilet use and required extensive assistance from one staff member for personal hygiene. The assessment revealed the resident had an indwelling urinary catheter and was frequently incontinent of bowel. On 10/28/21 at 8:23 A.M., 10:15 A.M. and 11:30 A.M. Resident #117 was observed sitting in a wheelchair in the dining area. The resident was observed to have a urinary catheter and the urinary catheter drainage collection bag was uncovered and visible with urine in it. (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	On 10/28/21 at 11:30 A.M. interview with Licensed Practical Nurse (LPN) #327 verified the resident's urinary catheter collection bag was uncovered and hanging on the wheelchair in the dining/lounge area. 32654 3. Review of Resident #87's medical record revealed an original admitted [DATE] with the latest readmission of 10/19/21. Resident #87 had diagnoses including pseudobulbar affect, aphasia, urinary tract infection (UTI), urine retention, peripheral vascular disease, gastro-esophageal reflux disease, Alzheimer's disease, osteoarthritis, psychosis, major depressive disorder, hyperlipidemia, anxiety disorder, hypertension. bipolar disorder, atrial fibrillation and dysphagia. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/30/21 revealed the resident had clear speech, sometimes understood others, sometimes made herself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of eight. The resident required extensive assistance of one staff for bed mobility, transfers and was dependent on one staff for toilet use. The resident was identified as being always incontinent of both bowel and bladder. Review of the admission assessment with baseline care plan, dated 10/19/21 revealed the resident was readmitted to the facility from an acute care hospital with an indwelling urinary catheter. Review of the plan of care, dated 10/19/21 revealed the resident had potential for complications related to indwelling urinary catheter use. Interventions included to assist with Foley catheter care as needed, educate resident to report signs/symptoms of urinary tract infection (UTI), encourage proper nutrition and adequate fluid intake, evaluate need for catheter and supporting diagnoses and observe for signs/symptoms of UTI. Review of the resident's monthly physician's orders for October 2021 identified orders, dated 10/19/21 for Foley catheter care every shift, change catheter collection bag as needed, change Foley catheter when blocked or unable to flow freely as needed, secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction, Foley catheter size 16 FR with 30 milliliter (ml) balloon, Foley catheter to remain covered for privacy. On 10/25/21 at 1:17 P.M. observation of the resident revealed she had no linen on her bed and was lying on an exposed mattress. Further observation revealed her hospital gown was pulled up around her waist resulting in her disposable brief being exposed and in view from the hallway. Licensed Practical Nurse (LPN) #304 verified the resident had no linens on her bed and her disposable brief was exposed and viewable from the hallway. On 10/26/21 at 10:59 A.M. observation of the resident revealed her indwelling urinary catheter collection bag was not covered and dark yellow urine was visible from the hallway. On 10/26/21 at 11:01 A.M. interview with LPN #482 verified the indwelling urinary catheter collection bag was not covered and dark yellow urine was visible from the hallway. On 10/28/21 at 11:37 A.M. Resident #87 was observed lying in a supine position in bed with a hospital gown pulled up exposing her disposable brief from the hallway. LPN #304 verified the resident's disposable brief was visible from the hallway at the time of the observation.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure Resident #87 and Resident #93's call lights were within reach to accommodate the residents' need to obtain staff assistance by ringing the call light. This affected two residents (#87 and #93) of 51 sampled residents. Findings include: 1. Review of Resident #87's medical record revealed an original admitted [DATE] with the latest readmission of 10/19/21. Resident #87 had diagnoses including pseudobulbar affect, aphasia, urinary tract infection (UTI), urine retention, peripheral vascular disease, gastro-esophageal reflux disease, Alzheimer's disease, osteoarthritis, psychosis, major depressive disorder, hyperlipidemia, anxiety disorder, hypertension, bipolar disorder, atrial fibrillation and dysphagia. Review of the plan of care, dated 02/05/21 revealed the resident required assistance for activities related to cognitive/communication deficits, no awareness of needs or limitations and incontinence of bowel and bladder. Interventions included to keep call light in reach while in bed. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/30/21 revealed the resident had clear speech, sometimes understood others, sometimes made self understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of eight. Review of the mood and behavior revealed the resident had delusions, displayed verbal behaviors directed towards others and behaviors not directed towards others. The resident required extensive assistance from one staff for bed mobility and transfers and was dependent on one staff for toilet use. On 10/25/21 at 1:17 P.M. observation of Resident #87 revealed her call light was wrapped around and tied to the privacy curtain at the bottom of the bed. Licensed Practical Nurse (LPN) #304 verified the call light was not within the resident's reach at that time. On 10/28/21 at 11:37 A.M. Resident #87 was observed lying in a supine position in bed with her call light at the bottom of the bed. LPN #304 verified the resident's call light was not within reach at that time. Review of the facility policy titled Call Lights, dated 11/2018 revealed it was the policy of the facility to provide an operational call light system for residents. The call light system would be available to facilitate resident use and safety in the resident's rooms, bathroom and bathing areas. 43060 2. Review of the medical record for Resident #93 revealed an admitted [DATE]. Resident #93's diagnoses included schizoaffective disorder, coronary artery disease, muscle weakness, hypertension and repeated falls. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care, dated 04/16/21 revealed Resident #93 was at risk for falls related to cognitive communication deficits, not recognizing limitations, presence of psychotropic medications, balance problems and incontinence of bowel and bladder. Interventions for Resident #93 included to ensure call light was within reach at all times, assist with transfers and monitor for side effects of psychotropic medications. Review of the Fall Risk Evaluations, dated 04/16/21 and 07/16/21 revealed Resident #93 was at high risk for falls. Review of the quarterly MDS 3.0 assessment, dated 07/15/21 revealed Resident #93 required extensive assistance from one staff for bed mobility, transfers and toileting. On 10/25/21 at 10:20 A.M. Resident #93 was observed sitting in a chair near his bed. Resident #93 was observed to ask for help getting in bed. The call light was observed to be on the other side of the bed, resting on the floor and not in reach of Resident #93. On 10/25/21 at 11:35 A.M. Resident #93 was observed laying in bed and the call light was laying on the floor and not within reach of the resident. On 10/25/21 at 11:36 A.M. interview with Agency STNA #539 confirmed Resident #93's call light was on the floor and not within reach of the resident. Additional observations on 10/26/21 at 9:06 AM and 10:21 A.M. revealed Resident #93 was laying in bed and his call light was laying on the floor. On 10/26/21 at 10:21 A.M. interview with STNA #485 confirmed Resident #93's call light was on the floor and there was not clip on the call light to keep it near the resident. On 10/28/21 at 2:30 P.M. and on 11/01/21 at 10:30 A.M. Resident #93 was observed in bed with the call light on the floor. The resident had no access to the call light which was a fall risk intervention. On 11/01/21 at 10:30 A.M. interview with STNA #485 confirmed Resident #93's call light was on the floor and there was not a clip to enable to call light to attach the resident or the blanket. STNA #485 revealed she did know how to put in maintenance order and request a clip.

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 43060 Based on record review and interview the facility failed to fulfill Resident Council member's (Resident #98 and #105) request for a wheelchair volleyball net, when the facility agreed to purchase wheelchair volleyball and did not follow through from March 2021 through November 2021. This affected two residents (#98 and #105) and had the potential to affect all 134 residents residing in the facility. Findings include: On 10/27/21 at 11:02 A.M. during an interview with Resident #98 and #105, both residents revealed they attended resident council meetings regularly and Resident #98 was currently the Resident Council President. During the interview, Resident #98 and #105 shared they had been asking for a wheelchair volleyball net since last March 2021 and it was never delivered by the facility. Resident #98 and #105 also shared they did not feel their ideas and suggestions were responded to by the facility. Review of the Resident Council Meeting Minutes from 03/25/21 through 09/29/21 revealed evidence members of the resident council requested a wheelchair volleyball net on 03/25/21. The wheelchair volleyball net was documented on the Resident Council Meeting Minutes every month, from March through September 2021. The Resident Council Meeting Minutes dated 09/29/21 revealed volleyball net ordered. On 10/27/21 at 11:20 A.M. interview with Activities Director #460 revealed she had been trying to purchase a wheelchair volleyball net, but hadn't as of this date. Activities Director #460 revealed she attempted to find a volleyball net to purchase and then would forget about it for a while.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 43060 Based on record review and interview the facility failed to provide quarterly statements for residents they managed personal fund accounts for. This affected two residents (#15 and #71) of seven residents reviewed for accounting of funds. The facility identified 84 residents for whom they managed personal fund accounts. Findings include: On 10/25/21 at 10:35 A.M. interview with Resident #15 revealed the facility had never provided him with an account statement for his personal funds account and he didn't know how much money he had. On 10/25/21 at 11:06 A.M. interview with Resident #71 revealed the facility managed personal funds for him and he had never received a balance statement. Review of the personal fund account documentation for Resident #121, #11, #112, #48, #39, #15 and #71 revealed no evidence quarterly statements were provided to the residents and/or their representatives each quarter. On 10/26/21 at 1:29 P.M. interview with Business Office Manager #550 verified there was no documentation/ evidence quarterly statements were issued to Resident #121, #11, #112, #48, #39, #15 or #71 who were reviewed for personal fund accounts.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and interview the facility failed to ensure Resident #21 and Resident #87's advance directives were accurate and based on the residents' current wishes. This affected two residents (#21 and #87) of five residents reviewed for advance directives. Findings include: 1. Review of Resident #87's medical record revealed an original admitted [DATE] with the latest readmission of [DATE]. Resident #87 had diagnoses including pseudobulbar affect, aphasia, urinary tract infection (UTI), urine retention, peripheral vascular disease, gastro-esophageal reflux disease, Alzheimer's disease, osteoarthritis, psychosis, major depressive disorder, hyperlipidemia, anxiety disorder, hypertension, bipolar disorder, atrial fibrillation and dysphagia. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed the resident had clear speech, sometimes understood others, sometimes made herself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of eight. Review of the plan of care, dated [DATE] revealed the resident was a full code indicating the resident/family had chosen that CPR would be attempted during a cardiac arrest. Interventions included if code status changed, code status would be posted in resident's chart and physician's orders; if resident was choking, perform Heimlich maneuver and proceed with CPR if needed, inform new caregivers of code status, notify family of change in condition, nursing staff would provide chest compressions when the resident was in cardiac arrest and call ambulance for transport to the hospital, offer reassurance and support to resident and family and staff would honor resident with privacy during CPR. Review of the resident's monthly physician's orders for [DATE] revealed an order, dated [DATE] for a Do Not Resuscitate Comfort Care (DNRCC). Review of the resident's signed DNRCC form, dated [DATE] revealed the resident was a DNRCC. On [DATE] at 11:05 A.M. interview with Registered Nurse (RN) #406 revealed the resident was in fact a DNRCC and the plan of care inaccurately reflected a Full Code status. 19571 2. Review of Resident #21's medical record revealed the resident had diagnoses including encephalopathy, aphasia, chronic obstructive pulmonary disease and chronic kidney disease. Review of the plan of care, dated [DATE] revealed the resident was a Full Code: Resident/ Family had chosen that CPR would be attempted during a cardiac arrest. Further review revealed a Do Not Resuscitate (DNR) identification form, dated [DATE] which indicated Resident #21 was a DNRCC Arrest. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS 3.0 assessment, dated [DATE] revealed the resident's cognition was moderately impaired. The assessment revealed the resident was independent with bed mobility, dressing, eating and toilet use and required staff supervision and set up help only for transfers. Review of the physician's orders for ,d+[DATE] revealed the resident was a Full Code. On [DATE] at 10:55 A.M. interview with Registered Nurse (RN) #406 verified there were two different code status in the medical record for Resident #21.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure privacy was provided during wound care for Resident #27 and during urinary catheter care for Resident #58. This affected one resident (#58) four residents reviewed urinary catheter use and one resident (#27) of three residents reviewed for pressure ulcers. Findings include: 1. Review of Resident #58's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behaviors, obstructive and reflux uropathy (urine regurgitates from the bladder back into the ureter) chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/04/21 revealed the resident was cognitively impaired, he required supervision with set up assistance and supervision from one staff for bed mobility, transfers and dressing with one person physical assist. Review of the current physician's orders revealed an order, initiated 02/05/21 for urinary catheter (tube into the bladder for drainage of urine) care every shift. On 10/28/21 at 1:01 P.M. observation of catheter care revealed Nurse Aide (NA) #486 closed the room door, but left the blinds open to the outside. The resident's room was noted to be facing the parking lot. The NA also failed to close the privacy curtain around the resident's bed. NA #486 then completed urinary catheter care. Interview with NA #486 at the time of the observation verified he had not pulled the privacy curtain or closed the window blinds during catheter care. Review of the facility policy titled Resident Privacy, revised 05/2014 revealed staff would provide care and treatment in such a way as to maintain resident dignity and privacy. 43060 2. On 10/28/21 at 11:20 A.M. Licensed Practical Nurse (LPN) #303 with the assistance of State tested Nursing Assistant (STNA) #372 was observed completing the physician ordered wound treatment to a deep tissue injury to Resident #27's heel. During the observation, neither the LPN or STNA attempted to provide any type of privacy for Resident #27 during the wound treatment. No privacy curtain was observed to be in the resident's room. On 10/28/21 at 11:30 A.M. interview with STNA #372 and LPN #303 confirmed they failed to provide privacy to Resident #27 during the wound care. Both staff members also verified there was no privacy curtain available for use in the resident's room. STNA #372 further revealed Resident #19 was moved to the room with Resident #27 on 10/22/21 (eight days earlier) and the room had been without a privacy curtain since that time. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #19 confirmed she was moved to Resident #27's room on 10/22/21. Review of the facility policy titled Resident Privacy, revised 05/2014 revealed staff would provide care and treatment in such a way as to maintain resident dignity and privacy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43060 Based on observation, record review and interview the facility failed to maintain a safe, clean and comfortable environment for all residents. This affected six residents (#34, #24, #71, #385, #46 and #11) of 14 residents reviewed for physical environment. Findings include: 1. On 10/25/21 at 10:46 A.M. Resident #34 was observed sitting on a bedside commode as if it were a chair. The bed side commode was next to the head of Resident #34's bed. Resident #34 was fully dressed and gazing out the window. There was not a personal (sitting) chair located in Resident #34's room. Additional observations on 10/27/21 at 8:38 A.M. and on 11/03/21 at 8:50 A.M. revealed the bedside commode remained beside Resident #34's bed and no other chair was observed to be in the resident's room. On 10/27/21 at 10:47 A.M. interview with State tested Nursing Assistant (STNA) #485 confirmed there was no chair available for Resident #34 or any visitors in the resident's room. STNA #485 revealed she thought the resident was OK sitting on a bedside commode. STNA #485 revealed Resident #34 was independent with toileting and did not use the bed side commode for toileting purposes. Additional observations throughout the survey from 10/25/21 through 11/03/21 revealed there were no chairs or any other furniture for sitting, in the rooms of Resident #24, #71 or #385, who all resided on the C Hall. On 10/25/21 at 11:06 A.M. interview with Resident #71 revealed he would like a chair in his room, to sit and read and he was not sure why the room did not have one. On 10/25/21 at 11:26 A.M. interview with Resident #24 revealed he would like a chair in his room. Review of the medical records for Resident #24, #34, #71, and #385 revealed the records contained no documentation of behaviors or interventions indicating safety concerns or other reasons the residents would not have chair in their room to sit on. On 10/27/21 at 9:36 A.M. interview with Regional Director of Clinical Services (RN) #406 revealed there was no facility policy preventing residents from having chairs in their rooms. RN #406 further confirmed if a resident did not have a chair in their room due to behaviors or safety, it would have to be in the individual plan of care. On 10/27/21 at 10:47 A.M. interview with STNA #485 confirmed there were no chairs available in the rooms of Resident #24, #71 or #385. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record revealed Resident #46 was admitted on [DATE] with diagnoses including major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominants side, muscle weakness, hypertension, atrial fibrillation and need for assistance with personal care. Review of the plan of care, dated 04/30/21 revealed Resident #46 needed assistance with activities of daily living (ADLs) due to cognitive impairment, hemiparesis, pain and limited mobility. Interventions listed for Resident #46 included one person physical assist for dressing, and staff to assist with daily hygiene. Review of the Minimum Date Set (MDS) 3.0 assessment, dated 07/23/21 revealed Resident #46 was severely cognitively impaired. The resident was noted to require assistance of one staff for dressing, hygiene and bathing. Resident #46 was noted to use his wheelchair independently for locomotion on the unit. On 10/25/21 at 10:52 A.M. Resident #46 was observed in his wheelchair, wheeling himself down the hallway using his feet. Resident #46's right hand was noted to be in a splint and the resident appeared to have limited range of motion to the hand. Observation of the splint revealed it had several darkened and discolored areas that appeared to be stains. The seat of Resident #46's wheelchair was observed to have pressure reducing cushion on it. Several multicolored stains and what appeared to be crumbs of food were dried to the seat of the wheelchair, the pressure reducing cushion and in between the two. On 10/27/21 at 8:39 A.M. Resident #46 was observed in his wheelchair, wheeling himself down the hallway using his feet. Resident #46 was again wearing his splint, which was observed to have a red spot approximately three by four centimeters that appeared to be dried red sauce, in addition to the darkened and discolored areas that appears to be stains. The seat of Resident #46's wheelchair was again observed to have several multicolored stains and what appeared to be crumbs of food dried to the seat of the wheelchair, the pressure reducing cushion and in between the two. On 10/27/21 at 8:40 A.M. interview with STNA #410 confirmed the presence of what appeared to be dried food and stains of Resident #46's wheelchair seat and splint. STNA #410 revealed night shift staff should clean resident wheelchairs and that it does not appear to have been done. STNA#410 revealed she did not know the policy for cleaning resident splints. On 10/27/21 at 9:36 A.M. interview with Regional Director of Clinical Services (RN) #406 confirmed the presence of what appeared to be food and dirt on Resident #46's wheelchair and splint. RN #406 revealed there was a cleaning schedule and third shift staff should clean wheelchairs, but the facility does not keep a sign off sheet or other documentation that it was completed. Review of the undated facility policy titled Night Shift Cleaning Schedule revealed wheelchairs should be cleaned on Mondays and Wednesdays. 19571 (continued on next page)

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	365644	A. Building B. Wing	11/05/2021

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a tour of the facility on 10/27/21 between 10:15 A.M. and 10:32 A.M. with Maintenance Man (MM) #346 observation of Resident #11's wheelchair revealed the right arm of the chair was taped and appeared dirty. The wheelchair seat was observed to be torn and had dried food debris and dirt on it. Interview with MM #346 at the time of the observation verified the above finding.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38604 Based on closed record review, review of an emergency medical service (EMS) run report, facility Post-Mortem policy and procedure review, facility Abuse/Neglect policy and procedure review, staff interview, interview with Emergency Medical Service/Paramedic #545 and #546 and interview with Contracted Funeral Home Transport #543, the facility failed to provide adequate and immediate post-mortem care to Resident #128 following the resident's death in the facility on [DATE] resulting in neglect of the resident's corpse. This resulted in Immediate Jeopardy, when on [DATE] at approximately 8:00 A.M. Resident #128's body was released to the funeral home without evidence of post-mortem care having been provided by facility staff. On [DATE] interviews with Contracted Funeral Home Transport #543, Agency Licensed Practical Nurse (LPN) #542 and Anonymous Staff #544 revealed postmortem care had not been completed following the resident being pronounced deceased on [DATE] at 3:46 A.M. Resident #128 was found lying on the floor in his room, where cardiopulmonary resuscitation (CPR) had been provided, with his eyes and mouth open, in urine and feces, with his cut clothes, defibrillator paddles and an intravenous line still attached to the resident. Actual harm occurred as the reasonable person concept involves caring for a deceased resident's body with sensitivity and in a manner consistent with a resident's religious and cultural beliefs. Post-mortem care should be provided immediately or as soon as possible to prevent tissue damage or disfigurement of a resident's body as the body starts decomposition immediately after death. The body should be preserved to delay decomposition so funeral services may take place. This affected one resident (#128) of three residents reviewed for death. The facility census was 134. On [DATE] at 3:30 P.M. the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services/Registered Nurse #406 were notified Immediate Jeopardy began on [DATE] at 3:46 A.M. when LPN #542 failed to complete post-mortem care following the resident's death at that time. On [DATE] at approximately 7:00 A.M., Anonymous Staff #544 observed the resident lying on the ground in his urine, without any postmortem/dignity care provided. At approximately 8:00 A.M. (approximately three hours and 14 minutes after death) the Contracted Funeral Home Transport #543 arrived at the facility to transport Resident #128 to the funeral home and observed the resident lying on the floor in feces, urine, with his eyes and mouth open and medical equipment still attached to his decomposing body. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 5:30 P.M. Senior DON #540 and Unit Manager/LPN #324 reviewed the medical records for all current in-house residents to verify code status order, care plan, and documentation to ensure all are congruent in the medical record. On [DATE] at 4:30 P.M. Regional Director of Clinical Services #406 initiated education for all licensed staff on timely postmortem care. Education was completed on [DATE] from 4:30 P.M. for nine Licensed Practical Nurses (LPNs), three Registered Nurses (RN), 14 State tested Nurse Assistants (STNA), 10 administrative staff, three regional staff, dietary staff and activity staff, and two therapy staff. A plan for no licensed staff to be permitted to work until education was received was implemented. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:50 P.M. Regional Director of Clinical Services #406 initiated online education for all staff with competencies via survey monkey for all licensed nurses regarding timely postmortem care. Seven RNs, 23 LPNs, 46 STNAs, 10 administrative staff, five activities staff, 11 dietary staff, 19 laundry and housekeeping, and eight therapy staff. A plan for no licensed staff to be permitted to work until education was received was implemented. On [DATE] at 5:30 P.M. the DON reviewed the last three months of resident facility deaths, and interviewed staff to ensure there were no other like instances regarding the absence of timely postmortem care. No like instances were noted. On [DATE] at 8:20 P.M. the Administrator sent the education packet to their three contracted staffing agencies (ConnectRN, VIP, and Buckeye) to have their staff educated on providing postmortem care. They are to send a sign off sheet to the Regional Director of Clinical Services #406. The staff are to have the education provided to the facility before they are able to return to the facility. On [DATE] a plan for education competencies to be reviewed by Regional Director of Clinical Services #406 to be completed on 10 random staff members daily for two weeks (via survey monkey) and then 10 random staff members three times weekly for two weeks via survey monkey) to ensure competencies of the processes related to timely postmortem care. On [DATE], at 7:00 P.M. the facility Quality Assessment and Performance Improvement (QAPI) Committee, including the Administrator, Regional Director of Clinical Service #406, SSD #481, Minimum Data Set (MDS) Nurse #453, Dietician #488, housekeeping and laundry #447, marketing #336, Human Resources (HR) #420, Director of Nursing (DON), activities #452, Therapy Director #548, Maintenance Director #346, Assistant DON (ADON)/LPN #304, and Physician Assistant #549 reviewed the Immediate Jeopardy deficiencies, the plan of action, the policies and procedures related to timely post mortem care and a root cause analysis was completed. On [DATE] a plan for audits of closed resident records reviewed for deaths to be completed by the DON/designee daily for five days a week for four weeks to ensure postmortem care was completed by staff timely. When she is informed of a death, she will be following up immediately and completing a postmortem audit form. On [DATE] a plan for weekly for four weeks QAPI meetings per the Administrator to ensure postmortem care and neglect policies and procedures were being followed. On [DATE] at 4:31 P.M. Regional Director of Clinical Services #406 initiated online education for all facility staff regarding the Neglect policy and the policy for the treatment of a deceased resident. Seventeen staff in the facility were educated at that time. On [DATE] at 5:00 P.M. Regional Director of Clinical Services #406 initiated education for all contracted agency staff regarding the Neglect policy and the policy for the treatment of a deceased resident. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of the closed medical record for Resident #128 revealed an admitted [DATE] with diagnoses including COVID-19, heart disease, congestive heart failure, chronic kidney disease stage three, and atrial fibrillation. Record review revealed the resident was a Full Code related to advance directives. The resident expired in the facility on [DATE]. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) of 12 indicating the resident had moderate cognitive impairment. The assessment revealed the resident required extensive assistance from one staff for bed mobility and toilet use, extensive assistance from two staff for transfers, supervision with one staff assistance for locomotion and limited assistance from one staff for personal hygiene. Review of Resident #128's care plan, dated [DATE] revealed the resident/family chose CPR would be attempted during cardiac arrest with interventions to inform new caregivers of code status, nursing staff to provide chest compressions when the resident was in cardiac arrest and call ambulance for transport to the hospital, and notify family of changes in condition. Review of Resident #128's medical record revealed the resident was not receiving Hospice services and/or palliative care during his stay at the facility. The plan of care revealed the resident's goal was to return home. A nurse's note, dated [DATE] at 4:23 A.M. revealed the resident continued to refuse all care this shift. Certified Nurse Practitioner (CNP) #547 was notified at 2:48 A.M. and gave a new order to send the resident to the emergency room for further evaluation. Paramedics (EMT) were contacted for transport. The nurse's notes revealed the resident was unresponsive upon EMT arrival at 3:10 A.M. and CPR was started, the resident was pronounced dead at 3:46 A.M. and CNP #547 was notified. A note, dated [DATE] at 8:45 A.M. revealed the resident was discharged . Review of Resident #128's medical record revealed no evidence facility staff provided Resident #128 any type of postmortem care. The medical record contained no information related to when the resident's body was released to the funeral home. Review of the Local Fire Department Report, dated [DATE] revealed a call/dispatch to transport Resident #128 on [DATE] at 3:01:18 A.M. The report showed staff enroute at 3:02:32 A.M., on the scene at 3:08:53 A.M. and at the patient (Resident #128) at 3:21:50 A.M. Resident #128 was pronounced deceased at 3:46 A.M. The report revealed Resident #128 was unresponsive and pale, he was in cardiac arrest. The narrative report revealed when they arrived at the patient, he was slumped over in his wheelchair and wasn't breathing. EMS slid the resident from the wheelchair onto the floor and manual CPR was performed. The local fire department was notified of the arrest and to send an engine for additional manpower. Paddles were placed on the resident's chest and the resident was assessed to be in ventricular fibrillation. The resident was shocked, and CPR continued. The report revealed the other patient was lying in his bed in the same room and stated he could hear Resident #128 moaning but had not heard a noise from him for at least 20 minutes. The next rhythm check, per monitor, showed Resident #128 had pulseless electrical activity and his blood sugar was 141. Epinephrine was administered to the patient via an Intraosseous Line (IO) and CPR continued but the resident remained without a pulse. CPR was discontinued after 20 minutes and the resident was pronounced dead. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:21 A.M. interview with EMT/Paramedic #545 revealed when they arrived at the resident's room, the resident was slumped over in his wheelchair with dried bodily fluids on his shirt and in his nares and CPR was not in progress. Paramedic #546 moved the resident to the ground and initiated manual CPR while Paramedic #545 went back out to the ambulance to retrieve a [NAME] Device (portable device that delivers consistent chest compression). On [DATE] at 1:01 P.M. interview with a staff member who wished to remain anonymous (Staff #544) revealed she worked the day shift on [DATE] and the resident was lethargic, had refused all care and was spitting at staff. Staff #544 revealed she notified the certified nurse practitioner (CNP) and the CNP revealed this was typical behavior of the resident, to refuse care and to notify the CNP if it continued. Staff #544 revealed the resident would let her check his oxygen saturation which was about 96% on room air but stated the resident wouldn't allow her to take any other vital signs. Staff #544 revealed on [DATE] when she arrived to work, around 7:00 A.M.-7:15 A.M. she found Resident #128 deceased on the floor. Staff #544 revealed she had to provide personal care to the resident. Staff #544 revealed no staff had provided post-mortem care to Resident #128 immediately after he passed away. Staff #544 revealed funeral transport arrived to the facility at approximately 8:00 A.M. and she did offer to assist moving the resident off the floor but they declined. Staff #544 revealed she had not notified anyone related to the condition of the resident because the resident had been deceased for hours and she assumed someone had known and would have already notified administrative staff. On [DATE] at 2:21 P.M. interview with the DON revealed the expectation following a resident's death would be for post-mortem care to be completed once everything had calmed down. The DON revealed it should not be multiple hours after a after the resident's death. On [DATE] at 2:43 P.M. interview with Contracted Funeral Home Transport (CFHT) #543 revealed when he arrived at the facility around 8:00 A.M. Resident #128 was laying on the floor, in soiled clothes (stated urine and feces), his skin had not been taken care of, his mouth and eyes were wide open and his arms were at his side. CFHT #543 revealed he did not recall what the resident's shirt looked like, but stated he had to wipe dried mucus off the resident's face and nose. CFHT #543 revealed he had to pull the defibrillator paddles off of him, remove the IV from his arm and stated the resident was still in the clothes EMS staff cut off of him. CFHT #543 revealed when he rolled the resident, blisters on his legs were popping, his skin was noted with skin slippage. CFHT #543 revealed the resident's body was definitely starting to decompose. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:55 P.M. and again on [DATE] at 1:14 P.M. interview with Agency LPN #542 revealed she was the nurse assigned to care for Resident #128 on [DATE]. Agency LPN #542 revealed Resident #128 had been refusing care (medications and meals) during the shift and the CNP was notified. The CNP reported the resident was just having normal behaviors and to monitor the resident. Agency LPN #542 revealed the resident was then subsequently unresponsive and without vital signs and was provided CPR which was unsuccessful. The resident was pronounced deceased by paramedic staff. Agency LPN #542 revealed paramedic staff covered Resident #128 with a sheet, but the resident didn't have any funeral home listed so she asked a supervisor. Agency LPN #542 revealed about an hour later she was provided information on which funeral service to use so she set up the transport. Agency LPN #542 revealed there were no state tested nursing assistant (STNA) staff working with her on the unit, she was working by herself and just left the resident on the floor covered with the sheet awaiting the funeral home to arrive. Agency LPN #542 verified the resident had urine and feces on him at the time he passed away and verified she had not provided any type of personal or post-mortem care to the resident. Agency LPN #542 revealed she left the facility at the end of her shift around 7:00 A.M., at which time the funeral home had not arrived. Agency LPN #542 indicated she was not sure what time the funeral home arrived that morning. During the interview, Agency LPN #542 verified she did not complete post-mortem care for Resident #128, the agency LPN revealed if you have help you can do the care, but she didn't have any help. Agency LPN #542 revealed she was not sure what the facility policy was on post mortem care so she wasn't sure if it was unacceptable the care wasn't provided. On [DATE] at 11:55 A.M. interview with EMS/Paramedic #546 revealed when they arrived at the resident, he was slumped over in his wheelchair. EMS #546 revealed himself and a nurse on duty assisted the patient to the floor while the other EMS/Paramedic ran to the truck to grab the [NAME] Device. The resident was in cardiac arrest and was not breathing, his skin was warm, he had dried mucus all over his clothes and he looked like he had been unresponsive. Review of the facility policy and procedure titled, Post-Mortem Care, dated [DATE] revealed residents who expire in the building receive the care appropriate for transporting to a receiving facility. The policy revealed post-mortem care was provided for a resident after their death had been pronounced and appropriate persons and agencies had been notified. The policy indicated the resident should be treated with dignity and respect; nurses would remove intravenous lines (IVs), tubes, catheters and replace soiled dressings; the residents' body should be washed carefully and the clothes should be changed if soiled. Review of the facility policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated [DATE] revealed neglect was defined as the failure of the facility, its employees, or facility service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. Mistreatment was defined as the inappropriate treatment or exploitation of a resident.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on record review and interview the facility failed to ensure Pre-Admission Screening and Resident Reviews (PASARR) were completed for residents diagnosed with a new mental diagnosis at the time of or after their admission to the facility. This affected five residents (#11, #63, #64, #98, and #109) of eight residents reviewed for PASRR. Findings include: 1. Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses including aphasia, anxiety disorder, dementia, chronic obstructive pulmonary disease, major depression disorder. A new diagnosis (dated [DATE]) for unspecified psychosis not due to a substance or known physiological condition was also included on the resident's diagnoses list. Review of the Preadmission Screening/Resident Review Identification Screen, dated [DATE] revealed Resident #63 had a mood disorder and depression. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed the resident had impaired cognition. On [DATE] from 4:36 P.M. to 4:48 P.M. interview with Social Worker (SW) #481 revealed she was responsible for completing the PASARR forms. SW #481 reported she completed them upon admission and if she noticed any that had been missed upon admission. SW #481 was unaware PASARR forms needed to be completed when a resident had a new mental illness and confirmed she had not been doing this. She reported the previous admissions director had been telling her when to complete the PASARR's for residents and she knew she missed some while she was learning to do it on her own. She confirmed the facility did not complete a new PASARR for Resident #63 following the [DATE] diagnosis of unspecified psychosis. 2. Review of the medical record revealed Resident #64 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, encephalopathy, unspecified dementia with behavioral disturbance, delusional disorders, hyperlipidemia and dysphagia. On [DATE] a new diagnosis of schizoaffective disorder was added. Review of the review results dated [DATE] revealed the pre-admission screening determination for Resident #64 was not applicable. On [DATE] from 4:36 P.M. to 4:48 P.M. interview with SW #481 revealed she was responsible for completing the PASARR forms. SW #481 reported she completed them upon admission and if she noticed any that had been missed upon admission. SW #481 was unaware PASARR forms needed to be completed when a resident had a new mental illness and confirmed she had not been doing this. She reported the previous admissions director had been telling her when to complete the PASARR's for residents and she knew she missed some while she was learning to do it on her own. SW #481 revealed the review results were all she was able to locate for Resident #64 and confirmed a new PASARR had not been completed when the resident received a new mental illness diagnosis. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32654 3. Review of Resident #98's medical record revealed an original admitted [DATE] with the latest readmission of [DATE] with admitting diagnoses of diffuse traumatic brain injury with loss of consciousness, nicotine dependence, right hip pain, diabetes mellitus, hyperlipidemia, bipolar disorder, mood disorder, dementia with behavioral disturbances, post traumatic stress disorder (PTSD), hypertension, asthma, epilepsy, hypothyroidism, insomnia, alcoholic cirrhosis of liver without ascites, and severe morbid obesity. The resident's diagnoses list was updated on [DATE] to reflect the addition of a diagnosis of schizoaffective disorder. Review of the hospital exemption from preadmission screening notification, dated [DATE] revealed the resident had a mood disorder with a description of mood disorder, depressive disorder. Record review revealed no evidence a new PASARR was completed on or after [DATE], when Resident #98 was given the diagnoses of schizoaffective disorder. Review of the resident's quarterly MDS 3.0 assessment, dated [DATE] revealed the resident had clear speech, understands others, makes herself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of 11. On [DATE] at 12:33 P.M. interview with Registered Nurse (RN) #406 verified a PASARR was not completed for the added schizoaffective disorder on [DATE]. 19571 4. Review of Resident #11's medical record revealed the resident had diagnoses including dementia with behaviors, schizophrenia, major depression and anemia. Review of the annual MDS 3.0 assessment, dated [DATE] revealed the resident was cognitively impaired, required extensive assistance of two plus staff members for bed mobility and extensive assistance of one plus staff member for toilet use, dressing and personal hygiene. Record review revealed the resident had a new diagnosis of schizophrenia on [DATE]. However, no updated PASARR was completed at that time or since hat time. On [DATE] from 4:36 P.M. to 4:48 P.M. interview with SW #481 revealed she was responsible for completing the PASARR forms. SW #481 reported she completed them upon admission and if she noticed any that had been missed upon admission. SW #481 was unaware PASARR forms needed to be completed when a resident had a new mental illness and confirmed she had not been doing this. She reported the previous admissions director had been telling her when to complete the PASARR's for residents and she knew she missed some while she was learning to do it on her own. During the interview SW #481 confirmed Resident #11 had new mental illness diagnoses since the last PASARR completed which was from 1993. 5. Review of Resident #109's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including end stage renal disease, dependence on renal dialysis and schizoaffective disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS 3.0 assessment, dated [DATE] revealed the resident had moderately impaired cognition, required supervision with set up help for dressing and personal hygiene and was independent with set up help for bed mobility, transfers and toilet use. Review of the PASARR, dated [DATE] revealed no evidence the form accurately reflected the resident's diagnosis of schizophrenia. Resident #109 was admitted to the facility on [DATE] with the diagnosis of schizophrenia. On [DATE] from 4:36 P.M. to 4:48 P.M. interview with SW #481 revealed she was responsible for completing the PASARR forms. SW #481 reported she completed them upon admission and if she noticed any that had been missed upon admission. SW #481 was unaware PASARR forms needed to be completed when a resident had a new mental illness and confirmed she had not been doing this. She reported the previous admissions director had been telling her when to complete the PASARR's for residents and she knew she missed some while she was learning to do it on her own. During the interview, SW #481 confirmed Resident #109 did not have an up to date PASARR, she revealed the hospital exemption had expired and nobody had completed a new one.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on record review and interview the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) Level I screen was completed accurately for Resident #126 upon admission. This affected one resident (#126) of eight residents reviewed for PASARR. Findings include: Review of the medical record for Resident #126 revealed an admitted [DATE] with diagnoses including personal history of malignant neoplasm of unspecified digestive organ, encephalopathy, altered mental status, hyperlipidemia, unspecified dementia without behavioral disturbance, cognitive communication deficit and aphasia. The diagnosis of delusional disorders was dated 05/20/21. Review of the review results, dated 05/21/21 revealed the Pre-Admission Screening (PAS) determination had no indications of serious mental illness nor a developmental disability. Review of the PASARR for Resident #126 dated 05/21/21 revealed no mental illness was noted. On 10/26/21 from 4:36 P.M. to 4:48 P.M. interview with Social Worker (SW) #481 revealed she was responsible for completing the PASARR forms for residents. SW #481 reported she completed them upon admission and if she noticed any that had been missed upon admission. SW #481 was unaware PASARR's needed to be completed when a resident had a new mental illness and confirmed she had not been doing this. She reported the previous admissions director had been telling her when to complete resident PASARR reviews and she knew she missed some while she was learning to do it on her own. SW #481 confirmed Resident #126's PASARR did not include the delusional disorder present on the resident's diagnosis list.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure comprehensive care plans including individualized interventions were developed for all residents and/or failed to implement care plans as written. This affected three residents (#87, #117 and #46) of 51 sampled residents whose care plans were reviewed. Findings include: 1. Review of Resident #87's medical record revealed an original admitted [DATE] with the latest readmission of 10/19/21. Resident #87 had diagnoses including pseudobulbar affect, aphasia, urinary tract infection (UTI), urine retention, peripheral vascular disease, gastro-esophageal reflux disease, Alzheimer's disease, osteoarthritis, psychosis, major depressive disorder, hyperlipidemia, anxiety disorder, hypertension, bipolar disorder, atrial fibrillation and dysphagia. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/30/21 revealed the resident had clear speech, sometimes understood others, sometimes made herself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of eight. The resident was identified as being always incontinent of both bowel and bladder. Review of the admission assessment with baseline care plan dated 10/19/21 revealed the resident was readmitted to the facility from an acute care hospital with an indwelling urinary catheter. Review of the plan of care dated 10/19/21 revealed the resident had potential for complications related to indwelling urinary catheter use. Interventions included to assist with Foley catheter care as needed, educate resident to report signs/symptoms of urinary tract infection (UTI), encourage proper nutrition and adequate fluid intake, evaluate need for catheter and supporting diagnoses and observe for signs/symptoms of UTI. On 10/25/21 at 1:14 P.M. observation of the resident revealed an indwelling urinary catheter did not have a privacy bag and was under the bed on the floor. On 11/01/21 at 8:56 A.M. interview with the Director of Nursing (DON) verified the resident's comprehensive plan of care failed to address the resident's indwelling urinary catheter interventions for care. 19571 2. Review of Resident #117's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia, chronic kidney disease, high blood pressure and anemia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission MDS 3.0 assessment, dated 09/23/21 revealed the resident's cognition was moderately impaired, he required extensive assistance of two staff members for bed mobility, transfers, dressing and toilet use and extensive assistance from one staff member for personal hygiene. The assessment revealed the resident had an indwelling urinary catheter and was frequently incontinent of bowel. Review of the physician's orders for 10/2021 revealed an order for Foley catheter care every shift and as needed, empty urinary catheter bag every shift and as needed (prn) and record output and total every 24 hours. Review of the plan of care, dated 10/16/21 revealed to obtain urine output each shift and total for 24 hour period. Further review of the medical record revealed the urine output and total was not completed every shift following the plan of care. On 11/01/21 at 2:20 P.M. interview with Licensed Practical Nurse (LPN) #453 verified the above finding. 43060 3. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominants side, muscle weakness, hypertension, atrial fibrillation and need for assistance with personal care. Review of the physician's orders dated 04/29/21 revealed an order to apply DermaSarra Anti-Itch Lotion 0. 5-0.5 % (Camphor-Menthol) every shift for itching for Resident #46. Review of the plan of care, dated 06/04/21 revealed Resident #46 had the potential for alteration in skin integrity related to cognitive communication deficit, hand contracture, weakness and reduce mobility. Interventions included to inspect skin condition daily during care, report any impaired areas to charge nurse and educate family and staff of risks for skin breakdown risk factor and preventative measures. Record review revealed no plan of care had been developed for Resident #46 related to itching or skin conditions associated to itching. On 10/25/21 at 2:34 P.M. Resident #46 was observed to pull his left pant leg up and revealed multiple small round scabbed areas, (ranging from approximately two by two centimeters (cm) to four by five cm). Some of the scabs were open and bleeding and there was an area of dried blood on Resident 46's outer ankle and sock, measuring approximately four cm by five cm. Resident #46 was then observed to scratch the area with his hand. When asked if the area itched, Resident #46 nodded his head yes. When asked if the nurses put cream on the area, Resident #46 made a side to side motion with his hand. Review of the shower sheets for Resident #46 dated 10/25/21, 10/23/21 and 10/18/21 revealed no mention of skin concerns to the resident's legs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin assessments, dated 10/20/21 and 10/24/21 documented Resident #46's skin was intact. Review of the Treatment Administration Record (TAR) for the month of October 2021 revealed the anti-itch cream was signed off as administered twice per day, including on 10/25/21 A.M. On 10/25/21 at 4:00 P.M. interview with Licensed Practical Nurse (LPN) #347 revealed she frequently cared for Resident #46 and administered his treatments and medications. When asked about Resident #46's legs and treatment, LPN #347 was unable to recall any concerns or treatments. LPN #347 further revealed she had not completed any treatments to Resident #46's legs on this date. LPN #347 further confirmed she did mark her initials in the TAR without administering the treatment that was ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure all residents who required staff assistance with activities of daily living (ADL) care received timely and appropriate care and services to maintain proper hygiene and grooming. This affected five residents (#11, #13, #18, #65 and #85) of nine residents reviewed for ADL care. Findings include: 1. Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behaviors, schizophrenia, major depression and anemia. Review of the plan of care, dated 09/24/20 revealed staff would assist as needed with daily hygiene and assist with showering resident as per facility policy weekly. Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 10/04/21 revealed the resident exhibited cognitive impairment, required extensive assistance of two plus staff members for bed mobility and extensive assistance of one plus staff member for toilet use, dressing and personal hygiene. On 10/26/21 at 10:20 A.M. and 3:13 P.M. Resident #11 was observed to have dried food on his clothes. In addition, the resident had a significant amount of facial hair; he appeared unshaven. Additional observations on 10/27/21 at 8:00 A.M. and 12:20 P.M. revealed the resident remained unshaven with a dried substance on his shirt. On 10/28/21 at 10:29 A.M. the resident remained unshaven. On 11/01/21 at 8:35 A.M. Resident #11 was observed up in his wheelchair with clothes that were stained. The resident was wearing sweat pants and a sweat shirt with dried food substances on them, holes in his sweatshirt and the resident remained unshaven at that time. At 11:27 A.M. Resident #11 was observed lying on his bed with his clothes stained (stains on his sweat pants and sweat shirt with dried food substance and holes in the sweat shirt). On 11/01/21 at 11:27 A.M. interview with Licensed Practical Nurse (LPN) #497 verified Resident #11 was unshaven and his clothes were in poor condition. The LPN did not provide any information that the resident refused care. 2. Review of Resident #13's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia without behaviors, major depression and encephalopathy. Review of the plan of care, dated 11/09/20 revealed staff would assist as needed with daily hygiene and would assist with showering resident as per facility policy weekly. Review of the quarterly MDS 3.0 assessment, dated 10/04/21 revealed the resident was cognitively impaired, he required supervision with one staff member physical assist for transfers and toilet use and extensive assistance from one staff member for dressing and personal hygiene. There were no behaviors identified. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/26/21 at 9:14 AM and 3:15 P.M. observation of Resident #13 revealed the resident's hair appeared greasy, uncombed and he had long hairs on his neck. Additional observations on 10/27/21 at 8:10 A.M. and 11:30 A.M. revealed the resident's hair was uncombed with long hairs remaining on his neck. On 10/28/21 at 9:00 A.M., 10:39 A.M. and 3:20 P.M. Resident #13 was observed wearing a hospital gown. The resident's hair remained uncombed and long hairs remained on his neck. On 11/01/21 at 8:55 A.M. and 11:27 A.M. Resident #13 was observed in bed unshaven with long hairs on his neck wearing a hospital gown. At 1:46 P.M. Resident #13 was up in the dining/lounge area and observed to be wearing a shirt with stains on it, his hair was uncombed, the resident was unshaven and he had long hairs on his neck. On 11/01/21 at 1:55 P.M. interview with LPN #497 verified the above condition of the resident. The LPN did not provide any information that the resident refused care. 3. Review of Resident #18's medical record revealed the was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia, chronic kidney disease, diabetes and anemia. Review of plan of care, dated 06/29/21 revealed the resident needed (staff) assistance for ADL care due to cognitive and communication deficits. Review of the MDS 3.0 assessment, dated 09/23/21 revealed the resident's cognition was moderately impaired. Resident #18 was assessed to require extensive assistance of two or more staff members for bed mobility, transfers, dressing and toilet use. On 10/25/21 at 12:25 P.M. Resident #18 was observed unkept wearing clothing that was stained and with dried food. On 10/26/21 8:05 A.M. and 3:16 P.M. Resident #18 was observed wearing the same clothes that had been on 10/25/21 with stains and dried food. On 10/26/21 at 3:18 P.M. interview with State tested Nursing Assistant (STNA) #331 verified the condition of the resident as noted above. The STNA did not provide any information that the resident refused care. 43060 4. Review of the medical record for Resident #65 revealed the resident was admitted to the facility on [DATE] with the most recent re-admission on 07/27/21. Resident #65's diagnoses included encephalopathy, atrial fibrillation, hypertension, end stage renal failure, non-Alzheimer's dementia and need for assistance with personal care. Review of the plan of care, dated 02/25/21 revealed Resident #65 needed assistance with ADL care related to immobility. Interventions include to assist with dressing, toileting, oral care and grooming. Review of most current MDS 3.0 assessment revealed the resident was moderately cognitively impaired, required extensive assistance from one staff for bed mobility, transfers, locomotion, dressing, personal hygiene and toileting and was dependent on staff for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/21 at 2:19 P.M. Resident #65's fingernails were observed to be long, with a brown substance under them, that appeared to be dirt or food. At the time of the observation, Resident #65 revealed he would like to have his fingernails trimmed. On 10/25/21 at 2:22 P.M. observation and interview with STNA #485 confirmed Resident #65's fingernails were too long and needed cleaned. Review of the shower sheets, dated 10/25/21 and 10/18/21 revealed they were both marked that fingernail care was completed. The record was observed to silent for documented showers or baths between 10/18/21 and 10/25/21. Further review of the record revealed personal hygiene and/or nail care/hand hygiene was provided once, on 10/20/21. On 11/01/21 at 3:45 P.M. interview with the Director of Nursing (DON) confirmed the medical record was silent for any showers from 10/18/21 through 10/25/21 for Resident #65, and that personal hygiene was documented as being provided once, in an eight day period. Review of the facility policy titled Resident Care revised 06/2018 revealed facility staff would provide general care as necessary for each resident per their preferences when able and per physician's orders. The policy clarified, typical personal hygiene for a resident included but was not limited to cleaning and cutting of fingernails and toenails. 38604 5. Review of Resident #85's medical record revealed an admitted [DATE] with diagnoses including need for assistance with personal care, abnormality of gait and mobility, muscle weakness and adult failure to thrive. Review of the care plan, dated 12/28/20 revealed the resident experienced bowel and/or bladder incontinence with interventions to provide incontinence care every two hours and as needed. Review of the MDS 3.0 assessment, dated 08/27/21 revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating impaired cognition. The assessment revealed the resident required limited assistance from one staff for bed mobility, extensive assistance of one staff for dressing and personal hygiene and extensive assistance of two staff for transfers and toilet use. The MDS also revealed the resident was always incontinent of bowel and bladder. On 10/25/21 at 10:57 A.M. interview with Resident #85 revealed she was dependent on staff for all care. During the interview, the resident did exhibit cognitive impairment but voiced a concern that staff were supposed to change her (bed) sheets but stated they didn't. At the time of the interview, Resident #85 was observed sitting on her bed with an incontinence (pull up) brief in place. There was a feces odor noted. As the resident was moving around on the bed, feces was observed smeared on the resident's bed sheets. The wheelchair next to the bed was observed was a soiled pull up sitting on top of a towel on the seat. On 10/25/21 at 11:04 A.M. observation and interview with STNA #372 confirmed the above findings. No additional information was provided to determine when the resident had last been provided personal care on this date prior to the surveyors observation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy and procedure titled, Resident Care, dated June 2018 revealed residents would be given nursing care and supervision based upon their individual needs.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38604 Based on observation, closed record review, review of an Emergency Medical Service (EMS) squad run report, review of a staff witness statement, review of the facility emergency response policy, staff interview and interview with Paramedic (EMT) #545 and EMT #546, the facility failed to initiate timely and adequate Cardio-pulmonary Resuscitation (CPR) for Resident #128 who was a full-code and required CPR after being found unresponsive and without vital signs. This resulted in Immediate Jeopardy on [DATE] at approximately 3:21 A.M. when Resident #128 was observed unresponsive. The facility failed to ensure EMS had timely access to the facility and failed to provide CPR timely for the resident. On [DATE] at 3:21 A.M., EMS arrived on-site and identified facility staff were not providing CPR to a resident whom staff had identified as unresponsive and coding. EMS staff immediately initiated CPR for the resident, however CPR efforts were not successful and the resident expired. The lack of immediate and adequate CPR and delay in staff allowing EMS into the facility resulted in life threatening harm and death for Resident #128. This affected one resident (#128) of three residents reviewed for death. The facility identified 75 residents who were a full code in the facility. The facility census was 134. On [DATE] at 3:30 P.M. the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services/Registered Nurse #406 were notified Immediate Jeopardy began on [DATE] at approximately 3:21 A.M. when facility staff, including Licensed Practical Nurse (LPN) #542 failed to initiate immediate CPR procedures for Resident #128 after he stopped breathing. Resident #128 subsequently expired in the facility. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 5:30 P.M. Senior DON #540 and Unit Manager/LPN #324 reviewed the medical records for all current in-house residents to verify code status order, care plan, and documentation to ensure all were congruent in the medical record. On [DATE] at 5:00 P.M. the facility layout was reviewed and assigned identifying numbers (related to code status), the numbers were placed on the doors by Maintenance Director #346 and Central Supply #329. On [DATE] at 7:15 P.M. the Administrator contacted the Local Fire Department and informed them of their new facility layout and door identification system. On [DATE] at 5:30 P.M. with day shift and at 7:00 P.M. with night shift Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #304 conducted code blue drills with all working staff which included 27 STNAs, 14 LPNs, four RNs, 10 administrative staff, three regional staff, three dietary staff, three activities staff, and two therapy staff to ensure knowledge of the policy and procedure for a code blue. A code blue is initiated when a patient is unresponsive in cardiopulmonary arrest and staff are required to initiate CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 7:00 P.M. the facility Quality Assessment and Performance Improvement (QAPI) Committee, including the Administrator, Regional Director of Clinical Service #406, SSD #481, MDS #453, Dietician #488, housekeeping and laundry #447, marketing #336, HR #420, Director of Nursing (DON), Activities #452, Therapy Director #548, Maintenance Director #346, ADON/LPN #304, and Physician Assistant #549 reviewed the Immediate Jeopardy finding, facility plan of action, the policies and procedures related to timely post mortem care, code blue, CPR, and the new floor plan and postings, and a root cause analysis was completed. On [DATE] 4:30 P.M. the Regional Director of Clinical Services #406 initiated education for all licensed nurses on the CPR code policy, code-blue drills (the code called when someone was identified to require CPR), timely post-mortem care, and new process with labeled doors to alert to location for entrance or exit. Education was completed on [DATE] from 4:30 P.M. for nine Licensed Practical Nurses (LPNs), three RNs, 14 STNAs, 10 administrative staff, three regional staff, dietary staff and activity staff, and two therapy staff. A plan for no licensed staff to be permitted to work until education was received was implemented. On [DATE] at 4:50 P.M. Regional Director of Clinical Services #406 initiated online education for all staff with competencies via survey monkey for all licensed nurses on the CPR code policy, code-blue drills, timely postmortem care, and new process with labeled doors to alert to location for entrance or exit. Seven RNs, 23 LPNs, 46 STNAs, 10 administrative staff, five activities staff, 11 dietary staff, 19 laundry and housekeeping, and eight therapy staff. A plan for no licensed staff to be permitted to work until education was received was implemented. On [DATE] at 5:30 P.M. the DON reviewed the last three months of resident facility deaths to ensure there were no other like instances. No like instances were noted. On [DATE] at 8:20 P.M. the Administrator sent an education packet to the facility three contracted staffing agencies (ConnectRN, VIP, and Buckeye) to have their staff educated on their new facility policies and procedures and to verify all nurses were CPR certified. They were to send a sign off sheet to the Regional Director of Clinical Services #406. The staff were to have the education provided to the facility before they are able to return to the facility. On [DATE] a plan for code-blue drills to be completed by the ADON/LPN #304 and the DON/designee every shift for three days and then weekly for four weeks on random shifts to ensure competencies of the process for a code blue. On [DATE] a plan for education competencies to be reviewed by Regional Director of Clinical Services #406 to be completed on 10 random staff members daily for two weeks (via survey monkey) and then 10 random staff members three times weekly for two weeks via survey monkey) to ensure competencies of the processes related to timely postmortem care, code blue, CPR, and the new floor plan and postings. On [DATE] a plan for audits of closed resident records reviewed for deaths to be completed by the DON/designee daily for five days a week for four weeks to ensure postmortem care was completed by staff timely. When she is informed of a death, she will be following up immediately and completing a post mortem audit form. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] a plan for weekly for four weeks QAPI meetings per the Administrator to ensure policies and procedures were being followed. Although the Immediate Jeopardy was removed on [DATE] the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #128 revealed an admitted [DATE] with diagnoses including COVID-19, heart disease, congestive heart failure, chronic kidney disease stage three, and atrial fibrillation. Record review revealed the resident was a Full Code related to advance directives. The resident expired in the facility on [DATE]. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) of 12 indicating the resident had moderate cognitive impairment. The assessment revealed the resident required extensive assistance from one staff for bed mobility and toilet use, extensive assistance from two staff for transfers, supervision with one staff assistance for locomotion and limited assistance from one staff for personal hygiene. Review of Resident #128's care plan, dated [DATE] revealed the resident/family chose CPR would be attempted during cardiac arrest with interventions to inform new caregivers of code status, nursing staff to provide chest compressions when the resident was in cardiac arrest and call ambulance for transport to the hospital, and notify family of changes in condition. Review of Resident #128's medical record revealed the resident was not receiving Hospice services and/or palliative care during his stay at the facility. The plan of care revealed the resident's goal was to return home. Review of Resident #128's care plan, dated [DATE] revealed the resident was tested and confirmed positive for COVID-19 with interventions to administer medications per physician orders, administer oxygen per physician orders, be alert for changes in activities of daily living assistance required, be alert for new or worsening symptoms including increased difficulty breathing, back or abdominal pain, increased lethargy and weakness, altered mental status and notify physician if this occurs, and follow Centers for Disease Control (CDC) and facility policies for isolation precautions related to COVID-19. Review of the physician's orders revealed an order, dated [DATE] for the resident to be placed on droplet precautions for 10 days due to COVID-19. The resident also had an order for a Full Code status. Review of the nurse's notes revealed on [DATE] at 5:49 P.M. Resident #128 was aware of his rapid positive COVID-19 test result and moved to the facility COVID unit. A nurse's note, dated [DATE] at 4:23 A.M. revealed the resident continued to refuse all care this shift. Certified Nurse Practitioner (CNP) #547 was notified at 2:48 A.M. and gave a new order to send the resident to the emergency room for further evaluation. Paramedics (EMT) were contacted for transport. The nurse's notes revealed the resident was unresponsive upon EMT arrival at 3:10 A.M. and CPR was started, the resident was pronounced dead at 3:46 A.M. and CNP #547 was notified. A note, dated [DATE] at 8:45 A.M. revealed the resident was discharged . (continued on next page)

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	365644	A. Building B. Wing	11/05/2021

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Local Fire Department Report, dated [DATE] revealed a call/dispatch to transport Resident #128 on [DATE] at 3:01:18 A.M. The report showed staff enroute at 3:02:32 A.M., on the scene at 3:08:53 A. M. and at the patient (Resident #128) at 3:21:50 A.M. Resident #128 was pronounced deceased at 3:46 A.M. The report revealed Resident #128 was unresponsive and pale, he was in cardiac arrest, and the only delay to the patient was a delay at the scene, documenting there was a delay to patient access. The narrative report revealed they had been dispatched for a medic run and upon arrival, at the front door of the facility it took several minutes for the nursing staff to come to the front door to tell the medics they needed to go to the side of the building to the isolation area. Facility staff indicated the patient was COVID positive and needed to be transported for further evaluation. The crew took the cot to the end of the building, knocked on the door and another staff member wouldn't open the door and then told them they needed to go around to the back of the building. The cot was taken back by the medic so they would drive to the back of the building. Facility staff came out to the medic and stated staff told them to drive to the back of the other building and apologized for the delay. They drove to the back of the building and found a staff member walking to take them to the correct door. When emergency medical staff entered the building a staff member shouted, CPR in progress. The report indicated this was 14 minutes after EMS arrival. The EMS crew continued to Resident #128's room and found the resident slumped over in his wheelchair with no CPR in progress. Resident #128 wasn't breathing and was in cardiac arrest. Nursing staff reported the physician was called by (a facility staff member via phone) at 2:38 A.M. and the resident was nonverbal but was moaning and the staff member was unsure when the resident's last normal activity was. The resident's skin was warm. EMS slid the resident from the wheelchair onto the floor and manual CPR was performed. Columbus Fire Department was notified of the arrest and to send an engine for additional manpower. Paddles were placed on the resident's chest and the resident was assessed to be in ventricular fibrillation. The resident was shocked, and CPR continued. The report revealed the other patient was lying in his bed in the same room and stated he could hear Resident #128 moaning but had not heard a noise from him for at least 20 minutes. The next rhythm check, per monitor, showed Resident #128 had pulseless electrical activity and his blood sugar was 141. Epinephrine was administered to the patient via an Intraosseous Line (IO) and CPR continued but the resident remained without a pulse. CPR was discontinued after 20 minutes and the resident was pronounced dead. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:21 A.M. interview with EMT/Paramedic #545 revealed they received a call around 3:00 A.M. that a resident was refusing his medications and care and needed an evaluation at the hospital. He stated they (himself and EMT #546) arrived at the facility a few minutes later but had not been notified the resident they were going to pick up was COVID positive, so they went to the front entrance door. Two staff were sitting behind the counter staring at them and didn't get up and answer the door. EMT/Paramedic #546 started aggressively pounding on the door until someone answered who directed them to another door stating they were going to an isolation door. When they arrived at the second door, they felt they woke the staff up and that staff stated the resident was on another isolation wing and sent them to a third door on the other side of the building. They loaded up the cot they had, and a staff member apologized for the confusion. They headed to the third door and changed their respirators to be prepared for a covid positive resident. When they finally got into the third door about eight to twelve feet into the hall, they heard a staff member saying CPR in progress. He stated the ball game had changed at this point because they were told this was a simple transport to the hospital. When EMT staff arrived at the resident's room, there were no staff in the room, the resident was slumped over in his wheelchair with dried bodily fluids on his shirt and in his nares and CPR was not in progress. EMT #545 revealed even if CPR had been initiated, it wouldn't have been effective (as the resident was in a wheelchair). Paramedic #546 moved the resident to the ground and initiated manual CPR while Paramedic #545 went back out to the ambulance to retrieve a [NAME] Device (portable device that delivers consistent chest compression). When he got back into the facility Paramedic #546 was still doing CPR with no staff assisting him. He stated he also had the [NAME] Device in his arms and the resident's wheelchair was still in front of the resident's door, no one helped move the wheelchair so he had to set the [NAME] Device down to move the wheelchair himself, then pick the [NAME] Device back up and apply it to the resident. He shocked the resident once with the defibrillator, but no vital signs were noted. EMT #545 revealed he wasn't sure who he stated this to, but said he was denied access so many times, he told one of the staff he would be getting into the facility on e way or another even if he had to call the sheriff to let him in. Paramedic #545 further revealed the resident's roommate shared with him that he heard Resident #128 moaning that morning for quite some time. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:55 A.M. interview with EMS/Paramedic #546 revealed they were called for a medic run to the facility and when they arrived at the main entrance staff were standing around the front desk looking at the EMS like they were stupid. It took staff a few minutes to come to the door and staff directed EMS to go to the other side of the building as the resident, Resident #128 was in isolation. EMS went to the other side of the building and there was a lady sitting in a chair who looked like she was asleep. EMS had to beat on the door which scared the lady but she wouldn't let them in. The lady was yelling at them through the door to go to the isolation unit. Paramedic #546 reported they didn't know where that was. The sidewalk had ended and the area where she was pointing them to go required EMS to load the cot back up into the truck and drive around the building. As they were in this process, a woman who they thought was a manager apologized for the confusion and EMS #546 stated he told her it was a good thing this wasn't a true emergency because as long as they had been at the facility the patient could be dead. They pulled around to the other side of the building and as they were approaching the ramp, the staff on the unit were heard saying CPR in progress. EMS staff got to Resident #128's room and the resident was slumped over in his wheelchair with no CPR in progress by facility staff. EMS #546 revealed himself and a nurse on duty assisted the patient to the floor while the other EMS/Paramedic ran to the truck to grab the [NAME] Device. The resident was in cardiac arrest and was not breathing, his skin was warm, he had dried mucus all over his clothes and he looked like he had been unresponsive. EMS #546 revealed if he had to speculate, he would have said the resident had been down for approximately 10 minutes. EMS staff radioed for a fire engine and he did CPR until the [NAME] Device was hooked up. He stated they utilized the defibrillator on the resident and continued CPR. The resident's roommate stated to the EMS staff the resident was moaning for quite awhile, but he hadn't heard the resident making noise for 20 minutes to a half hour. He stated getting into the building was the biggest delay of getting to Resident #128 and the nurse on duty had no sense of urgency or worry. When asked what made him think the resident was unresponsive for approximately 10 minutes, he stated he just looked like he had been like that for a while. On [DATE] at 3:55 P.M. and again on [DATE] at 1:14 P.M. interview with Agency LPN #542 revealed she was working in the facility on [DATE] and assigned to care for Resident #128. The LPN revealed when she got onto the unit Resident #128 was refusing medications, meals and care and he did the same during her night shift. She stated around 10:30 P.M. the CNP was called for new orders and she stated the resident was just having a behavior, it was his normal and staff could just monitor him. LPN #542 revealed around 2:00 A. M. or something CNP #547 told staff to send the resident out for an evaluation. LPN #542 revealed she printed everything for EMS and called the paramedics. LPN #542 revealed she saw the resident around five minutes before EMS arrived and he was fine, then she went to answer another resident's call light and when she came out to let EMS in, she noticed the resident was unresponsive in his chair. LPN #542 revealed she and the paramedics got the resident out of the wheelchair and started CPR. They did CPR for about 30 minutes until they pronounced the resident deceased . At the time of the incident, LPN #542 revealed she was the only staff member working on the COVID unit. There were no STNAs or other staff with her on the unit, it was just herself, but she didn't think she needed any STNAs to help as she did okay on her own. LPN #542 verified there was a delay in the time it took EMS to get to the resident because they went to the wrong door as the COVID positive unit was in the back of the building. LPN #542 revealed she knew the resident's code status when EMS arrived because she saw it on his chart when she printed the information for EMS but had not started CPR for the resident prior to EMS arriving to the room even though the resident was unresponsive. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of LPN #542's signed witness statement, dated [DATE] at 6:00 A.M. revealed on [DATE] at 10:45 P. M. Resident #128 continued to refuse medications, meals and personal care. Resident #128 was sitting in his room in a wheelchair with no signs of respiratory distress noted. The on-call provider was called and notified of the refusals and no new orders were received. On [DATE] at 2:48 A.M. the resident continued to refuse care. CNP #547 was notified and gave a new order to send the resident to the emergency room for an evaluation. Paramedics were contacted for transport. The resident was unresponsive as EMS arrived and CPR was started at 3:10 A.M. via EMS. He was pronounced dead at 3:46 A.M. The resident's provider was contacted, the DON was contacted, and funeral services were contacted. Review of the facility policy and procedure titled, Medical Emergency Response, dated [DATE] revealed in the event of a medical emergency any staff member, visitor or resident may initiate a medical emergency response. Staff would immediately notify the nurse in charge of the unit and they would announce a code blue and the general location. Staff in the vicinity would respond to the area immediately. The (resident's) code status would be verified by the nurse, staff would obtain a crash cart and 911 would be called. Once CPR was initiated, responders would continue until a physician provided the order to stop, the resident recovered with heart beat and breaths or emergency response team arrived and took over and transported the resident to a higher level of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43060 Based on observation, record review and interview the facility failed to accurately assess and monitor areas of non-pressure related skin impairment for Resident #46 and failed to ensure physician ordered skin treatments were documented only when completed. This affected one resident (#46) of three residents reviewed for skin treatments. Findings include: Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting right dominants side, muscle weakness, hypertension, atrial fibrillation and need for assistance with personal care. Review of the physician's orders dated 04/29/21 revealed an order to apply DermaSarra Anti-Itch Lotion 0. 5-0.5 % (Camphor-Menthol) every shift for itching for Resident #46. Review of the plan of care, dated 06/04/21 revealed Resident #46 had the potential for alteration in skin integrity related to cognitive communication deficit, hand contracture, weakness and reduce mobility. Interventions included to inspect skin condition daily during care, report any impaired areas to charge nurse and educate family and staff of risks for skin breakdown risk factor and preventative measures. Record review revealed no plan of care had been developed for Resident #46 related to itching or skin conditions associated to itching. On 10/25/21 at 2:34 P.M. Resident #46 was observed to pull his left pant leg up and revealed multiple small round scabbed areas, (ranging from approximately two by two centimeters (cm) to four by five cm). Some of the scabs were open and bleeding and there was an area of dried blood on Resident 46's outer ankle and sock, measuring approximately four cm by five cm. Resident #46 was then observed to scratch the area with his hand. When asked if the area itched, Resident #46 nodded his head yes. When asked if the nurses put cream on the area, Resident #46 made a side to side motion with his hand. Review of the shower sheets for Resident #46 dated 10/25/21, 10/23/21 and 10/18/21 revealed no mention of skin concerns to the resident's legs. Review of the skin assessments, dated 10/20/21 and 10/24/21 documented Resident #46's skin was intact. Review of the Treatment Administration Record (TAR) for the month of October 2021 revealed the anti-itch cream was signed off as administered twice per day, including on 10/25/21 A.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/21 at 4:00 P.M. interview with Licensed Practical Nurse (LPN) #347 revealed she frequently cared for Resident #46 and administered his treatments and medications. When asked about Resident #46's legs and treatment, LPN #347 was unable to recall any concerns or treatments. LPN #347 further revealed she had not completed any treatments to Resident #46's legs on this date. LPN #347 further confirmed she did mark her initials in the TAR without administering the treatment that was ordered. Review of the undated facility policy titled Medication Administration revealed medications must be administered in accordance with the orders, including the required time frame and the individual administering the medication must initial on the resident's medication administration record (MAR), on the appropriate line after giving the medication and before administering the next medications.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38604 Based on record review and interview the facility failed to ensure Resident #123 received a vision follow up for complaints of double vision. This affected one resident (#123) of two residents reviewed for vision services. Findings include: Record review for Resident #123 revealed an admitted [DATE] with diagnoses including heart failure, anxiety, diabetes type two, depression, weakness and chronic pain syndrome. Review of the care plan, dated 02/15/21 revealed the resident was at risk for visual decline/undetected eye diseases, or currently exhibited deficits as evidenced by diabetes type two. Interventions included to arrange eye appointments if increased visual deficits were noted Review of an eye exam, dated 08/23/21 revealed the resident's right and left eyes were in stable condition, the resident denied changes in vision and eye pain. There was no active diabetic retinopathy in either eye. Hypertensive retinopathy noted with mild retinal changes consistent with high blood pressure and minimal occlusive risk. New orders to return in six to nine months for a follow up. Review of the physician note, dated 09/07/21 revealed the physician documented the eye doctor saw the resident recently without new orders. The resident complained of interim double vision. The assessment plan revealed to follow up on the most recent eye appointment. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 09/25/21 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition. The assessment revealed the resident required supervision with one (staff) assist for activities of daily living. The MDS further revealed the resident utilized corrective lenses. On 11/01/21 at 1:56 P.M. interview with Resident #123 revealed he complained of double vision to the physician but no one had done anything about it. On 11/02/21 at 3:19 P.M. interview with Regional Director of Clinical Services #406 confirmed the facility didn't follow up with any eye doctor after the 09/07/21 physician note.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on observation, record review and interview the facility failed to provide adequate supervision and/or assistive devices to prevent falls and/or resident injury. Actual Harm occurred on 10/31/21 when Resident #35, who required extensive assistance from two (plus) staff for bed mobility sustained a fall out of bed resulting in a fractured nose when State tested Nursing Assistant (STNA) #407 was providing bed mobility without a second staff member assisting. Actual Harm occurred on 10/07/21 when Resident #33, who was dependent on two staff for transfers sustained an injury/hematoma with increased excruciating pain and subsequent two week hospitalization with surgical intervention during a staff assisted mechanical (Hoyer) lift transfer. This affected four residents (#12, #33, #35 and #93) of six residents reviewed for accidents. Findings include: 1. Review of Resident #35's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses included schizophrenia, atrial fibrillation, osteoporosis and encephalopathy. Review of a fall risk evaluation, dated 03/30/21 revealed Resident #35 was at high risk for falls. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 07/17/21 revealed the resident required extensive assistance from two plus staff members for bed mobility, dressing and personal hygiene and total dependence from two plus staff members for transfers and toilet use. Review of an incident report, dated 10/31/21 revealed Resident #35 was positioned on his left side during personal care. The resident then rolled to the side of the bed and off of the bed landing face down. The resident's nose was bleeding with a significant amount of blood noted. The resident was assessed to have a laceration to the nose and an abrasion to the knee. Resident #35 was transported to the emergency room for an evaluation. A hospital after summary report revealed Resident #35 was to have a follow up appointment with plastic surgeon for a fracture of his nose. On 11/01/21 at 1:49 P.M. Resident #35 was observed in his room in a wheelchair with purplish bruising around both eyes and a laceration to the bridge of his nose with dried blood. At the time of the observation, the resident revealed he had a broken nose. The resident revealed an STNA was turning him over (in bed) and rolled him out of bed. The resident indicated he hit the floor with his face and shoulder. On 11/01/21 at 2:41 P.M. interview with Licensed Practical Nurse (LPN) #497 revealed STNA #407 was turning Resident #35 in bed by herself and when she turned him he rolled out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a statement from STNA #407 revealed she was in (Resident #35's) room doing last check and change on Resident #35. The statement indicated the resident was rolled over on his left side and as the STNA was cleaning him up, he rolled out of bed on the floor and landed on his left side. The statement revealed the nurse was immediately notified. 32654 2. Review of Resident #33's medical record revealed an original admitted [DATE] with the latest readmission of 10/21/21 with the admitting diagnoses of diabetes mellitus, sleep apnea, anemia, hypertension, congestive heart failure, severe morbid obesity, atrial fibrillation, chronic obstructive pulmonary disease, chronic respiratory failure and gastro-esophageal reflux disease. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 had clear speech, understood others, made herself understood and had no cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score 15. The resident required extensive assistance of two persons for bed mobility and toileting and was dependent on two staff for transfers and bathing. Review of a telehealth note, dated 10/01/21 at 12:00 A.M. revealed the nurse reported the resident's left foot was bumped during a transfer yesterday and the resident was now complaining of pain, in addition to bruising and swelling. An x-ray of the left foot/ankle were ordered and nursing to continue to monitor and care team was notified. Review of a nursing note, dated 10/01/21 at 5:45 P.M. revealed Resident #33 asked the nurse to look at her left foot due to pain. The top of the resident's left foot was noted with edema, redness and was warm to touch, with the area measuring 6.0 cm in length by 6.0 cm width. Bruising was noted to the left side of the foot measuring 8.0 cm in length. The resident rated her pain an 8 out of ten (on a scale of one to ten with ten being the most severe pain) and was medicated with Tylenol 650 milligrams (mg) for pain. The resident's foot was elevated on a pillow. The nursing note revealed the resident stated her foot was bumped on 09/30/21 during a transfer with the Hoyer (a mechanical lift device used for transfers). Review of the facility investigation revealed a skin alteration report, dated 10/01/21 at 5:58 P.M. which indicated Resident #33 reported left foot pain to the floor nurse and an assessment was completed. Bruising across the top of the resident's foot to lateral side of the foot was noted. The resident stated, They bumped my foot. There was no indication of any new intervention(s) being initiated following this incident to decrease the resident's risk for injury associated with staff assisted transfers using the Hoyer (mechanical)+ lift. Review of a nursing note, dated 10/02/21 at 8:00 A.M. revealed the left foot x-ray received on night shift had negative results. The nurse practitioner (NP) on call was notified. The resident was medicated with Tylenol 650 mg for pain with positive results. The resident's left foot continued with edema, slightly red on top of foot and bruising continues with edema, slightly red on top of foot and bruising on outer foot. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a telehealth progress note, dated 10/07/1 at 12:00 A.M. revealed nursing reported a large purple bump to the resident's shin. The nurse stated the resident was in excruciating pain and had concerns for blood clot. The nurse revealed the resident's foot was warm to touch with edema and erythema noted. The resident was given Tylenol but it was ineffective. A one time dose of Oxycodone (narcotic analgesic) 5 mg was administered. The nurse attempted to assess capillary refill and vital signs but nursing was concerned for the resident's pain at this time, therefore the resident was sent (to the hospital) for further evaluation. Review of a skin altercation report, dated 10/07/21 at 3:53 P.M. revealed (during a transfer) an STNA reported standing beside Resident #33 while a second STNA was lowering the resident into her motorized wheelchair. The report indicated the first STNA had placed one hand on the front of each lower extremity to assist with placement the in wheelchair. The resident yelled out and voiced her lower leg hurt. The STNA lowered the resident to leave her in a safe position and immediately called for nurse. Upon assessment by the nurse a four cm long by four cm wide bruise was observed to the resident's left lower leg with the bruising continuing to spread down her leg. A subsequent assessment revealed a bruise to the resident's left lower leg measured 24.0 cm in length by seven cm width at the time the resident was transferred to the local emergency room . The resident was admitted to the hospital. Review of a statement from Nurse Aide (NA) #506, revealed staff were lifting the resident up in the Hoyer pad to transfer her to her chair. The statement revealed during the transfer the staff separated the resident's legs and the resident instantly started to cry in pain after noticing bruising on her left shin. The statement indicated the staff stopped and put the resident down. The statement revealed the bruise continued getting bigger and bigger and the resident was still crying in pain. Review of the local hospital discharge instructions, dated 10/21/21 revealed the resident was hospitalized from 10/07/21 to 10/21/21 for a hematoma to her left lower leg. The resident required an incision and drainage surgical procedure and placement of a negative pressure wound vacuum to the wound for healing. Review of the resident's admission assessment, dated 10/21/21 revealed Resident #33 was readmitted to the facility with a surgical incision to her left lower leg measuring 22.0 cm in length by 21.0 cm width. Review of the resident's monthly physician's orders for November 2021 revealed an order, dated 11/01/21 to cleanse left lower leg wound with normal saline, pat dry, apply Xeroform and ABD pad, wrap with Kerlix and secure with medical tape every shift and as needed. On 10/25/21 at 12:43 P.M. interview with Resident #33 revealed staff hit her foot on the Hoyer causing a bruise and then again (on at later date) hit her leg on the Hoyer and she had to go to the hospital and have surgery. On 11/01/21 at 2:40 P.M. interview with NA #506 revealed Resident #33 required the use of a Hoyer lift for transfers. During the transfer on 11/07/21, NA #506 revealed the resident's legs were positioned on the right side of the Hoyer and they swung her whole body around so she would be on the left side of the Hoyer and when staff lowered her into the wheelchair, the resident started screaming, looked down and noticed a big purple bump growing rapidly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/02/21 at 3:30 P.M. Licensed Practical Nurse (LPN) #304, LPN #453 and LPN #480 were observed providing the physician ordered treatment to Resident #33's left lower leg. The nurse set up the required supplies on a barrier on a bedside table. LPN #304 washed her hands and applied gloves. She placed a disposable chux under the resident's leg. LPN #304 removed the soiled dressing from the resident's left lower leg. The dressing was saturated with a blood tinged drainage. Then assessed the wound to measure 22.0 cm in length by 18.75 cm width with 0.5 cm depth with the wound bed reddish pink in color. The wound was covered with Xeroform, covered with ABD pad, wrapped with Kerlix and secured with tape. The facility failed to provide any additional information regarding the injury to Resident #33's left leg that occurred on 11/07/21 during staff care that required hospitalization and surgical intervention. Review of the facility policy titled, Hoyer Lift Transfer, dated 07/2018 revealed staff would follow procedure to assist and/or transfer residents in a safe manner to reduce the risk of injury to residents or staff. One person utilized and stabilized the lift while a second person guided and stabilized the resident. Guide the sling with the resident slowly and steadily, until over the surface the resident was being transferred to. Don't allow the sling with the resident to swing freely. 43060 3. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, personal history of traumatic brain injury, aphasia, hypertension, major depressive disorder, epileptic seizures, disorientation and repeated falls. Review of the plan of care, dated 05/14/21 revealed Resident #12 had potential for falls with history of falls at previous facility, impaired cognition communication and poor safety awareness. Interventions for Resident #12 included foot board to bed, perimeter mattress to bed, non-skid footwear while out of bed and to observe for side effects of psychotropic medications. Resident #12's plan of care was revised on 07/13/21 to include encourage resident to walk to and from meals in dining areas. Resident #12's care plan was revised again on 10/23/21 to include resident to lay resident down after meals as tolerated. Review of the Fall Risk Evaluations for Resident #12, dated 07/13/21, 07/29/21 and 10/23/21 all indicated the resident was at high risk for falls. Additionally, Resident #12 was noted to have falls on 07/13/21 and 10/23/21. On 10/25/21 at 3:54 P.M. Resident #12 was observed to be asleep in bed A of his room, which was not the resident's bed. Resident #12 was observed to be wearing regular socks rather than non-skid socks and the call light was on the floor, not within the resident's reach. On 10/25/21 at 3:56 P.M. interview with STNA #485 confirmed Resident #12 was asleep in the wrong bed, wearing regular socks and without access to the call light. STNA #485 shared activities staff assisted Resident #12 in bed earlier and they must not have known which bed was his and did not ensure fall interventions were in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/27/21 at 8:45 A.M. Resident #12 was observed asleep in his wheelchair at the dining table, in the resident lounge with wearing non-skid socks. At 8:53 A.M. Resident #12 was observed away from the dining table with a gait belt around his waist, and wheeling himself to the hall. Agency STNA #539 was observed to ask Resident #12 where he was going. On 10/27/21 at 8:53 A.M. interview with Agency STNA #539 revealed she does not know what fall precautions should be in place for Resident #12. Agency STNA #539 revealed she assisted Resident #12 to walk the halls with his walker and gait belt, at times which helped with the resident's restlessness. Agency STNA #539 revealed they (she and the resident) had just finished walking a little while ago. Agency STNA #539 confirmed Resident #12 was not wearing non-skid socks and also confirmed she had not encouraged the resident to lay down following breakfast. 4. Review of the medical record for Resident #93 revealed an admitted [DATE]. Resident #93's diagnoses included schizoaffective disorder, coronary artery disease, muscle weakness, hypertension and repeated falls. Review of the plan of care, dated 04/16/21 revealed Resident #93 was at risk for falls related to cognitive communication deficits, not recognizing limitations, presence of psychotropic medications, balance problems and incontinence of bowel and bladder. Interventions for Resident #93 included to ensure call light was within reach at all times, assist with transfers and monitor for side effects of psychotropic medications. Review of the Fall Risk Evaluations, dated 04/16/21 and 07/16/21 revealed Resident #93 was at high risk for falls. Review of the quarterly MDS 3.0 assessment, dated 07/15/21 revealed Resident #93 required extensive assistance from one staff for bed mobility, transfers and toileting. On 10/25/21 at 10:20 A.M. Resident #93 was observed sitting in a chair near his bed. Resident #93 was observed to ask for help getting in bed. The call light was observed to be on the other side of the bed, resting on the floor and not in reach of Resident #93. On 10/25/21 at 11:35 A.M. Resident #93 was observed laying in bed and the call light was laying on the floor and not within reach of the resident. On 10/25/21 at 11:36 A.M. interview with Agency STNA #539 confirmed Resident #93's call light was on the floor and not within reach of the resident. Additional observations on 10/26/21 at 9:06 AM and 10:21 A.M. revealed Resident #93 was laying in bed and his call light was laying on the floor. On 10/26/21 at 10:21 A.M. interview with STNA #485 confirmed Resident #93's call light was on the floor and there was not clip on the call light to keep it near the resident. On 10/28/21 at 2:30 P.M. and on 11/01/21 at 10:30 A.M. Resident #93 was observed in bed with the call light on the floor. The resident had no access to the call light which was a fall risk intervention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/01/21 at 10:30 A.M. interview with STNA #485 confirmed Resident #93's call light was on the floor and there was not a clip to enable to call light to attach the resident or the blanket. STNA #485 revealed she did know how to put in maintenance order and request a clip.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43060 Based on observation, record review, facility policy and procedure review and interview the facility failed to provide appropriate urinary catheter care to prevent the risk of urinary tract infections for residents. This affected four residents (#61, #383, #87 and #11) of five residents reviewed for urinary catheters and/or urinary tract infections. Findings include: 1. Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnoses including encounter for orthopedic aftercare following surgical amputation, muscle weakness, paraplegia, neuromuscular dysfunction of bladder, urinary tract infection, adult failure to thrive, diabetes, dementia, major depressive disorder and personal history of cerebral infarction. Review of the plan of care, dated 05/03/21 revealed Resident #61 had potential for complications related to suprapubic catheter. Interventions for Resident #61 included to assist with catheter care as needed, educate resident on signs and symptoms of urinary tract infection (UTI), observe for signs and symptoms of UTI and report to physician. On 10/25/21 at 3:30 P.M. Resident #61 was observed to be sleeping in bed, with the bed in low position. Resident #61's catheter bag and tubing were observed to be hanging on the side of the bed and both the bottom of the catheter bag and a section of the tubing were observed to be resting directly on the floor. On 10/25/21 at 4:00 P.M. interview with State tested Nursing Assistant (STNA) #507 confirmed Resident #61's catheter bag and tubing were resting directly on the floor. Review of the facility policy titled Foley Catheter Care, revised 04/2016 revealed the caregiver should not to allow the catheter bag to touch the floor. 2. Review of the medical record for Resident #383 revealed an admitted [DATE] with diagnoses including neuromuscular dysfunction of bladder, paraplegia, polyneuropathy and chronic pain. Review of the plan of care, dated 08/31/21 revealed Resident #383 had the potential for complications related to use of an indwelling (Foley) catheter. Interventions included to assist with catheter care as needed and educate resident to report signs and symptoms of UTI. On 10/25/21 at 3:43 P.M. Resident #383 was observed resting in bed, with the bed in low position. Resident #383's catheter bag and tubing were observed to be hanging on the side of the bed and both the bottom of the catheter bag and a section of the tubing were observed to be resting directly on the floor. On 10/25/21 at 4:00 P.M. interview with State tested Nursing Assistant (STNA) #507 confirmed Resident #383's catheter bag and tubing were resting directly on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Foley Catheter Care, revised 04/2016 revealed the caregiver should not to allow the catheter bag to touch the floor. 32654 3. Review of Resident #87's medical record revealed an original admitted [DATE] with the latest readmission of 10/19/21. Resident #87 had diagnoses including pseudobulbar affect, aphasia, urinary tract infection (UTI), urine retention, peripheral vascular disease, gastro-esophageal reflux disease, Alzheimer's disease, osteoarthritis, psychosis, major depressive disorder, hyperlipidemia, anxiety disorder, hypertension, bipolar disorder, atrial fibrillation and dysphagia. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/30/21 revealed the resident had clear speech, sometimes understood others, sometimes made herself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of eight. The resident required extensive assistance of one staff for bed mobility, transfers and dependent on one staff for toilet use. The resident was identified as being always incontinent of both bowel and bladder. Review of the admission assessment with baseline care plan, dated 10/19/21 revealed the resident was readmitted to the facility from an acute care hospital and was admitted with an indwelling urinary catheter. Review of the resident's bowel and bladder evaluation, dated 10/19/21 revealed the resident was incontinent of bowel and bladder. The assessment failed to identify the resident had an indwelling urinary catheter. Review of the plan of care dated 10/19/21 revealed the resident had potential for complications related to indwelling urinary catheter use. Interventions included to assist with Foley catheter care as needed, educate resident to report signs/symptoms of urinary tract infection (UTI), encourage proper nutrition and adequate fluid intake, evaluate need for catheter and supporting diagnoses and observe for signs/symptoms of UTI. Review of the resident's monthly physician's orders for October 2021 revealed an order, dated 10/19/21 for Foley catheter care every shift, change catheter collection bag as needed, change Foley catheter when blocked or unable to flow freely as needed, secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction, Foley catheter size 16 FR with 30 milliliter (ml) balloon and Foley catheter to remain covered for privacy and 10/28/21 Foley catheter for comfort care. On 10/25/21 at 1:14 P.M. observation of Resident #87's indwelling urinary catheter collection bag revealed it did not have a privacy bag and was placed under the bed directly on the floor. On 10/26/21 at 10:59 A.M. observation of Resident #87's indwelling urinary catheter collection bag revealed it was not covered and dark yellow urine was visible from the hallway. On 10/26/21 at 11:01 A.M. interview with Licensed Practical Nurse (LPN) #482 verified the resident's indwelling urinary catheter collection bag was not covered and dark yellow urine was visible from the hallway. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/21 at 11:37 A.M. observation of the resident revealed she was lying in a supine position in bed wearing a hospital gown with a disposable brief visible from the hallway. The resident's indwelling catheter collection bag was observed hanging on the bed frame above the resident's bladder. At the time of the observation, interview with LPN #406 verified the resident's indwelling urinary catheter collection bag was positioned above the resident's bladder. Review of the facility policy titled Foley Catheter Care Procedure, dated 04/2016 revealed to keep the catheter bag below the level of the resident's bladder to keep the urine from returning to the bladder and do not allow the catheter bag to touch the floor. 19571 4. Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behaviors, schizophrenia, major depression and anemia. Review of the annual MDS 3.0 assessment, dated 10/04/21 revealed the resident was cognitively impaired, he required extensive assistance of two plus staff members for bed mobility and extensive assistance of one plus staff member for toilet use, dressing and personal hygiene. On 11/01/21 at 8:55 A.M. STNA #385 was observed to take Resident #11 to the shower room. The STNA applied gloves, had the resident stand up and removed the resident's incontinent (Depends) brief. The resident was observed to have had a bowel movement. The resident refused to sit on the toilet. STNA #385 proceeded to wash the resident's buttocks and rectal area and then placed a new Depends on the resident without first washing his penis or scrotum. On 11/01/21 at 9:00 A.M. interview with STNA #385 verified the resident had been incontinent of bowel and she did not thoroughly clean around the resident's penis/scrotum area to prevent the resident from developing a urinary tract infection. Review of the policy and procedure titled Perineal Care, revised in 2018 revealed for a male resident perineal care included starting starting with the urethra and working outward.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, facility policy and procedure review and interview the facility failed to assess and implement weight loss interventions for Resident #87, a resident identified with a a significant weight loss following a hospitalization . This affected one resident (#87) of six residents reviewed for nutrition. Findings include: Review of Resident #87's medical record revealed an original admitted [DATE] with the latest readmission of 10/19/21. Resident #87 had diagnoses including pseudobulbar affect, aphasia, urinary tract infection (UTI), urine retention, peripheral vascular disease, gastro-esophageal reflux disease, Alzheimer's disease, osteoarthritis, psychosis, major depressive disorder, hyperlipidemia, anxiety disorder, hypertension, bipolar disorder, atrial fibrillation and dysphagia. Review of the plan of care, dated 02/05/21 revealed Resident #87 was at risk for alteration in nutrition and/or hydration related to behavioral problems, edentulous, need for feeding assistance and mechanically altered diet. Interventions included to address any chewing/swallowing problems that occur, address any sings of aspiration, assist with feeding needs as needed, administer medications as ordered, monitor for signs/symptoms of dehydration, monitor weight every month and as needed, observe skin condition and request dietary interventions as needed, offer finger foods, offer meal substitutes for dislikes, provide diet counseling as needed, provide diet as ordered, record consumption of meals including fluid intake and review labs as ordered. Review of the resident's medical nutrition therapy progress/quarterly note, dated 08/17/21 revealed the resident was on a regular mechanical soft diet with med pass (supplement) twice daily. The resident required assistance with eating. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/30/21 revealed the resident had clear speech, sometimes understood others, sometimes made herself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of eight. The resident had no known weight loss and received a mechanically altered diet. Review of the admission assessment with baseline care plan, dated 10/19/21 revealed the resident was readmitted to the facility from an acute care hospital and weighed 141.0 pounds upon readmission to facility. Review of the plan of care, dated 10/19/21 revealed the resident had dietary risks for weight loss/gain related to swallowing and chewing problems. Interventions included to follow physician ordered diet. Review of the resident's monthly physician's orders for October 2021 revealed an order (dated 10/19/21) for a regular diet, puree texture, nectar thick liquids and Med pass 2.0 (supplement) four ounces two times a day. This was the same supplement order as prior to the resident's hospitalization . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's weights revealed on 09/22/21 she weighed 156.3 pounds. On 10/19/21 (readmission) the resident's weight was 141 pounds which indicated a significant weight loss of 10.85% in 30 days. On 10/26/21 a weight of 141.7 pounds was obtained. Review of the medical record failed to provide evidence of a comprehensive and individualized nutritional assessment or newly implemented interventions addressing the resident's significant weight loss following re-admission. Review of the resident's meal percentages from 10/06/21 through 11/03/21 revealed the facility failed to document the resident's meal percentage intakes except one meal on 10/06/21, 10/17/21 and 10/29/21. On 10/25/21 at 2:30 P.M. observation of the resident's lunch meal revealed the staff placed a disposable container on a tray in her room and left. The resident was in bed. The meal tray had no drinks or utensils on the tray. On 10/28/21 at 2:58 P.M. interview with Registered Dietician (RD) #488 revealed she knew the resident had a weight loss on admission so added fortified foods and a magic cup at lunch and dinner. She said she also placed the resident on weekly weights. RD #488 revealed she had been assisting in the kitchen and knew there were several new admissions but had not had time to document on the resident as of this time. Review of the facility policy titled Weight Policy, dated 11/18 revealed it was the policy of the facility to attain/maintain a resident's weight within the recommended range as appropriate in relation to their medical and physical status. The Dietitian would be notified of significant changes in weights, insidious weight loss and other concerns related to diet and intake. Acute and chronic weight changes would be documented and recommendations would be provided by the dietitian as appropriate. The dietician would work with the facility staff during the routine weight meeting to review resident weight trends and determine any additional interventions for the resident's weight change.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38604 Based on observation, record review, facility policy review and interview the facility failed to ensure Resident #92's oxygen equipment was maintained in a clean and sanitary manner and failed to ensure oxygen tubing was changed per physician order. This affected one resident (#92) of three residents reviewed for respiratory care. Findings include: Review of Resident #92's medical record revealed an admitted [DATE] and diagnoses of acute respiratory failure and oxygen dependence. Review of the physician's orders, dated 09/03/21 revealed staff were to change the resident's oxygen tubing and set up every Friday. On 09/02/21 the resident was ordered oxygen on one liter via nasal cannula. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 09/09/21 revealed the resident had a Brief Interview of Mental Status (BIMS) of 02, indicating impaired cognition. The assessment revealed the resident required limited assistance from one staff for bed mobility, transfers, locomotion via walker and personal hygiene and the resident utilized oxygen therapy. Review of the care plan, dated 09/16/21 revealed the resident was at risk for respiratory insufficiency as evidenced by acute respiratory failure and oxygen dependence with interventions to auscultate lung sounds upon admission, observe the resident for difficulty breathing and elevate the head of the bed. On 10/25/21 at 11:10 A.M. observation revealed Resident #92's oxygen tubing was dated 10/09/21. On 10/27/21 at 9:56 A.M. observation and interview with Regional Director of Clinical Services #406 confirmed the date on the resident's oxygen tubing was 10/09/21. There was no evidence the oxygen tubing and set up were being changed every Friday as ordered. Review of the facility policy and procedure titled, Oxygen Administration, dated 2021 revealed staff should change oxygen tubing and delivery devices every 72 hours or per facility policy and as needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on record review and staff interview the facility failed to ensure ongoing communication with the hemodialysis center regarding care and services for Resident #109. This affected one resident (#109) of one resident reviewed for hemodialysis. Findings include: Review of Resident #109's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including end stage renal disease, dependence on renal dialysis and schizoaffective disorder. Review of the plan of care, dated 06/15/21 revealed communicate with dialysis center staff regarding plan of care, lab values and diet/fluid restriction recommendations. Nurse to utilize dialysis communication form for pre-dialysis assessment including obtaining vital signs. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 09/16/21 revealed the resident's cognition was moderately impaired. The assessment revealed the resident required supervision from staff with set up assistance for dressing and personal hygiene. The resident was independent with set up assistance from staff for bed mobility, transfers and toilet use. Review of the current physician's orders revealed an order to monitor right chest port for signs and symptoms of infection, edema and bleeding and hemodialysis days (Monday, Wednesday and Friday). Review of the communication forms between the facility and the hemodialysis center revealed the facility failed to have completed documentation of communication with the dialysis center on all the days the resident received treatment. On 08/06/21, 08/11/21, 08/13/21, 08/30/21, 09/03/21, 09/17/21, 09/22/21, 09/24/21, 09/27/21, 09/29/21, 10/01/21, 10/08/21, 10/15/21 and 10/29/21 there was no documented communication with the hemodialysis available to review in the resident's medical record information. On 11/01/21 at 3:00 P.M. interview with Registered Nurse #350 verified the above findings.

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	365644	A. Building B. Wing	11/05/2021

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Embassy of Winchester	36 Lehman Dr Canal Winchester, OH 43110

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38604 Based on record review and interview the facility failed to maintain sufficient levels of nursing staff to meet the total care needs of all residents in a timely manner. This affected eight residents (#128, #123, #33, #103, #113, #19, #98 and #105) and had the potential to affect all 134 residents residing in the facility. Findings include: 1. Review of the closed medical record for Resident #128 revealed an admitted [DATE] with diagnoses including COVID-19, heart disease, congestive heart failure, chronic kidney disease stage three, and atrial fibrillation. Record review revealed the resident was a Full Code related to advance directives. The resident expired in the facility on [DATE]. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) of 12 indicating the resident had moderate cognitive impairment. The assessment revealed the resident required extensive assistance from one staff for bed mobility and toilet use, extensive assistance from two staff for transfers, supervision with one staff assistance for locomotion and limited assistance from one staff for personal hygiene. Review of Resident #128's care plan, dated [DATE] revealed the resident/family chose CPR would be attempted during cardiac arrest with interventions to inform new caregivers of code status, nursing staff to provide chest compressions when the resident was in cardiac arrest and call ambulance for transport to the hospital, and notify family of changes in condition. Review of Resident #128's medical record revealed the resident was not receiving Hospice services and/or palliative care during his stay at the facility. The plan of care revealed the resident's goal was to return home. Review of Resident #128's care plan, dated [DATE] revealed the resident was tested and confirmed positive for COVID 19 with interventions to administer medications per physician orders, administer oxygen per physician orders, be alert for changes in activities of daily living assistance required, be alert for new or worsening symptoms including increased difficulty breathing, back or abdominal pain, increased lethargy and weakness, altered mental status and notify physician if this occurs, and follow Centers for Disease Control (CDC) and facility policies for isolation precautions related to COVID 19. Review of the physician's orders revealed an order, dated [DATE] for the resident to be placed on droplet precautions for 10 days due to COVID-19. The resident also had an order for a Full Code status. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the nurse's notes revealed on [DATE] at 5:49 P.M. Resident #128 was aware of his rapid positive COVID-19 test result and moved to the facility COVID unit. A nurse's note, dated [DATE] at 4:23 A.M. revealed the resident continued to refuse all care this shift. Certified Nurse Practitioner (CNP) #547 was notified at 2:48 A.M. and gave a new order to send the resident to the emergency room for further evaluation. Paramedics (EMT) were contacted for transport. The nurse's notes revealed the resident was unresponsive upon EMT arrival at 3:10 A.M. and CPR was started, the resident was pronounced dead at 3:46 A.M. and CNP #547 was notified. A note, dated [DATE] at 8:45 A.M. revealed the resident was discharged . On [DATE] at 11:21 A.M. interview with EMT/Paramedic #545 revealed they received a call around 3:00 A.M. that a resident was refusing his medications and care and needed an evaluation at the hospital. He stated they (himself and EMT #546) arrived at the facility a few minutes later but had not been notified the resident they were going to pick up was COVID positive, so they went to the front entrance door. Two staff were sitting behind the counter staring at them and didn't get up and answer the door. EMT/Paramedic #546 started aggressively pounding on the door until someone answered who directed them to another door stating they were going to an isolation door. When they arrived at the second door, they felt they woke the staff up and that staff stated the resident was on another isolation wing and sent them to a third door on the other side of the building. They loaded up the cot they had, and a staff member apologized for the confusion. They headed to the third door and changed their respirators to be prepared for a covid positive resident. When they finally got into the third door about eight to twelve feet into the hall, they heard a staff member saying CPR in progress. He stated the ball game had changed at this point because they were told this was a simple transport to the hospital. When EMT staff arrived at the resident's room, there were no staff in the room, the resident was slumped over in his wheelchair with dried bodily fluids on his shirt and in his nares and CPR was not in progress. EMT #545 revealed even if CPR had been initiated, it wouldn't have been effective (as the resident was in a wheelchair). Paramedic #546 moved the resident to the ground and initiated manual CPR while Paramedic #545 went back out to the ambulance to retrieve a [NAME] Device (portable device that delivers consistent chest compression). When he got back into the facility Paramedic #546 was still doing CPR with no staff assisting him. He stated he also had the [NAME] Device in his arms and the resident's wheelchair was still in front of the resident's door, no one helped move the wheelchair so he had to set the [NAME] Device down to move the wheelchair himself, then pick the [NAME] Device back up and apply it to the resident. On [DATE] at 3:55 P.M. and again on [DATE] at 1:14 P.M. interview with Agency LPN #542 revealed she was working in the facility on [DATE] and assigned to care for Resident #128. The LPN revealed when she got onto the unit Resident #128 was refusing medications, meals and care and he did the same during her night shift. She stated around 10:30 P.M. the CNP was called for new orders and she stated the resident was just having a behavior, it was his normal and staff could just monitor him. LPN #542 revealed around 2:00 A.M. or something CNP #547 told staff to send the resident out for an evaluation. LPN #542 revealed she printed everything for EMS and called the paramedics. LPN #542 revealed she saw the resident around five minutes before EMS arrived and he was fine, then she went to answer another resident's call light and when she came out to let EMS in, she noticed the resident was unresponsive in his chair. LPN #542 revealed she and the paramedics got the resident out of the wheelchair and started CPR. They did CPR for about 30 minutes until they pronounced the resident deceased . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At the time of the incident, LPN #542 revealed she was the only staff member working on the COVID unit. There were no STNAs or other staff with her on the unit, it was just herself, but she didn't think she needed any STNAs to help as she did okay on her own. Agency LPN #542 revealed paramedic staff covered Resident #128 with a sheet, but the resident didn't have any funeral home listed so she asked a supervisor. Agency LPN #542 revealed about an hour later she was provided information on which funeral service to use so she set up the transport. Agency LPN #542 revealed there were no STNA staff working with her on the unit, she was working by herself and just left the resident on the floor covered with the sheet awaiting the funeral home to arrive. Agency LPN #542 verified the resident had urine and feces on him at the time he passed away and verified she had not provided any type of personal or post-mortem care to the resident. Agency LPN #542 revealed she left the facility at the end of her shift around 7:00 A.M., at which time the funeral home had not arrived. Agency LPN #542 indicated she was not sure what time the funeral home arrived that morning. During the interview, Agency LPN #542 verified she did not complete post-mortem care for Resident #128, the agency LPN revealed if you have help you can do the care, but she didn't have any help. Agency LPN #542 revealed she was not sure what the facility policy was on post mortem care so she wasn't sure if it was unacceptable the care wasn't provided. On [DATE] at 2:21 P.M. interview with the DON revealed the expectation following a resident's death would be for post-mortem care to be completed once everything had calmed down. The DON revealed it should not be multiple hours after a after the resident's death. On [DATE] at 1:01 P.M. interview with a staff member who wished to remain anonymous (Staff #544) revealed she worked the day shift on [DATE] and the resident was lethargic, had refused all care and was spitting at staff. Staff #544 revealed she notified the certified nurse practitioner (CNP) and the CNP revealed this was typical behavior of the resident, to refuse care and to notify the CNP if it continued. Staff #544 revealed the resident would let her check his oxygen saturation which was about 96% on room air but stated the resident wouldn't allow her to take any other vital signs. Staff #544 revealed on [DATE] when she arrived to work, around 7:00 A.M.-7:15 A.M. she found Resident #128 deceased on the floor. Staff #544 revealed she had to provide personal care to the resident. Staff #544 revealed no staff had provided post-mortem care to Resident #128 immediately after he passed away. Staff #544 revealed funeral transport arrived to the facility at approximately 8:00 A.M. and she did offer to assist moving the resident off the floor but they declined. Staff #544 revealed she had not notified anyone related to the condition of the resident because the resident had been deceased for hours and she assumed someone had known and would have already notified administrative staff. On [DATE] at 2:43 P.M. interview with Contracted Funeral Home Transport (CFHT) #543 revealed when he arrived at the facility around 8:00 A.M. Resident #128 was laying on the floor, in soiled clothes (stated urine and feces), his skin had not been taken care of, his mouth and eyes were wide open and his arms were at his side. CFHT #543 revealed he did not recall what the resident's shirt looked like, but stated he had to wipe dried mucus off the resident's face and nose. CFHT #543 revealed he had to pull the defibrillator paddles off of him, remove the IV from his arm and stated the resident was still in the clothes EMS staff cut off of him. CFHT #543 revealed when he rolled the resident, blisters on his legs were popping, his skin was noted with skin slippage. CFHT #543 revealed the resident's body was definitely starting to decompose. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy and procedure titled, Medical Emergency Response, dated [DATE] revealed in the event of a medical emergency any staff member, visitor or resident may initiate a medical emergency response. Staff would immediately notify the nurse in charge of the unit and they would announce a code blue and the general location. Staff in the vicinity would respond to the area immediately. The (resident's) code status would be verified by the nurse, staff would obtain a crash cart and 911 would be called. Once CPR was initiated, responders would continue until a physician provided the order to stop, the resident recovered with heart beat and breaths or emergency response team arrived and took over and transported the resident to a higher level of care. Review of the facility policy and procedure titled, Post-Mortem Care, dated [DATE] revealed residents who expire in the building receive the care appropriate for transporting to a receiving facility. The policy revealed post-mortem care was provided for a resident after their death had been pronounced and appropriate persons and agencies had been notified. The policy indicated the resident should be treated with dignity and respect; nurses would remove intravenous lines (IVs), tubes, catheters and replace soiled dressings; the residents' body should be washed carefully and the clothes should be changed if soiled. 2. On [DATE] at 10:31 A.M. interview with Resident #123 revealed concerns there were not enough nursing staff working in the facility. The resident did not share any specific concerns or dates/times of a lack of staff but rather indicated it was a general concern with the facility. On [DATE] at 12:49 A.M. interview with Resident #33 revealed concerns there were not enough nursing staff working in the facility. The resident did not share any specific concerns or dates/times of a lack of staff but rather indicated it was a general concern with the facility. On [DATE] 11:45 A.M. interview with Resident #103 revealed concerns there were not enough nursing staff working in the facility. The resident did not share any specific concerns or dates/times of a lack of staff but rather indicated it was a general concern with the facility. 43060 On [DATE] at 1:33 P.M. interview with STNA #537 revealed she was the only STNA scheduled on this date on her assigned unit, the E hall/West Building. There were 20 residents on the hall including residents who required two or more staff for assistance with care and/or transferring. STNA #537 revealed she was unable to deliver all care the residents' required being the only scheduled STNA on the unit. The STNA revealed many days when there was only one STNA assigned to care for the residents on this hall. On [DATE] at 11:02 A.M. interview with Resident #98 and Resident #105 revealed both residents attended Resident Council meetings regularly and Resident #98 was the Resident Council President. During the interview, Resident #98 and Resident #105 voiced concerns there was not enough staff to answer call lights and provide the care and assistance resident's needed. Resident #98 and Resident #105 revealed they sometimes waited an hour or more for call lights to be answered and sometimes the staff don't answer the call light at all. Review of the facility policy titled Call Lights, revised ,d+[DATE] revealed staff would attempt to respond to call lights timely and resolve the issue. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	43064 3. During the onsite recertification, extended and complaint survey concerns were identified related to the facility not developing and implementing comprehensive and individualized behavior management programs for residents (including Resident #113) with dementia to prevent resident to resident altercations and to ensure each resident maintained their highest practicable physical, mental and psychosocial well-being. See findings at F744. Resident #113 resided on the D hall which had a total census of 21 residents. Review of a facility self-reported incident, dated [DATE] revealed there was an allegation of physical abuse between two residents, Resident #19 and Resident #113. According to the summary of the incident Resident #113 stated Resident #11 struck her. The nurse completed a head to toe assessment with no negative outcomes. The residents were separated, and the doctor and responsible parties were notified. Review of the witness statement, dated [DATE] revealed Nurse Aide #301 was on the D hall by herself. Resident #19's door was open and Resident #113 entered the room. Nurse Aide #301 revealed she was in the doorway when Resident #19 yelled at Resident #113 to get out and jumped up to pin her against the door. The aide separated the two, Resident #19 stood there and as she was trying to talk her down, she punched Resident #113 in the face. Resident #19 grabbed the aide by the left arm roughly. The aide was able to free herself and get Resident #113 out of the room. Review of the witness statement dated [DATE], revealed Nurse Aide #541 was on a different hall when the incident occurred. She stated when she returned to the D Hall, Nurse Aide #301 reported she had to break up a fight between Resident #19 and Resident #113. Review of the witness statement dated [DATE], revealed LPN #497 was on the A Hall passing dinner trays when Nurse Aide #301 came to get her (related to the incident). On [DATE] at 3:05 P.M. interview with STNA #444 revealed staff needed to keep eyes on Resident #113 all day, every day, to prevent incidents with other residents. She reported Resident #113 was constantly wandering around the unit and in resident rooms. She reported residents got aggravated with Resident #113 because she wandered, entered other people's space and was grabby. STNA #444 revealed ideally there would be two STNAs on the unit, one STNA in the dining room at all times to monitor the room and the hallway and another STNA to address residents in their rooms. On [DATE] at 3:14 P.M. interview with LPN #327 revealed it was difficult to manage the D Hall with one staff member. She revealed this was because one person could not help the residents as needed and watch everyone. On [DATE] at 10:05 A.M. interview with STNA #456 revealed it was difficult to manage the D Hall with one staff member on the unit. She stated, there's nothing I can do to prevent wandering when I am by myself'. STNA #456 revealed if she was with another resident, she was unable to prevent Resident #113 from wandering into resident rooms. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] from 2:45 P.M. to 3:30 P.M. interview with the Administrator, Director of Nursing, and the Regional Director of Clinical Services #407 revealed they were aware of Resident #113's wandering. The Administrator confirmed there was only one staff member on the unit at the time of the incident. The Administrator revealed ideally there would be 1.5 to 2.0 staff members on both units. Review of the facility staffing schedule for [DATE] confirmed there was only one staff member on the D hall/East building at the time of the incident.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, record review, review of facility self-reported incidents (SRIs), review of facility investigations and interview the facility failed to develop and implement comprehensive and individualized behavior management programs for residents with dementia to prevent resident to resident altercations and to ensure each resident maintained their highest practicable physical, mental, and psychosocial well-being. This affected five residents (#10, #19, #113, #126 and #127) with the potential to affect all 21 residents residing on D hall/East Building and two residents (#13 and #111) with the potential to affect all 19 residents residing on A hall/East Building. The facility census was 134. Findings include: 1. Review of the medical record revealed Resident #113 admitted to the facility on [DATE] with diagnoses including aphasia, metabolic encephalopathy, Alzheimer's disease, major depressive disorder, essential hypertension, type two diabetes mellitus, dysphagia, obsessive-compulsive disorder, anxiety disorder. Review of the plan of care, dated 10/01/20 revealed Resident #113 had a behavior problem related to diagnoses of dementia, confusion, poor awareness of others personal space, history of biting another resident, resistance to care, combative with caregivers including hitting and pinching during care and tendency to take food from other meal trays. Interventions included administering medications as ordered, anticipating and meeting needs as able, documenting behavior, informing doctor or nurse practitioner of worsening behavior, intervening as needed to protect the rights and safety of others, praise all appropriate behaviors, remind resident that behavior is unacceptable and redirect. Additional review of the plan of care, dated 05/05/21 revealed the resident was at risk for wandering and elopement and was currently on a secured unit. Interventions included developing an activity program to divert attention and meet individual needs, discuss with resident and family the risks of wandering, redirect if resident was wandering in potentially unsafe area or situation, and observing and reporting to doctor risk factors for potential elopement. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 09/20/21 revealed Resident #113 was rarely or never understood. The resident experienced physical behavioral symptoms directed towards others and verbal behavioral symptoms directed towards others one to three days during look back period. She rejected care four to six days during look back period and experienced wandering four to six days. Review of the physician's orders revealed an order dated 07/08/21 to redirect Resident #113 when seen entering other's rooms. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including other schizoaffective disorder, type two diabetes mellitus, anxiety disorder, major depressive disorder, hypertension, unspecified dementia with behavioral disturbance, and aphasia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS 3.0 assessment, dated 10/06/21 revealed Resident #19 had a Brief Interview for Mental Status (BIMS) of seven indicating severe cognitive impairment. Review of a facility self-reported incident, dated 07/08/21 revealed there was an allegation of physical abuse between two residents, Resident #19 and Resident #113. According to the summary of the incident Resident #113 stated Resident #11 struck her. The nurse completed a head to toe assessment with no negative outcomes. The residents were separated, and the doctor and responsible parties were notified. The incident was determined to be unsubstantiated by the Administrator. The actions the facility took included separating the residents and Resident #19 was moved to a different room or area per the request of the responsible party. Review of the change in condition evaluation dated 07/08/21, revealed there had been a resident-to-resident interaction involving Resident #113. The resident's skin and pain were assessed with no concerns and neurological checks were initiated. Review of the incident report dated 07/08/21 for Resident #19 revealed Resident #113 had wandered into her room and Resident #19 yelled at her to get out. Resident #19 pinned Resident #113 against the wall. A State tested Nursing Aide (STNA) separated the two residents, in the meantime, Resident #19 struck Resident #113 in the face. Resident #19 denied the incident, she was assessed with no negative outcomes and placed on 15-minute checks. The predisposing factor was listed as another resident entering Resident #19's room. Review of the incident report, dated 07/08/21 for Resident #113 repeated the narrative in the incident report for Resident #19. The intervention that was implemented was to redirect Resident #113 when seen wandering into other rooms. The predisposing factors for the resident were confusion and wandering. The skin and pain assessments revealed no concerns and neurological checks were initiated. Review of the witness statement, dated 07/08/21 revealed Nurse Aide #301 was on the D hall by herself. Resident #19's door was open and Resident #113 entered the room. Nurse Aide #301 revealed she was in the doorway when Resident #19 yelled at Resident #113 to get out and jumped up to pin her against the door. The aide separated the two, Resident #19 stood there and as she was trying to talk her down, she punched Resident #113 in the face. Resident #19 grabbed the aide by the left arm roughly. The aide was able to free herself and get Resident #113 out of the room. Review of the witness statement dated 07/08/21, revealed Nurse Aide #541 was on a different hall when the incident occurred. She stated when she returned to the D Hall, Nurse Aide #301 reported she had to break up a fight between Resident #19 and Resident #113. Review of the witness statement dated 07/08/21, revealed LPN #497 was on the A Hall passing dinner trays when Nurse Aide #301 came to get her (related to the incident). On 10/25/21 at 3:05 P.M. interview with STNA #444 revealed staff needed to keep eyes on Resident #113 all day, every day, to prevent incidents with other residents. She reported Resident #113 was constantly wandering around the unit and in resident rooms. She reported residents got aggravated with Resident #113 because she wandered, entered other people's space and was grabby. STNA #444 revealed ideally there would be two STNAs on the unit, one STNA in the dining room at all times to monitor the room and the hallway and another STNA to address residents in their rooms. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/26/21 at 3:14 P.M. interview with LPN #327 revealed it was difficult to manage the D Hall with one staff member. She revealed this was because one person could not help the residents as needed and watch everyone. On 10/27/21 at 10:05 A.M. interview with STNA #456 revealed it was difficult to manage the D Hall with one staff member on the unit. She stated, there's nothing I can do to prevent wandering when I am by myself'. STNA #456 revealed if she was with another resident, she was unable to prevent Resident #113 from wandering into resident rooms. On 10/27/21 from 2:45 P.M. to 3:30 P.M. interview with the Administrator, Director of Nursing, and the Regional Director of Clinical Services #407 revealed they were aware of Resident #113's wandering. They reported it was difficult to redirect Resident #113 at times. In reference to the 07/08/21 incident the DON and Administrator confirmed the best practice when dealing with a resident to resident interaction would have been to get Resident #113 out of the room as soon as possible. The DON and Administrator were unsure why the STNA stayed to talk Resident #19 down but said Resident #19 was a larger woman and could have gotten around the STNA to get to Resident #113. The Administrator confirmed there was only one staff member on the unit at the time of the incident. The Administrator revealed ideally there would be 1.5 to 2.0 staff members on both units. The Administrator revealed the facility unsubstantiated an incident of resident to resident abuse because Resident #19 did not have cognitive intent. The DON revealed with Resident #11's dementia her mental status fluctuated. Additionally, the Administrator confirmed the 07/08/21 self-reported incident did not reflect the incident was witnessed. However, based on record review and the investigation completed, there was no evidence the facility had implemented comprehensive and individualized behavior management programs for Resident #113 or Resident #19 to prevent the resident to resident altercation and no evidence the facility had provided adequate supervision to the residents residing on the D hall to prevent this incident from occurring. 2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, epilepsy, liver disease, dementia, obsessive compulsive disorder, schizophrenia and dysphagia. Review of the quarterly MDS 3.0 assessment, dated 10/05/21 revealed Resident #10 had severely impaired cognition. The resident had physical and verbal behaviors directed towards others one to three days during look back period. (continued on next page)

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	365644	A. Building B. Wing	11/05/2021

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a self-reported incident (SRI), dated 08/26/21 revealed an allegation of physical abuse was reported to the State agency involving Resident #10. The brief description of the allegation revealed resident entered another resident room. Resident residing in room became upset and made physical contact with visiting resident. The perpetrator was listed as being another resident, but no name was provided. The involved resident's section revealed Resident #10 was confused and unable to provide meaningful information but had slight redness to her cheek. The summary of the incident revealed staff reported the resident entered a resident's room and as staff were entering to intervene, the resident who resided in the room became upset and made contact with her open hand to the resident's cheeks. Slight redness was noted initially but faded quickly and no residual skin alterations were noted. Staff immediately separated the residents and placed the wandering resident on increased supervision to ensure she did not re-enter room. An allegation of physical abuse was determined to be unsubstantiated. The facility determined the event did not meet criteria for abuse as neither resident was able to express intent and reacted due to their diagnoses. The resident's skin was unremarkable and neither resident recalled the event. Following the incident, staff were educated on behaviors and redirecting residents who wander. Review of an interdisciplinary progress note for Resident #113, dated 08/26/21 revealed the resident had an altercation with another resident and was slapped by that resident. The intervention was to separate the residents and apply ice to the resident's face. Review of the nurse's progress note for Resident #113, dated 08/26/21 revealed the nurse was called to the unit by an STNA, the resident had been slapped hard on the left side of the face. The area was slightly puffy and red, and ice was applied. The two residents were separated, Resident #113 was noted to be ambulating in the hall and the other resident was in her room Review of the incident report for Resident #10, dated 08/26/21 at 7:13 A.M. revealed the resident was observed by the STNA slapping another resident in the face, the resident denied the allegation. The predisposing factors to the incident were noise, clutter, ambulating without assistance, and Resident #10 had other residents she did not like. Review of the incident report for Resident #113, dated 08/26/21 at 6:30 A.M. revealed an STNA observed the resident being physically abused by another resident. The resident was slapped by another resident on the left facial cheek with a red mark noted. The residents were immediately separated, and ice was placed on the resident's left cheek. The resident had a pain rated a two based on facial expression and body language. The predisposing factors to the incident were active exit seeker and wanderer. On 10/27/21 from 2:45 P.M. to 3:30 P.M. interview with the Administrator and the Director of Nursing confirmed the SRI reported to the state did not reflect Resident #113's part in the incident, it was additionally confirmed the SRI did not match what occurred according to the incident reports and made it appear as though Resident #10 was the victim of physical abuse. In addition, based on record review and the investigation completed, there was no evidence the facility had implemented comprehensive and individualized behavior management programs for Resident #113 or Resident #10 to prevent the resident to resident altercation and no evidence the facility had provided adequate supervision to the residents residing on the D hall to prevent this incident from occurring. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 10/25/21 from 12:55 P.M. to 1:37 P.M. and 10/26/21 from 3:20 P.M. to 4:55 P.M. observation revealed Resident #113 wandering up and down the hallway and in the dining room. On 10/26/21 at 3:24 P.M. she entered another resident's room. On 10/25/21 at 1:37 P.M. observation revealed STNA #456 was passing lunch trays, behind her Resident #127 was standing in the doorway of a room (not her own) asking for salt. Resident #113 was walking past the room Resident #127 was standing in and Resident #127 rushed over and pushed her, yelling get out of here. Resident #113 stepped back and began walking down the hallway again. At 1:39 P.M. Resident #113 walked by Resident #127 again, Resident #127 pushed her with two hands against her chest. STNA #456 separated the two residents and redirected Resident #113 down the hallway. STNA #456 directed Resident #127 back to the room she had been in, spoke to her and shut the door. She then informed STNA #444 she was going to get the nurse and asked her to watch Resident #113. At 1:42 P.M. LPN #497 arrived to the unit to assess Resident #113. Review of the medical record revealed Resident #127 was admitted to the facility on [DATE] with diagnoses including alcohol abuse, anxiety disorder, major depressive disorder, gastro-esophageal reflux disease, encephalopathy, dysphagia and cognitive communication deficit. Review of the quarterly MDS 3.0 assessment for Resident #127, dated 09/28/21 revealed the resident had severely impaired cognition. The resident experienced wandering and refusal of care one to three days during look back period. Review of the in-progress self-reported incident, dated 10/25/21 revealed there was an allegation of physical abuse between two residents (Resident #113 and #127). Both residents were listed as having dementia and it was documented the incident had no ill effect on them. Review of the physician's orders for Resident #113 revealed an order, dated 10/25/21 to involve in activities as tolerated. Review of a staff statement, dated 10/25/21 by STNA #456 revealed she was passing trays on the hall when Resident #127 came to her door asking for salt, Resident #113 walked up to Resident #127's door and was pushed. She reported she took Resident #113 down to the dining room to separate them and then reported the incident to the nurse. Review of the staff statement, dated 10/25/21 by STNA #444 revealed around 1:40 P.M. she heard somebody scream in the hallway while she was in a room with a resident. She stopped everything and saw Resident #113 running away from Resident #127. She believed the residents may have had an argument that made Resident #127 push Resident #113. Review of the staff statement, dated 10/25/21 by LPN #497 revealed she was on the A Hall when she was notified of Resident #127 pushing Resident #113. She went to the D Hall and both residents were already away from each other. On 10/25/21 at 2:12 P.M. interview with STNA #444 revealed she did not witness the incident between Resident #113 and #127. She reported she was aware Resident #127 was trying to find help and she heard her say go away. She stated by the time she arrived in the hallway Resident #113 was walking away. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/21 at 2:16 P.M. interview with STNA #456 revealed the information provided was consistent with her written statement. On 10/27/21 at 9:52 A.M. interview with Activities #329 and Activities #452 revealed Resident #113 did not participate in a lot of activities. They reported Resident #113 would get aggravated when they tried to get her to sit for activities. They revealed she wandered and observed group activities, otherwise they would do activities with her while she wandered, including snacks, reading and music. Activities #329 and #452 reported they had not found an activity that prevented the resident from wandering. They reported her wandering did include entering rooms and she was stated she was difficult to redirect. Activities #452 reported the most effective method was to dance with her and direct her away from rooms. On 10/27/21 from 2:45 P.M. to 3:30 P.M. interview with the Administrator, Director of Nursing and Regional Director of Clinical Services #407 confirmed the intervention for the 10/25/21 incident was to include the resident in activities. The Administrator and DON additionally confirmed this had been a part of Resident #113's care plan to prevent wandering prior to the incident. They were aware Resident #113's activities usually included the activities staff following her while she wandered and reported it was difficult to distract her. The Administrator stated a stop sign had been put on the room Resident #127 had been in that day. He stated this intervention did not last long as the resident continuously pulled the sign down. 4. On 10/25/21 at 1:55 P.M. observation of the dining room revealed the Administrator and STNA #444 were present in the area. At the time of the observation, Resident #113 grabbed Resident #126's coffee. Resident #126 yelled at Resident #113 and grabbed the resident's arm. STNA #444 redirected Resident #113 down the hallway. At 1:57 P.M. Resident #113 came back and reached for another resident's belongings. Resident #126 grabbed Resident #113's hand and told her to get out of her face. At 1:59 P.M. STNA #444 escorted Resident #113 to her room while the Administrator pulled up a chair at the table with Resident #126. Review of the medical record revealed Resident #126 admitted to the facility on [DATE] with diagnoses including heart disease, encephalopathy, altered mental status, hypertension, unspecified dementia without behavioral disturbance, delusional disorders and cognitive communication deficit. Review of the quarterly MDS 3.0 assessment Resident #126, dated 09/27/21 revealed the resident had a moderate cognitive impairment. No behavior concerns were documented. Review of the facility SRI's dated 10/25/21, 10/26/21 and 10/27/21 revealed no evidence this incident had been reported to the State agency as an incident of potential abuse. Review of a witness statement by STNA #444, dated 10/25/21 revealed at lunch time in the dining room Resident #126 was about to touch Resident #113 because she grabbed her cup of coffee, but she had prevented that. She reported she asked Resident #126 to return to her seat and redirected Resident #113 down the hallway. On 10/25/21 at 2:57 P.M. interview with Licensed Practical Nurse (LPN) #327 revealed she was unaware of any negative interactions between Resident #126 and Resident #113. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/21 at 3:05 P.M. interview with STNA #444 confirmed she observed the interaction between Resident #126 and Resident #113 on 10/25/21 resulting in Resident #126 grabbing Resident #113. She additionally stated nursing should be informed immediately of instances where residents put their hands on each other. On 10/27/21 from 2:45 P.M. to 3:30 P.M. interview with the Administrator, Director of Nursing and Regional Director of Clinical Services #407 confirmed the incident involving Resident #113 and Resident #126 had not been reported to the State on 10/25/21, as they did not believe it was a reportable incident. The Administrator confirmed he was in the dining room at the time of the incident, that Resident #113 was wandering around the dining room table, and that he sat at the table with Resident #126, but he denied observing a physical interaction. The DON stated she was told Resident #126 placed her hand on Resident #113's arm but she did not view this as harmful. It was confirmed STNA #444's witness statement said the contact did not happen, which was contrary to what was observed and what the DON stated she was told. The DON related this discrepancy to language barriers as the STNA was from a different country. RDCS #407 revealed the incident was not reported to the State agency because residents on the dementia unit touch each other all the time and the intent mattered. RDCS #407 then said she did not feel any interactions with demented resident's should be reported to the State as they did not have the intent to harm. Interview revealed the plan was to continue to attempt to redirect and involve Resident #113 in activities to prevent further resident-to-resident interactions. However, there was no evidence of any type of new interventions being implemented to address the resident's psychosocial needs related to her diagnosis of dementia. 19571 5. Review of Resident #13's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia without behaviors, major depression and encephalopathy. Resident #13 resided on the facility A hall, a memory care unit. Review of Resident #13's quarterly MDS 3.0 assessment dated [DATE] revealed the resident was cognitively impaired, he required supervision from staff for transfers and toilet use and extensive assistance from one staff member for dressing and personal hygiene. There were no behaviors identified on the MDS assessment. Review of Resident #13's plan of care, dated 10/09/21 revealed the resident was at high risk for wandering into other's space. Interventions included to redirect when resident goes into other residents' personal space. Review of a progress notes, dated 10/13/21 revealed Resident #111 pushed Resident #13 out of his room. Resident #13 fell to ground and hit his head. An STNA saw the resident fall to the ground and immediately notified the charge nurse. Resident #13 was assessed to have a laceration to the right eye area, was unbalanced and complained of pain to the left knee. The physician was notified and new orders were obtained to send the resident to the emergency room for an evaluation. Resident #13 was diagnosed with a fractured patella (knee), was sent back to facility with an immobilizer and an order for a follow up appointment with orthopedic doctor. Resident #111 was placed on 15 minute checks. The note revealed both residents' were located on the memory care unit. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility self-reported incident, dated 10/09/21 revealed Resident #111 (who had a Brief Interview for Mental Status (BIMS) score of six (cognitive impairment) was in his room when Resident #13 wandered into the room. Resident #111 got upset and yelled Get out of room and pushed Resident #13 to the ground. Staff immediately went to Resident #111's room and separated both residents. Resident #111 was placed on 15 minute checks and staff were educated when Resident #111 was in his room to try and keep his door closed. The SRI documented no injuries were noted. However, Resident #13 sustained a fractured knee and laceration to his right eye. The SRI revealed to try to redirect Resident #13 when seen entering other residents' rooms. Review of the incident revealed there was no evidence the facility had implemented comprehensive and individualized behavior management programs for Resident #13 or Resident #111 to prevent the resident to resident altercation and no evidence the facility had provided adequate supervision to the residents residing on the A hall to prevent this incident from occurring. On 11/01/21 at 10:39 A.M. the DON verified the above resident to resident altercation had occurred. No additional information was provided to show evidence of the implementation of comprehensive and individualized behavior management programs to address the total care needs for residents with dementia.

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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** 38604 Based on record review, facility policy and procedure review and interview the facility failed to ensure medications were available for administration as ordered. This affected three residents (#31, #91 and #282) of 51 sampled residents. Findings include: 1. Review of the medical record for Resident #91 revealed an admitted [DATE] with diagnoses including intellectual disabilities, psychosis, mood disorder, weakness, insomnia, difficulty walking, need for assistance with personal care and paranoid schizophrenia. Review of the care plan, dated 08/26/21 revealed Resident #91 had impaired cognitive process for daily decision making and she was at risk for further decline in cognitive function. Interventions included to encourage the resident to make routine daily decisions and administer medications as ordered. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 09/08/21 revealed a Brief Interview of Mental Status (BIMS) of 11 indicating impaired cognition. The assessment revealed the resident was independent for activities of daily living. Review of a nurse's note, dated 10/13/21 at 11:38 A.M. revealed the nurse spoke with resident about her allergy pill. The resident was requesting to take Claritin-D instead of just Claritin. Resident stated the Claritin wasn't working and she used to take Claritin-D and it worked better. The physician was notified. Review of the physician's orders revealed the resident was ordered Claritin 10 mg daily for allergies until 10/13/21 when it was discontinued and the resident started on Claritin-D Extended Release 24 Hour 10-240 milligram (mg) as needed for congestion. Review of the Medication Administration Record (MAR) revealed the medication was administered on 10/30/21 and 11/01/21. On 10/25/21 at 10:16 A.M. interview with Resident #91 revealed her eyes were hurting and watering because she needed her allergy medications. She stated she was started on Claritin but she said it didn't work. On 10/25/21 at 2:00 P.M. interview with Regional Director of Clinical Services (RDCS) #406 revealed staff had ordered The Claritin-D but they had to wait on pharmacy. On 11/02/21 at 12:33 P.M. during a follow up interview, RDCS #406 revealed staff had not ordered the medication until 10/25/21. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/02/21 at 1:35 P.M. interview with RDCS #406 revealed the Claritin D medication was in the cart the whole time with a date of 09/30/21 and staff just didn't see it in the cart in order for it to be administered to the resident as ordered. Review of the facility undated policy and procedure titled, Administering Medications revealed medications shall be administered in a safe and timely manner as prescribed. 2. Medical record review for Resident #282 revealed an admitted [DATE] with diagnoses including pancreatitis, depression, [NAME] syndrome, anxiety, migraines, bipolar disorder, diabetes type two, cognitive communication deficit, other signs and symptoms involving cognitive functions and awareness and panic disorder. Review of the care plan, dated 10/06/21 revealed the resident had the potential for mood swings and behavioral issues related to depression, anxiety, bipolar, attention deficit hyperactivity disorder (ADHD) and panic disorder with interventions to administer medications as ordered. Review of the MDS 3.0 assessment, dated 10/07/21 revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. The assessment revealed the resident was independent for activities of daily living and had behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Review of the residents physician orders revealed an order for Clonazepam 1 mg with instructions to give three times daily (6:00 A.M., 2:00 P.M., and 10:00 P.M.) for anxiety. Review of the Medication Administration Record (MAR) revealed the medication was not administered on 10/09/21 at 2:00 P.M. or 10:00 P.M. Review of the nurse's notes from 10/09/21 at 11:58 P.M. revealed the resident's Clonazepam 1 milligram (mg) for anxiety was not received. Pharmacy contacted and confirmed delivery of the medication for tonight but the medication had not arrived. Pharmacy contacted again stating the medication would be in the morning tote. The physician was notified. On 11/03/21 from 12:36 P.M. through 12:54 P.M. interview with RDCS #406 confirmed Resident #282 did not receive both doses of Clonazepam on 10/09/21 in the afternoon. RDCS #406 revealed the medication was available in the facility emergency medication kit (EBox), but it was 0.5 mg. RDCS #406 further revealed there were four of the Clonazepam 0.5 mg doses in the EBox which could have been used to administer to Resident #282. Review of the facility policy and procedure titled Controlled Substances, dated 06/21/17 revealed it was the facility and prescriber responsibility to obtain the required prescription needed to meet the needs of the resident. 19571 3. Review of Resident #31's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia, atrial fibrillation, osteoporosis and encephalopathy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS 3.0 assessment, dated 07/17/21 revealed the resident required extensive assistance from two plus staff members for bed mobility, dressing and personal hygiene and total dependence from two plus staff members for transfers and toilet use. Review of the physician's orders revealed Resident #31 had an order (status post hospitalization on [DATE]) for Afrin Nasal Spray two sprays into each nostril twice a day until 11/03/21 at 2:31 P.M. On 11/02/21 at 2:31 P.M. interview with Licensed Practical Nurse (LPN) #327 revealed the nasal spray was not available to administer to Resident #31, had not been administered and she would need to call pharmacy about it. Review of the Medication Administration Record (MAR) revealed nursing staff were incorrectly documenting the Afrin nasal spray had been given on 11/01/21 and 11/02/21 even though it was unavailable from pharmacy on these dates.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38604 Based on record review and interview the facility failed to timely clarify conflicting physician recommendations from a pharmacy medication regimen review dated 06/23/21 to ensure Resident #79 received appropriate care and treatment related to the use of an anti-anxiety medication. This affected one resident (#79) of six residents reviewed for unnecessary medication use. Findings include: Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses of anxiety, depression, psychosis, dementia with behavior disturbances, encephalopathy and insomnia. Review of the care plan, dated 06/10/20 revealed the resident had the potential for mood swings and behavioral issues related to depression, psychosis and anxiety. Interventions included to administer as needed medications as ordered when the resident exhibited any increased agitation, anxiety, pacing, hallucinations, mood changes, restlessness, wandering or abusive behaviors, etc. Review of the resident's physician orders revealed from 06/19/21 through 07/07/21 the resident had an order for Ativan 0.5 milligrams (mg) as needed every four hours for shortness of breath. Review of the medication regimen reviews (MRR) revealed on 06/23/21 the resident was receiving Ativan 0.5 mg every four hours as needed and the pharmacist recommended the facility document the rationale for the medication if it was to continue past 14 days in duration. On 07/06/21 a nurse practitioner ordered the medication to be discontinued, and it was discontinued on 07/07/21. On 07/29/21 a different physician reviewed the same MRR (dated 06/23/21) and ordered the Ativan medication to continue, documenting the resident had anxiety related to the dying process and to continue the medication for 14 days. However, no order for the medication was written on this date. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/17/21 revealed a Brief Interview of Mental Status (BIMS) of 10 indicating impaired cognition. The assessment revealed the resident required supervision one staff assist for bed mobility and locomotion. The assessment revealed the resident had no behaviors. On 11/02/21 at 9:58 A.M. interview with the Director of Nursing (DON) confirmed the physician recommendation on 07/29/21 was not clarified and no order for Ativan was written at that time.

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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** 38604 Based on record review, facility policy and procedure review and interview the facility failed to ensure as needed (PRN) psychotropic medications were limited to 14 days without a rationale extending the medication for Resident #79 and failed to ensure non-pharmacological interventions were attempted prior to the use of an as needed psychotropic medication for Resident #87. This affected two residents (#79 and #87) of six residents reviewed for unnecessary medications use. Findings include: 1. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including anxiety, depression, psychosis, dementia with behavior disturbances, encephalopathy and insomnia. Review of the care plan, dated 06/10/20 revealed the resident had the potential for mood swings and behavioral issues related to depression, psychosis and anxiety. Interventions included to administer as needed medications as ordered when the resident exhibited any increased agitation, anxiety, pacing, hallucinations, mood changes, restlessness, wandering or abusive behaviors, etc. Review of the resident's physician orders revealed an order from 06/19/21 through 09/09/21 for the antipsychotic medication, Haldol 0.5 milligrams (mg) as needed every four hours for agitation and restlessness. Review of the medication regimen reviews (MRR) revealed on 08/16/21 the resident was receiving Haldol 0. 5 mg every four hours as needed and the pharmacist recommendation noted the use of as needed antipsychotics was not generally recommended to manage behaviors and required regular re-evaluation to support continuation. The review indicated PRN antipsychotics may be appropriate if documentation showed acute potential harm to the resident or others. Additionally, there were federal regulations limiting the use of PRN antipsychotics and PRN orders were now limited to 14 days initially and if continuation was intended, the resident must be reevaluated every 14 days for each subsequent renewal. Record review revealed the medication was discontinued, but not until 09/09/21. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/17/21 revealed a Brief Interview of Mental Status (BIMS) score of 10 indicating impaired cognition. The assessment revealed the resident required supervision one assist from staff for bed mobility and locomotion. The assessment revealed the resident had no behaviors. On 11/02/21 at 9:58 A.M. interview with the Director of Nursing (DON) confirmed there was no indication for use of the Haldol for Resident #79 for longer than 14 days after originally ordered on 06/19/21. The DON verified the medication was not discontinued until 09/09/21. Review of the facility policy and procedure titled Consulting Pharmacist Monthly Drug Review, dated 2016 revealed an unnecessary drug was any drug used in excessive duration or without adequate indications for use. (continued on next page)

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	365644	A. Building B. Wing	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Winchester	36 Lehman Dr Canal Winchester, OH 43110

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32654 2. Review of Resident #87's medical record revealed an original admitted [DATE] with the latest readmission of 10/19/21 and diagnoses including pseudobulbar affect, aphasia, urinary tract infection (UTI), urine retention, peripheral vascular disease, gastro-esophageal reflux disease, Alzheimer's disease, osteoarthritis, psychosis, major depressive disorder, hyperlipidemia, anxiety disorder, hypertension, bipolar disorder, atrial fibrillation and dysphagia. Review of the plan of care, dated 02/05/21 revealed the resident had an alteration in behaviors related to yelling out disturbing other residents, throwing things into the hallway and tearing down privacy curtain. Interventions included to administer medications as physician ordered and document behaviors as to type, duration and precipitating factors. Review of the MDS 3.0 assessment, dated 08/30/21 revealed the resident had clear speech, sometimes understood others, sometimes made herself understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of eight. Review of the mood and behavior section of the MDS revealed the resident had delusions, displayed verbal behaviors directed towards others and behaviors not directed towards others. The resident received antipsychotic, antianxiety, antidepressant and hypnotic medications. Review of the resident's monthly physician's orders for October 2021 revealed an order, (dated 10/19/21) for the antipsychotic medication, Haloperidol (Haldol) two milligrams (mg) with the special instructions to give 2 mg by mouth every 12 hours as needed for agitation, an order (dated 10/21/21) for Haloperidol Lactate Concentrate 2 mg/milliliter (ml) with the special instructions to give 0.25 ml by mouth every four hours as needed for anxiety, agitation or restlessness for 14 days and an order (dated 10/28/21) for the antianxiety medication, Lorazepam Intensol Concentrate 2 mg/ml with the special instructions to give 0.5 mg by mouth every four hours as needed for anxiety, agitation or restlessness for six months. Review of the resident's October 2021 Medication Administration Record (MAR) revealed she was medicated with Haldol 2 mg by mouth on 10/24/21 at 10:53 A.M. and Haldol Lactate Concentrate 0.25 ml by mouth on 10/26/21 at 1:49 A.M. and 11:46 P.M. with no evidence of any non-pharmacological interventions being attempted prior to the administration of the as needed medication. On 11/01/21 at 8:56 A.M. interview with the Director of Nursing (DON) verified the resident had been given as needed antipsychotic medication without non-pharmacological interventions attempts prior to the administration of the medication. Review of the facility policy titled, Unnecessary Drug Information,dated 07/2018 revealed when administering an as needed medication for pain or behavior you must evaluate and assess the resident's signs and symptoms and identify the specific behaviors that warrant and intervention for behavior, attempt to determine if there was a cause of the behavior or pain and meet that need if possible. Attempt to use non-medication interventions to redirect, stop or reduce the identified behavior. If the non-medication interventions were not successful the as needed medication may be administered as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43060 Based on observation, facility policy and procedure review and interview the facility failed to ensure medications were stored and labeled properly and were disposed of following expiration. This affected four residents (#61, #115, #128 and #59) of 21 residents who resided on the F Hall. Findings include: On [DATE] at 1:15 P.M. observation of the F Hall medication cart revealed several medications were observed to be without open or expiration dates. Several insulin pens, including Novolog insulin pens for Residents #61 and #115, were observed sitting loosely in the top drawer of the medication cart and were not stored in a bag or box. Novolog insulin pens were observed to be labeled for Residents #61 and #115 with no expiration dates written on the pens. Further observation revealed a Novolog insulin pen labeled for Resident #59 was penned with an expiration date of ,d+[DATE]. A Humalog insulin pen was observed to be labeled for Resident #128 (who expired in the facility on [DATE]), with no expiration date. Additionally, a used, unlabeled, undated Humalog insulin pen was observed to be in the top drawer of the medication cart. On [DATE] interview with Agency Registered Nurse (RN) #560 at the time of the observation verified the absence of expiration dates on the insulin pens for Resident #61, #115 and #128, as well as the expired insulin for Resident #59 and the presence of an unlabeled, undated, open insulin pen in the top drawer of the medication cart. Review of the facility policy titled Insulin Administration, revised ,d+[DATE] revealed the expiration dated should be checked prior to administration, if using an opened multi-dose vial and if opening a new vial, record the expiration date and time on the vial (follow manufactures recommendations for expiration after opening). Review of the Humalog KwikPen manufacturer's instructions, revised ,d+[DATE] revealed the insulin should not be used longer than 28 days after opening. Review of the Novolog FlexPen manufacturer's instructions, revised ,d+[DATE] revealed Novolog FlexPens may be kept at room temperature for up to 28 days.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on record review and interview the facility failed to obtain dental services in a timely manner for Resident #11, Resident #18 and Resident #98. This affected three residents (#11, #18 and #98) of three residents reviewed for dental services. Findings include: 1. Review of Resident #11's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behaviors, schizophrenia, major depression and anemia. Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 10/04/21 revealed the resident was cognitively impaired. The assessment revealed the resident required extensive assistance of two plus staff members for bed mobility and extensive assistance of one plus staff member for toilet use, dressing and personal hygiene. Review of the dental record revealed on 05/20/21 an emergency exam was completed and the resident was to be seen for further dental care. Record review revealed no further dental care had been provided for the resident as recommended following the 05/20/21 emergency exam. On 10/28/21 at 12:37 P.M. interview with Social Worker (SW) #481 verified the above findings. Following the interview, a dental appointment was made for the resident on 11/16/21 at 1:00 P.M. 2. Review of Resident #18's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's dementia, chronic kidney disease, diabetes and anemia. Record review revealed the most recent dental visit for the resident was completed on 02/12/20. There was no evidence the resident had been seen for a routine dental visit since this time. Review of the admission MDS 3.0 assessment, dated 09/23/21 revealed the resident's cognition was moderately impaired. The resident required extensive assistance from two or more staff members for bed mobility, transfers, dressing and toilet use. On 10/28/21 at 12:37 P.M. interview with SW #481 verified the above findings. The SW was unable to provide any additional information as to why the resident had not been seen for routine dental care since 02/12/20. 32654 3. Review of Resident #98's medical record revealed an original admitted [DATE] with the latest readmission of 08/05/19 with admitting diagnoses of diffuse traumatic brain injury with loss of consciousness, nicotine dependence, right hip pain, schizoaffective disorder, diabetes mellitus, hyperlipidemia, bipolar disorder, mood disorder, dementia with behavioral disturbances, PTSD, hypertension, asthma, epilepsy, hypothyroidism, insomnia, alcoholic cirrhosis of liver without ascites, and severe morbid obesity. The resident was discharged to another skilled nursing facility on 11/01/21. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #98 had a physician's order, dated 09/12/19 indicating may see in house dentist. Review of the plan of care, dated 09/07/20 revealed the resident was at risk for dental or chewing problems related to obvious, likely cavity. Interventions included to apply lip balm/moisturizer to lips as needed, arrange periodic dental consult, assist as needed with oral hygiene, including denture care if applicable, diet as ordered, dietary to review nutritional status at least quarterly and as needed, encourage resident to report any oral discomfort, note % of intake at each meal and document and review for weight changes. Review of the resident's dental summary report revealed the resident was seen on 02/08/21 by the facility contracted dentist. Further review revealed the dentist referred the resident for a crown for tooth number three. The resident's medical record contained no evidence the resident was sent for the crown placement. Review of an oral assessment, dated 08/11/21 revealed the resident had natural teeth with no issues. The resident had no complaints of pain or chewing problems per the assessment completed at that time. Review of the resident's quarterly MDS 3.0 assessment, dated 08/13/21 revealed the resident had clear speech, understand others, makes self understood and had a moderate cognitive deficit as indicated by a Brief Interview for Mental Status (BIMS) score of 11. The assessment indicated the resident had no dental issues. On 11/02/21 at 2:39 P.M. interview with Registered Nurse (RN) #406 verified the resident had not had any dental follow up for the crown.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38604 Based on observation, record review and interview the facility failed to ensure it was administered in a manner to ensure all residents received the care and services necessary to attain or maintain their highest practicable physical, mental and psychosocial well-being. This had the potential to affect all 134 residents residing in the facility. Findings include: During the annual recertification, extended and complaint survey completed from [DATE] through [DATE] the following concerns were identified through observation, record review, facility policy and procedure review and interview: a. The facility failed to ensure all residents (including Resident #11, #13, #65 and #85) who required staff assistance with activities of daily living (ADL) care received timely and appropriate care and services to maintain proper hygiene and grooming. See findings at F677. b. The facility failed to initiate timely and adequate Cardio-pulmonary Resuscitation (CPR) for Resident #128 who was a full-code and required CPR after being found unresponsive and without vital signs. This resulted in Immediate Jeopardy on [DATE] at approximately 3:21 A.M. when Resident #128 was observed unresponsive. The facility failed to ensure EMS had timely access to the facility and failed to provide CPR timely for the resident. On [DATE] at 3:21 A.M., EMS arrived on-site and identified facility staff were not providing CPR to a resident whom staff had identified as unresponsive and coding. EMS staff immediately initiated CPR for the resident, however CPR efforts were not successful and the resident expired. The lack of immediate and adequate CPR and delay in staff allowing EMS into the facility resulted in life threatening harm and death for Resident #128. See findings at F678. c. The facility failed to provide adequate supervision and/or assistive devices to prevent falls and/or resident injury for Resident #12, Resident #33, Resident #35 and Resident #93. Actual Harm occurred on [DATE] when Resident #35, who required extensive assistance from two (plus) staff for bed mobility sustained a fall out of bed resulting in a fractured nose when State tested Nursing Assistant (STNA) #407 was providing bed mobility without a second staff member assisting. Actual Harm occurred on [DATE] when Resident #33, who was dependent on two staff for transfers sustained an injury/hematoma with increased excruciating pain and subsequent two week hospitalization with surgical intervention during a staff assisted mechanical (Hoyer) lift transfer. See findings at F689. d. The facility failed to maintain sufficient levels of nursing staff to meet the total care needs of all residents in a timely manner. This affected six residents (#128, #123, #33, #103, #113, #98 and #105) and had the potential to affect all 134 residents residing in the facility. See findings at F725. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. The facility failed to develop and implement comprehensive and individualized behavior management programs for residents with dementia to prevent resident to resident altercations and to ensure each resident maintained their highest practicable physical, mental and psychosocial well-being. This affected five residents (#10, #19, #113, #126 and #127) and had the potential to affect all 21 residents residing on the D hall/East Building. See findings at F744. f. The facility failed to implement effective and recommended infection control practices, including the implementation of appropriate isolation and quarantine procedures to prevent the spread of COVID-19 within the facility. This resulted in Immediate Jeopardy when the facility failed to implement adequate infection control measures increasing the resident outbreak status of five residents (#22, #47, #61, #128 and #383) testing positive for COVID-19 on [DATE] to seven residents (#44, #52, #59, #64, #115, #384 and #482) testing positive for COVID-19 on [DATE]. Furthermore, Resident #128 who was COVID-19 positive expired on [DATE] in the facility. See findings at F880. In addition, concerns were also identified related to documentation, medication storage, oxygen therapy, dental services, vision services, resident assessments, care planning, skin management, unnecessary medication use, nutritional services, pharmacy services, physical environment, dignity and hemodialysis services. On [DATE] at 11:40 A.M. interview with RDCS #406 revealed she knew this survey identified multiple issues and the facility was considering it a reset to start over. On [DATE] at 8:30 A.M. interview with the Administrator and Regional Director of Clinical Services (RDCS) #406 revealed if a problem was identified it could be addressed by the facility quality assurance process. The Administrator and RDCS #406 revealed overall this survey highlighted certain circumstances and they had been so focused on reducing the number of complaint surveys there didn't seem to be any issues. Review of the facility demographic administrator information revealed the effective date for the current Administrator was [DATE]. Review of the facility survey history revealed complaint surveys were conducted at the facility on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. The surveys completed on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] resulted in certification deficiencies. The survey conducted on [DATE] resulted in concerns related to Treatment/Services for Dementia (F744) and Infection Prevention & Control (F880). Review of the facility assessment, revised 2021 revealed the assessment did not address the system failures identified during the survey.

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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** 19571 Based on record review and interview the facility failed to ensure Resident #117's medical record was maintained in a complete and accurate manner related to monitoring the resident's output. This affected one resident (#117) of 51 sampled residents whose medical records were reviewed. Findings include: Review of Resident #117's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia, chronic kidney disease, high blood pressure and anemia. On 09/19/21 a physician's orders was received to record output every shift (qshift). Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 09/23/21 revealed the resident's cognition was moderately impaired, he required extensive assistance of two staff members for bed mobility, transfers, dressing and toilet use and extensive assistance from one staff member for personal hygiene. The assessment revealed the resident had an indwelling urinary catheter and was frequently incontinent of bowel. Review of the treatment records for 09/2021 and 10/2021 revealed incomplete output documentation on 09/26/21, 10/04/21, 10/12/21, 10/14/21, 10/19/21, 10/20/21, and 10/26/21. On 11/01/21 at 10:43 A.M. interview with the Director of Nursing (DON) verified the incomplete output monitoring and documentation for Resident #117 as noted above.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memos, Nursing Home Guidance from the Centers for Disease Control (CDC), review of facility policy and procedures, review of the facility floor plan, observations, staff interviews and record reviews, the facility failed to implement effective and recommended infection control practices, including the implementation of appropriate isolation and quarantine procedures to prevent the spread of COVID-19 within the facility. This resulted in Immediate Jeopardy when the facility failed to implement adequate infection control measures increasing the resident outbreak status of five residents (#22, #47, #61, #128 and #383) testing positive for COVID-19 on [DATE] to seven residents (#44, #52, #59, #64, #115, #384 and #482) testing positive for COVID-19 on [DATE]. Furthermore, Resident #128 who was COVID-19 positive expired on [DATE] in the facility. On [DATE] observations made onsite revealed the COVID-19 unit and quarantine units lacked personal protection equipment (PPE) carts and biohazard waste receptacles for each room, resulting in staff walking down the hallways in soiled PPE, staff wearing N95 masks without a covering while entering and exiting quarantine rooms, staff not wearing goggles or face shield and not cleansing the goggles and/or face shield if worn when exiting COVID-19 positive rooms and/or quarantine rooms. Biohazard receptacles were overflowing with soiled PPE, staff were observed not washing hands after removing PPE and transporting soiled linens, and staff placed soiled N95 mask on the clean PPE storage cart while donning clean PPE then picking the soiled N95 mask up with clean PPE. The lack of current effective infection control practices during a COVID-19 outbreak in the facility placed all 134 residents at risk for the likelihood of harm, complications and/or death. The facility census was 134 residents. On [DATE] at 3:37 P.M. the Administrator was notified that Immediate Jeopardy began on [DATE] when infection control practices were not maintained resulting in the risk of continued transmission of COVID-19 amongst staff and residents. Continued breaches in infection control practices on the COVID-19 and quarantine unit after five residents tested positive on [DATE] and seven more on [DATE] put all 134 residents at risk of potential harm. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 2:30 P.M. immediate education was provided to 14 State tested Nursing Assistants (STNA), four Licensed Practical Nurses (LPN) and two Registered Nurses (RN) on duty by RN #540 regarding PPE for quarantine and isolation rooms, and PPE should be readily available near rooms. N95 masks should be changed out within each room or a surgical mask placed over and then the surgical masks changed out after each room. Goggles should be cleaned in between each room. Biohazard boxes should be emptied when full and joint equipment must be cleaned before exiting hall of quarantine or isolation hallways. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 3:05 P.M. education was provided to all facility staff by RN #406 via text application. The RN sent all staff education including PPE must be placed near each door for easy reach and use. Trash can bins must be placed inside the doorway of each room on quarantine or isolation units. N95 masks must be changed after each room or place a surgical mask over N95 in each room and discard after each room. Goggles are to be cleaned in between use. Biohazard boxes must be emptied and not allowed to spill over. PPE must be changed between units and equipment cannot be taken off quarantine or isolation units with cleaning. On [DATE] at 3:05 P.M. review of all residents potentially affected per RN #406 revealed all residents from G unit (quarantine unit for COVID-19 exposure) were already in quarantine due to potential exposure. Review of all residents on the F unit (COVID-19 positive unit) revealed all residents were already in quarantine. On [DATE] at 3:30 P.M. all staff working completed competency on correct process and procedure including changing the N95 mask between each room or place a surgical mask over the N95 mask and change the surgical mask in between each room. When entering a COVID-19 or quarantine room all PPE (gown, gloves, N95 (surgical mask over) and eyewear must be worn. When leaving an isolation room all PPE must be removed inside the doorway and eye coverage must be cleansed between each room per the Administrator. On [DATE] at 4:30 P.M. the Administrator and RN #406 verified all rooms on quarantine units (located on unit B and G) have a designated biohazard trash can in each room. On [DATE] at 4:45 P.M. signs were placed on hallways/doorways explaining PPE procedure by the Administrator. On [DATE] at 5:00 P.M. an emergency Quality Assurance Performance Improvement (QAPI) with the Administrator, Social Services #481, MDS Coordinator #453, Registered Dietician (RD) #488, Housekeeping/Laundry Supervisor #447, Admissions/Marketing #336, Human Resources #420, Director of Nursing (DON) #374, Activities #460, Therapy #548, Maintenance Director #346, Licensed Practical Nurse (LPN) #304 and Registered Nurse (RN) #406. On [DATE] at 9:00 P.M. a root cause analysis was competed by RN #406 and out of an abundance of caution the facility implemented the following QAPI measures: 1. On [DATE] staff member and/or manager was assigned to oversee each designated unit to initiate and continue ongoing auditing of practices. Ongoing QAPI includes: Infection Control Nurse/Infection Preventionist and governing body will review ongoing audits weekly and as needed. 2. On [DATE] audits initiated per designated staff members of Interdisciplinary Team (IDT) to be assigned to each unit to complete audits of donning/doffing PPE, use of PPE, and hand hygiene every one to two hours for 12 hours on each hall, then reduce to three times daily on each hallway for two weeks or until outbreak is complete. Once outbreak completed, audits are to continue on each hall daily four times a week for two weeks. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Weekly QAPI for four weeks per the Administrator. On [DATE] at 10:05 A.M. individual education was provided to STNA #423 by RN #540 on PPE (gown, gloves, N95, and goggles or face shield) use when escorting residents outside to smoke. On [DATE] at 4:54 P.M. education was provided to all facility staff by RN #406 via text application. The RN sent all staff education including all staff must wear PPE (gown, gloves, N95 mask, and goggles or face shield) when assisting residents outside to smoke who are residing in the quarantine areas (housed residents with COVID-19 exposure). PPE must be worn while assisting the residents. On [DATE] at 6:00 P.M. reeducation was provided to Admission/Marketing #334 on proper mask wearing and removal and disposal of soiled PPE (gown, gloves, masks, goggles/face shield). Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: On [DATE] at 8:00 A.M. upon arrival to the facility the Administrator revealed the facility was in a COVID-19 outbreak from a positive staff member. Review of the facility's floor plan provided by the Administrator revealed the East building B unit had five resident rooms (Resident #18, #19, #20, #21 and #23's room) barriered off with plastic and labeled as a yellow quarantine unit for COVID-19 exposure. Further review revealed the [NAME] Building F unit had seven rooms (Resident #67, #68, #69, #70, #70, #72 and #73's room) barriered off with plastic and labeled as a red COVID-19 unit which housed the facility's COVID-19 positive residents. The three remaining rooms on the F unit (#65, #66 and #75) were labeled as a yellow quarantine unit. Additionally, the entire G unit of the [NAME] building was labeled as a yellow quarantine unit for COVID-19 exposure. Review of the COVID-19 test results provided by the facility revealed STNA #300 tested positive for COVID-19 on [DATE] at which time the entire G unit was placed on quarantine for COVID-19 exposure as well as five resident rooms on the B unit contained in the [NAME] building. Review of the Outbreak Timeline provided by the facility revealed on [DATE] mass testing was completed for both staff and residents following a COVID-19 positive staff result on [DATE]. Five residents (#22, #47, #61, #128 and #383) tested positive for COVID-19 and were moved to the [NAME] building F unit which contained the COVID-19 positive unit. Review of the COVID-19 test results provided by the facility revealed STNA #301 tested positive for COVID-19 on [DATE]. The facility conducted mass testing on [DATE] and an additional seven residents (#44, #52, #59, #64, #115, #384 and #482) tested positive for COVID-19. The entire F unit was then converted to the COVID-19 unit. Additionally, LPN #302 tested positive for COVID-19 on [DATE]. (continued on next page)

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	365644	A. Building B. Wing	11/05/2021

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the CDC guidelines revealed for residents with new-onset suspected or confirmed COVID-19 test results the facility should: Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of SARS-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross transmission. If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). On [DATE] at 11:18 A.M. through 12:30 P.M. an initial observation of the G hallway, quarantine unit for COVID-19 exposure, revealed two red plastic biohazard totes sitting on the left side of the hallway with overflowing soiled PPE. Further observations revealed each resident room was not allotted a PPE storage container or a biohazard container to discard soiled PPE prior to leaving various resident rooms. STNA #303, LPN #304 and Housekeeper #305 were observed entering and exiting quarantine rooms without having a covering over their N95 mask or changing their N95 mask upon exiting resident rooms. Additionally, the staff failed to cleanse their goggles between resident rooms. Three unidentified residents who were in quarantine were outside the exit door at the end of the hallway smoking without social distancing between residents and STNA #303. STNA #303 was not utilizing the required mask, eye protection, gown and gloves while supervising the quarantined residents who were smoking. On [DATE] at 1:11 P.M. observation of STNA #302 revealed she exited Resident #32 and Resident #74's room, who were on quarantine for COVID-19 exposure, without a covering on her N95 or changing her N95 mask, carrying a clear plastic bag of soiled linen. The STNA walked to the end of the hallway and placed the soiled linen in a black plastic covered trash can and entered Resident #36's room, who was on quarantine for COVID-19 exposure, without changing her N95 mask or washing her hands and assisted Resident #36. Interview with STNA #304 confirmed she did not change her N95 mask or wash and/or sanitize her hands. On [DATE] at 1:12 P.M. observation of Housekeeper #305 revealed she exited Resident #62 and Resident #83's room who were on quarantine for COVID-19 exposure without a covering to her N95 mask or changing her mask. She placed her housekeeping cart on the right side of the hallway and exited the G unit (quarantine unit) with the same N95 mask she had on in the above-named resident room and failed to wash or sanitize her hands. Interview with Housekeeper #305 confirmed she had not changed her N95 mask or washed and/or sanitized her hands. Observation on [DATE] at 1:14 P.M. revealed STNA #307 exited Resident #87's (quarantined for COVID-19 exposure) room after providing care, walked to a black covered trash can, removed gown and gloves and walked down the hallway. Interview with STNA #307 verified at the time of the observations she had not sanitized her hands or changed her N95 mask once she completed her care for Resident #87. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 1:22 P.M. Activity Assistant #306 was observed exiting the G unit (quarantine unit) with a mechanical lift without sanitizing the equipment prior to exiting the unit. After surveyor intervention, Activity Assistant #306 stopped RN #468 and asked if she was supposed to do anything with the mechanical lift. On [DATE] at 2:07 P.M. the G unit (quarantine unit) meal cart was delivered by an unidentified dietary aide wearing an N95 mask. The dietary aide's goggles were sitting on top of his head. The dietary aide was observed exiting the unit with the same N95 mask and failed to cleanse his hands and goggles. On [DATE] at 2:11 P.M. observation of STNA #307 revealed she delivered Resident #284, who was in quarantine, his lunch meal with a gown, gloves, N95 mask and goggles in place. She exited the room, walked down the hallway to the meal cart and obtained Resident #131's lunch tray. The STNA walked back to Resident #131's room and entered the room. The resident refused the meal after the STNA placed the tray on the resident's bedside table. STNA #307 exited the room, walked across the hallway and placed the meal tray in an empty wheelchair sitting against the wall. The STNA verified the observations and was unable to verbalize who the empty wheelchair belonged to. Further observations revealed LPN #304, STNA #303, and STNA #307 continued to deliver resident meal trays without washing and/or sanitizing hands between changing PPE. Interview with STNA #303, STNA #307 and LPN #304 verified the lack of handwashing and/or sanitizing their hands when changing PPE. On [DATE] at 2:27 P.M. observation of LPN #304 revealed she exited Resident #43 and Resident #125's room, who were in quarantine for COVID-19 exposure, with a soiled N95 mask on, walked across the hallway to the plastic cart containing clean PPE, removed the soiled N95 mask and placed it on top of the plastic cart containing clean PPE. The LPN then donned a gown, gloves, and a N95 mask. LPN #304 failed to wash and/or sanitize her hands or cleanse her goggles prior to donning the clean PPE. LPN #304 then picked the soiled N95 mask up and walked to a biohazard trash can and discarded the mask. LPN #304 then removed a tray from the meal cart to deliver. Interview with LPN #304 confirmed she placed a soiled N95 mask on the clean PPE container, failed to wash and/or sanitize her hands, and did not cleanse her goggles prior to donning the clean PPE. On [DATE] at 4:20 P.M. observation of STNA #506 revealed the STNA exited Resident #383's (COVID-19 positive resident) room wearing full PPE, walked to other end of the COVID-19 unit to the biohazard bin, took off her PPE, did not wash hands, washed her eye protection, donned clean PPE then washed hands. The STNA verified that she walked across the covid unit with soiled PPE and did not wash her hands after removing the soiled PPE. On [DATE] at 9:03 A.M. observation of STNA #539 revealed the STNA was wearing her eye protection on top of her head, not covering her eyes, while cleaning up a breakfast tray from Resident #65 in the unit lounge. Interview at the time of the observation with STNA #539 confirmed she was not wearing eye protection appropriately while providing resident care. Observation on [DATE] at 9:48 A.M. revealed Resident #73 (a quarantined resident) was outside smoking with STNA #423 assisting. The only PPE STNA #423 was utilizing was an N95 mask and a face shield, she did not have gloves or a gown on, and was not social distancing. Interview on [DATE] at 9:50 A.M. with RN #406 stated she would expect staff to wear full PPE when taking a quarantine resident out to smoke. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] at 9:55 A.M. with STNA #423 and RN #406 present confirmed STNA #423 did not utilize all appropriate PPE while assisting a resident to smoke who was under quarantine status for COVID-19 exposure. On [DATE] at 3:37 P.M. observation of Admission/Marketing #336 exiting Resident #52's room, who was in quarantine for COVID-19 exposure, revealed she removed her N95 mask at the resident's door and put on a clean N95 mask. She then placed the soiled mask into her pocket and exited the G unit (quarantine unit for COVID-19 exposure) in the [NAME] building. Admission/Marketing #336 confirmed by pulling out the soiled N95 mask from her pocket and state, I don't know what to do with it. Review of the CDC guidelines Sparkling Surfaces: Stop COVID-19's Spread revealed the virus that causes COVID-19 can be spread by indirect contact with contaminated surfaces. Surfaces that were touched frequently increase the chance that germs could be spread to residents and staff. On surfaces which look clean, pathogens might be present. The coronavirus causing COVID-19 has been shown to survive on surfaces from several hours to days. Review of the facility policy titled, Care for the Patient with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19), last revised on [DATE], revealed the facility had designated specific areas within the facility, with facility staff to care for known or suspected COVID-19 patients with options for extended use of respirators, facemasks and eye protection on such units or patient areas. The facility would follow the CDC recommendations in caring for the known or suspected COVID-19 patient. Patients with known or suspected COVID-19 should be cared for in a single person room with the door closed with a private bathroom and/or bedside commode as able. A sign would be placed on the door and PPE will be placed outside of the resident room. N95 masks or disposable masks should be discarded after exiting the patient's room and/or quarantine unit or care area (COVID-19 unit) and closing the door. The staff member should then perform hand hygiene after discarding the respirator or facemask. Put on eye protection (goggles and/or disposable face shield) that covers the front and sides of the face upon entry to the patient's room or care area. Reusable eye protection must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use. Staff should put on clean, non-sterile gloves upon entry into the patient room or care area. Remove and discard gloves when leaving the patient room or care area and immediately perform hand hygiene. The facility would utilize PPE items in facility and patient care areas in accordance to current guidance per local, state or federal guidance. Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19 as able. All non-dedicated, non-disposable medical equipment used for patient care will be cleaned and disinfected according to manufactures instructions and cleaning schedule. This deficiency substantiates Complaint Number OH00126920.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43060 Based on observation and interview the facility failed to maintain a safe, functional and sanitary environment for all residents. This affected Resident #383 who resided on the F hall and had the potential to affect all 21 residents who resided on the D hall/East Building and all 19 residents who resided on the A hall/East Building. The facility census was 134. Findings include: 1. On 11/02/21 at 1:30 P.M. Resident #383 was observed to be resting in bed A of her room. At the time of the observation, the privacy curtain in the room was observed bunched in the middle corner of the L shaped track for bed A, and partially blocking the view of Resident #383 from the door. When attempting to pull the privacy curtain to the side, to gain entrance to the room and observe and interview Resident #383, the curtain was observed to feel lose and flimsy, and spring up and down several inches. Further observation revealed the metal, L shaped track that was connected to the ceiling and holding up the privacy curtain, was partially detached from the ceiling and hanging down approximately four to six inches at the location of the inside corner. On 11/02/21 at 1:37 P.M. interview with Agency Registered Nurse (RN) #560 confirmed the privacy curtain was coming detached from the ceiling. RN #560 revealed she would need to call maintenance to fix it. 43064 2. From 10/25/21 at 8:00 A.M. to 10/27/21 at 10:32 A.M. observation of the D Hall in the East building revealed the following environmental concerns: To the left of the entrance to the unit the wallpaper was peeing from the wall up to the hand railing. The entryway for Rooms 39, 40, 41, 42, 45, 46, 49 and 50 had a build up of dirt one to two inches on either side of the transition strip. In the dining room there was a build up of dirt and multiple spills and splatters along the bottom of the cabinets. In the back left corner there was a stained area approximately 1.5 feet by 2.5 feet, this area had a variety of unidentifiable stains that were layered. Next to this area was a rust brown splatter down the edge of the baseboard and onto the floor. To the left of the refrigerator extending to the cabinets was a light brown stain topped with black splatters and to the left of the couch were light brown stains under the end table with multiple brown smears. Under the television was a large brown stain extending from the baseboard. In the area in front of the nurse's station approximately five feet by six feet and to the side of the nurse's station approximately one foot by four feet were multiple unidentifiable brown and red splatters and gray stains. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In room [ROOM NUMBER] in the corner of the room next to the window, the baseboard was hanging off the wall exposing the white wall underneath. In the bathroom the baseboard on either side of the toilet was coming off the wall, exposing the white wall and brown underneath. Towards the entrance of the restroom there was a large light brown stain next to the baseboard, it appeared to come from the baseboard. In the right corner behind the toilet there was a white substance that was suspected to be toilet paper spread across the wall. In room [ROOM NUMBER] the baseboard under the window and to the left was hanging off the wall exposing the white wall and brown underneath. In room [ROOM NUMBER] the paint was chipped in multiple locations on either side of the window, additionally the paint was chipped and there was an indent in the wall next to the bedside table. Under the window to the right the baseboard was missing for about two and a half feet exposing the wall. Underneath the second bedside table were splatters of an unidentifiable brown substances extending along the side of the stand. To the left of the door was an area of the wall that had been spackled and not painted. During a tour on 10/27/21 from 10:15 AM to 10:32 AM with Maintenance #346 and Housekeeper #447 the above observations were confirmed. Housekeeper #447 reported the refrigerator in the dining room had been moved and that was likely the cause of the 1.5 foot by 2.5 foot stain. However, he revealed the floor should have been stripped and waxed when this happened. Housekeeper #447 revealed the resident who resided in room [ROOM NUMBER] had behaviors including causing messes in the bathroom. He stated facility staff were to notify housekeeping when this occurred, and confirmed he was unaware of this incident. There were 21 residents who resided on the D hall. 19571 3. On 10/27/21 from 10:15 A.M. to 10:32 A.M. an environmental tour of the A hall/East Building with Maintenance Man #346 revealed the following environmental concerns which were verified with MM #346 at the time of the observations: Room A11 had dark stained tiles around the commode and chipped paint on the door to the room and the walls. Room A8 had holes in the drywall in the bathroom, chips in the paint in the room and the wood finish was peeling off the night stand. Room A12 had holes in the drywall and the baseboard was coming off the wall in the bathroom. Room A7's door and door jams had chipped paint, the wall in the room had chipped paint. The call string in the bathroom had a dried brown substance on half of the string. Room A2 had the paint chipped on the walls, the toilet had bowel movement on it, the wall near the baseboard was bubbled and peeling. The blinds were broken on the window. The bedside stand had the top drawer missing. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Room A9's baseboard was loose from the wall. Room A4 had paint chipped on the walls and dark stains on the tile around the commode. Room A10's baseboard was missing in the bathroom. There were 19 residents who resided on the A hall.