STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365416	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Westminster-Thurber	717 Neil Avenue Columbus, OH 43215

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of the medical record, staff interviews, and review of Food and Drug Administration (FDA) guidelines, the facility failed to ensure adequate behavioral monitoring to evaluate effectiveness and psychotropic medication necessity for Resident #136. This affected one resident (#136) of five reviewed for unnecessary medications. The facility census was 29. Findings include: Review of Resident #136's medical record revealed an admission date of 05/20/25 with diagnoses including Parkinson's Disease without dyskinesia, cognitive communication deficit, muscle weakness, major depressive disorder, type two diabetes mellitus without complications, age-related osteoporosis without current pathological fracture, history of falling, neurocognitive disorder with Lewy bodies, and severe dementia with agitation. Review of Resident #136's Minimum Data Set (MDS) assessment completed on 05/28/25, revealed the resident was dependent on staff for upper and lower body dressing, toileting and showering. She required substantial assistance for changing positions and she was dependent on others for moving the wheelchair 50 feet. Review of Resident #136's physician orders revealed two orders dated 05/20/25 for Seroquel (an antipsychotic medication) for dementia in other diseases, classified elsewhere, severe with agitation. One order was for Seroquel 25 milligrams (mg) to be given twice a day and the other order was for Seroquel 50 mg to be given in the evening with the 25 mg Seroquel. Neither order specified instructions regarding monitoring Resident #136's behaviors. There were no orders for Resident #136 specifying behavioral monitoring. Review of progress notes for Resident #136 from 05/20/25 through 05/29/25 revealed no progress notes regarding any negative behaviors for Resident #136. Review of Resident #136's Medication Administration Record (MAR) dated 05/20/25 through 05/28/25 revealed no documentation the resident received monitoring for effectiveness and adverse consequences for the use of the medication Seroquel. Review of Pharmacy Progress Note dated 05/26/25 revealed an Medication Regimen Review (MRR) was completed for Resident #136 and there were no recommendations. Interview on 05/28/25 at 2:21 P.M. with Licensed Practical Nurse (LPN) #14 who stated she had worked with Resident #136 in her prior memory care assisted living setting revealed Resident #136 used to (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be a fall risk but wasn't a fall risk now. She spoke of resident's physical decline and said Resident #136 had no recent behavioral issues. Interview on 05/28/25 at 2:39 P.M. with the Director of Nursing (DON) revealed Resident #136's medications were not new as she was a transfer from the facility's memory care unit in assisted living. She said the resident's normal body posture was to lean forward and that they had a care conference with the family regarding the need for more care due to her significant decline. She said she didn't think the resident was a risk for elopement and that they charted behaviors by exception. Observation on 05/29/25 at 8:15 A.M. in the alcove of the dining room, revealed CNA #555 greeted Resident #136, asked her to pick up her feet and then wheeled her to dining room table and locked the wheelchair. Resident #136 was leaning forward with her head over the table. Observation on 05/29/25 from 8:22 A.M. to 8:41 A.M., Resident #136 touched her nose once with the clothing protector, but otherwise had no body movement; she did not attempt to move towards or away from the breakfast in front of her and was exhibiting no negative behaviors. Interview on 05/29/25 at 8:46 A.M. with CNA #555 revealed she worked with Resident #136 at her previous assisted living setting and acknowledged Resident #136 had declined since that time. Observation on 05/29/25 at 12:20 P.M., Resident #136 was seated in her wheelchair at a table in the dining room. The resident was exhibiting no negative behaviors. Interview on 05/29/25 at 12:41 P.M. with Physician #500 revealed he was aware of the black box warning that Seroquel should not be used in patients who had dementia. He said that Resident #136 used to have significant behavioral issues. He confirmed he wrote the prescription for the Seroquel to continue with her medication regimen and not because of recent behaviors. He confirmed he did not have orders for behavioral monitoring. He said that while she was in memory care she was followed by an outside psychiatric consulting group. He said the last known visit he had with resident in which behaviors were reported to be a concern was August of 2024. He reviewed his notes from appointments since that time and confirmed that he did not have any notes regarding behavioral issues since August 2024. He also had not received any reports of significant behavioral issues from staff since that time. He was uncertain regarding the last time a gradual dose reduction (GDR) had been attempted and stated it would be appropriate to try again. He said he did not think Resident #136 had been seen by the outside psychiatric consulting group in four or five months. Review of the Food and Drug Administration (FDA) manufacture's guideline for Seroquel revealed Seroquel is an atypical antipsychotic indicated for the treatment of Schizophrenia, Bipolar I disorder manic episodes and Bipolar disorder, depressive episodes. There is a black box warning that states elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for elderly patients with dementia related psychosis.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, record review, and review of the facility policy and procedure, the facility failed to ensure an allegation of sexual and physical abuse were reported to the State agency within the required timeframe's. This affected one resident (#1) of two reviewed for abuse. The facility census was 29. Findings include: Review of the medical record for Resident #1 revealed an admission date of 05/06/21. Diagnoses included arthritis, weakness, obesity, depression, and colostomy status. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and required substantial/maximum assistance from staff members for toileting assistance. Interview on 05/27/25 at 10:11 A.M. with Resident #1 revealed a concern of staff giving rough care during incontinence care and also a report of sexual abuse. Resident #1 reported Certified Nursing Aide (CNA) #200 had, on one occasion, provided rough care and was asked to stop as she thought he was making her bleed. On a second occasion the same week, Resident #1 reported CNA #200 had used his finger to penetrate her in a sexual manner during incontinence care. Resident #1 reported she requested him to stop which he informed her he was cleaning her and did not stop right away upon her request. She reported these situations were physical abuse and sexual abuse. Resident reported this occurred around the March or April 2025 timeframe, but could not be certain. Review of the grievance form dated 03/03/25 revealed Resident #1's sister reported to staff that she had concerns related to rough care by a Certified Nursing Aide. The DON completed a grievance concern form. The investigation included an interview from Resident #1 and Resident #1's sister. Interview on 05/27/25 at 3:24 P.M. with Director of Nursing (DON) revealed she had received customer service concerns about staff being rough during incontinence care, but denied any concerns were brought to her attention related to penetration during care or sexual or physical abuse. The DON revealed she completed a grievance concern report and took statements from the resident and family, and they agreed for a long stick sponge to be provided for resident to be able to assist in some of her own incontinence care. The DON reported CNA #200 was terminated 03/03/25 after being found sleeping after a previous warning for sleeping while on duty. During the interview the DON was informed of Resident #1's statements and allegations of physical and sexual abuse. Review of the State reporting site on 05/28/25 at 11:50 A.M. and again at 4:45 P.M., an allegation of abuse was not reported to the State agency for Resident #1. Interview on 05/28/25 at 4:50 P.M. with DON confirmed facility had not reported the allegation of sexual/physical abuse to the state agency within the required 24 hours window after the surveyor report. The DON revealed she misunderstood and would complete the report and start investigating for the allegation. Review of the State reporting site revealed the Self Reported Incident was initiated on 05/28/25 at (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5:07 P.M., for an allegation of sexual abuse related to Resident #1. Review of facility policy titled Abuse, Neglect and Misappropriation and Crime Reporting dated 01/18/23, revealed all allegations of abuse shall be reported immediately and will be investigated. The policy noted that annually, covered individuals (each individual who is an owner, operator, employee, manager, agent, or contractor of a long term care facility) will be notified of their obligation to report crime or suspicion of a crime occurring to residents and anyone receiving care in the facility, to the State agency and one or more law enforcement agencies. It noted that the covered individual shall report no later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and policy review, the facility failed to ensure care conferences were completed as required. This affected two (#6 and #18) of two residents reviewed for care conferences. This had the potential to affect all 29 residents in the facility. Findings include: Review of the medical record of Resident #18 revealed an admission date of 04/11/24. Diagnoses included major depressive disorder with psychotic symptoms, myotonia congenita, and age-related physical debility. Review of Resident #18's care conferences revealed they were held for the resident on 04/12/24, 07/31/24, and 04/25/25. Review of Resident #18's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Interview on 05/27/25 at 9:35 A.M. with Resident #18 revealed she only recalled having a care conference about a year prior. Interview on 05/28/25 at 10:17 A.M., Director of Social Services (DSS) #38 stated care conferences were to be held quarterly and she verified Resident #18 did not have any evidence of any additional care conferences being conducted between 07/31/24 and 04/25/25. Review of the facility policy titled, Resident-Centered Care Advanced Care Planning, revealed care planning discussions were available for each resident as directed by federal and state guidelines and as requested by the resident, responsible party, and/or the interdisciplinary team. 2. Review of the medical record for Resident #6 revealed an admission date of 06/17/17. Diagnoses included psychotic disorder with delusions, muscle weakness, dementia, malnutrition, delusion disorder and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was cognitively impaired with a Brief Interview of Mental Status (BIMS) of 06, indicating impaired cognition. It noted the resident was dependent on staff assistance for bed mobility, and required total dependence of one staff for eating. Review of Resident #6's care conference dated 09/27/24 revealed a care conference was in process. Review of Resident #6's care conference dated 03/27/25 (entered on 05/28/25) revealed most sections were left blank including code status, physical enablers, nursing needs, therapy services, activities, and dietary service. The care conference included a narrative comment that discussed activities, medications, care plans, and hospice, but did not mention resident code status, dietary services, or other specific nursing needs. Interview on 05/28/25 at 10:27 A.M. with Social Services Director (DDS) #38 acknowledged the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility only had evidence of two quarterly care conferences (09/27/24 and 03/27/25) in the previous year. SSD #38 confirmed the care conference dated 09/27/24 was listed as being in progress but was not completed. SSD confirmed facility had no evidence of care conferences from the second and fourth quarters of 2024. SSD #38 also confirmed documentation was not completed thoroughly, with most sections not documented. Review of facility policy titled Resident-Centered Care Advanced Care Planning, dated 01/10/23 revealed facility shall give residents an opportunity to discuss care plans including goals and preferences. Care planning discussion be available as required by federal and state regulations. Problems, goals, interventions, advanced directives and care planning shall be documented in the medical record.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, medical record review, and staff interviews, the facility failed to follow podiatry recommendations. This affected one resident (Resident #16) out of one resident reviewed for limited range of motion. The facility census was 29. Findings include: Review of Resident #16's medical record revealed an admission date of 06/03/15. Medical diagnoses included right foot talipes equinovarus (a club-like deformity), hemiplegia, mild cognitive impairment, muscle weakness, and marked limited ambulation. Review of the Minimum Data Set (MDS) assessment completed on 04/29/25 revealed Resident #16 had intact cognition and was independent with eating, oral hygiene, showering, and dressing. He required partial to moderate staff assistance with toileting and was dependent on a manual wheelchair for mobility due to a severe foot deformity and the inability to walk. Review of Resident #16's care plan dated 02/05/24 included a goal that the resident would receive the appropriate staff support with all functional abilities and interventions to include mobility devices as ordered. The care plan also revealed the resident was at risk for pressure areas and frequent skin tears to extremities secondary to thin, fragile skin, and history of leukemia, anemia, reduced mobility, muscle weakness, contractures to the right hand, fingers, right ankle/foot, and right foot club deformity and he preferred not to wear the splint/brace. The skin care plan (updated on 06/08/24) stated the resident was seen by the podiatrist, he was diagnosed with onychomycosis (a fungal infection) and his shoes were worn out and he needed new shoes. Interventions included to administer medications/treatments as ordered and encourage the residents not to ambulate on his right foot. Review of Resident #16's podiatry notes dated 06/07/24 stated Shoes are worn out, needs new shoes, right foot severely deformed. Interview with Resident #16 on 05/27/25 at 1:23 P.M. confirmed he would like to have a new orthopedic boot to help with positioning of his right foot. He stated his boot went bad, and that he would wear it regularly if he had a newer boot. Observation on 05/27/25 at 12:36 P.M. of Resident #16's orthopedic boot revealed the bottom area was worn down with no tread, there was a medium sized hole out of the fabric of the heel, and it was unkempt with wear and dirt. Interview with Licensed Practical Nurse #14 on 05/28/25 at 2:42 P.M. confirmed she had not seen Resident #16 wear his orthopedic boot unless he went to an outside appointment, which did not happen often. Interview with the Director of Nursing (DON) on 05/29/25 at 9:57 A.M. confirmed the Podiatrist recommended a new boot for Resident #16 at his last appointment on 06/07/24, but the facility did not follow up on the recommendations.

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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** Based on record review, interview, and review of facility policy, the facility failed to ensure timely follow-up of pharmacy recommendations. This affected one (Resident #24) out of five residents reviewed for pharmacy recommendations. The facility census was 29. Findings include: Review of the medical record for Resident #24 revealed the resident was admitted on [DATE] with diagnoses including Parkinson's disease, dementia, atherosclerotic heart disease, bradycardia, coronary artery disease (CAD), chronic diastolic heart failure, and hyperlipidemia. Review of the care plan dated 12/31/19 revealed the resident had cardiopulmonary/circulatory/coronary conditions with interventions that included to administer medications as ordered. Review of physician orders dated 03/01/24 revealed Resident #24 was prescribed Aspirin 81 milligrams (mg) daily for CAD. Review of Resident #24's progress note dated 07/16/24 documented a monthly medication regimen review was completed with recommendations made. Review of Resident #24's medication regimen review dated 07/16/24 revealed the pharmacist recommended evaluating the resident's Aspirin use in the context of current cardiovascular disease (CVD) primary prevention guidelines and suggested discontinuation. There were two options to mark, to discontinue the Aspirin or other. The Director of Nursing (DON) selected other with a notation to continue CVD prevention and indicated the medical director was notified, and no new order was provided. The prescriber response section was left blank, and the form contained only the Director of Nursing's signature. Review of Resident #24's progress note dated 08/14/24 revealed a subsequent monthly medication regimen review was completed with no new recommendations. Review of the email dated 08/15/24 from the facility's pharmacist to the Director of Nursing revealed there was a request for response from 07/16/24 regarding Resident #24 and another resident's medication regimen review. Review of Resident #24's medication regimen review recommendations follow-up form dated 08/15/24 noted the recommendation from 07/16/24 was still pending final response. The form documented a physician acknowledgment to discontinue Aspirin, signed by the provider, but lacked a date. Review of Resident #24's physician orders revealed on 08/20/24 the residents Aspirin was discontinued. Interview on 05/28/25 at 2:26 PM with the Director of Nursing confirmed the residents medical record did not provide a rationale or date on the recommendation from 07/16/24 from the physician. Additionally, although a response was requested again on 08/15/24, the discontinuation order was not finalized until 08/20/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Medication Regimen Review, dated 08/05/24, revealed all medication regimen review findings must be documented in the resident's medical record by the attending physician, including the action taken or rationale for no change.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to ensure proper food handling techniques when checking food temperatures. This had the potential to affect all 29 residents in the facility. Findings include: Observation on 05/28/25 at 11:35 A.M. revealed [NAME] #36 checked the temperature of the lunch meal including the pork, beef, German potato salad, peas, ground meats, and soup, in that order. Between each food checked, [NAME] #36 wiped the thermometer on a dry rag, which was resting on the steam table counter. Interview on 05/28/25 at 11:39 A.M., [NAME] #36 verified she wiped the thermometer on a dry rag between each food. [NAME] #36 stated she normally used alcohol wipes, but could not locate them when she started checking the temperatures. Interview on 05/28/25 at 11:40 A.M., Chef #57 verified alcohol wipes should have been used to clean the thermometer in between obtaining the temperature of each food. Review of the facility policy titled, Hazard Analysis Critical Control Points and Food Safety, dated 2023, revealed staff would be aware of sources of food-borne organisms in food service including contaminated equipment, improper sanitation, and cross contamination.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, hospice record review, staff interviews, and review of facility policy and procedure, the facility failed to ensure hospice communication/documentation was maintained by the facility. This affected one (Resident #6) of one reviewed for hospice services. The facility census was 29. Findings include Review of the medical record for Resident #6 revealed an admission date of 06/17/17. Diagnoses included psychotic disorder with delusions, muscle weakness, dementia, malnutrition, delusion disorder and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was cognitively impaired. It noted he was dependent on staff assistance for bed mobility, and required total dependence of one staff for eating. Review of physician orders for Resident #6 revealed an order dated 09/14/23 for admission to hospice services. Review of Resident #6's hospice episode detail report dated 03/27/25 revealed a summary of hospice orders. Review of Resident #6's hospice notes revealed the facility had only maintained documentation through 03/25/25. Observation, record review, and interview on 05/28/25 at 8:49 A.M. with Licensed Practical Nurse (LPN) #14 revealed a hospice binder was found at the nursing station. Within the binder included documents of a calendar for 2023, 2024 and 2025 with visits written by N, SW, HC, and CH over the date. The calendar included no details about what was occurring on those visits, what staff treated the resident, or needs/concerns addressed and/or care provided. The binder included a comprehensive assessment from hospice dated 04/03/24 and 05/15/24, and a set of orders reviewed and signed by the physician dated 05/01/24. LPN #14 confirmed the binder contained no documentation from the previous year and confirmed the binder included no notes or details of the visits. LPN #14 revealed she would have to check with social services to see if he maintained updated records. Interview on 05/28/25 at 9:07 A.M. with Liaison #30 who reported the facility maintained the hospice records in the medical record. He revealed it was under the observations section in the electronic health record and after reviewing the electronic medical record with Liaison #30, he confirmed updated hospice documentation was not found in the electronic medical record. He revealed he was uncertain where to find documentation and revealed the Director of Nursing (DON) should have it. Interview on 05/28/25 at 9:20 A.M. to 10:15 A.M. with the DON confirmed the hospice documentation should be present in the facility and confirmed she did not have the records. The DON revealed the documentation was likely in the queue to be scanned into the medical record. The DON confirmed the facility found documents in the queue and the Director of Social Services was scanning them in now. She provided evidence of progress notes from past dates up to March 2025. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/28/25 at 10:27 A.M. with the Director of Social Services #38 confirmed the remainder of hospice documents were provided for review and the most recent date was March 2025. The facility was unable to provide evidence of hospice notes and documentation from April 2025 or May 2025. Interview on 05/28/25 at 10:35 A.M. with Hospice Registered Nurse #255 confirmed hospice completed comprehensive assessments at least quarterly and hospice sent progress notes over to the facility from nursing, social services, pastoral services and bath aide on a weekly basis in a bundle. Hospice RN #255 confirmed the facility should maintain the records that were transmitted to them and confirmed hospice kept on track with sending weekly notes and confirmed hospice tracked the timeliness of and completeness of notes to verify the facility received timely information. She denied any concerns related to a delay. Review of facility policy titled, Hospice dated 07/22/24, revealed the facility shall ensure coordination of care for all skilled nursing facility hospice patients.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure sanitary practices were performed during medication administration. This affected three residents (#22, #29, and #136) out of twelve observed during medication administration. The facility census was 29. Findings include: 1. Review of the medical record for Resident #29 revealed an admission date of 12/23/24 with diagnoses including pulmonary hypertension, gastro-esophageal reflux disease with esophagitis, hypertension, cardiomegaly, and chronic systolic heart failure. Review of the care plans dated 01/02/25 and 03/10/25 revealed Resident #29 had chronic cardiopulmonary and gastrointestinal conditions, with an approach to administer medications as ordered by the physician. Review of physician orders dated 03/26/25 revealed an order for Carvedilol 6.25 milligrams (mg), one tablet, scheduled between 10:00 A.M. and 1:00 P.M. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 had no cognitive impairment. Review of physician orders dated 04/04/25 revealed an order for Protonix delayed-release 40 mg, one tablet, scheduled between 10:00 A.M. and 1:00 P.M. Observation on 05/28/25 at 12:05 P.M. during medication administration with Licensed Practical Nurse (LPN) #14 revealed Protonix and Carvedilol, each in a single-dose blister pod, were prepared for administration. LPN #14 used the tip of a pen retrieved from a stack of papers on the medication cart to create a U-shaped opening in the blister pod. The tablets were then removed through the opening, and the pen was returned to the paper. 2. Review of the medical record for Resident #22 revealed an admission date of 04/23/20 with diagnoses including Parkinson's disease, mild cognitive impairment, mood disorder, and ataxic gait. Review of physician orders dated 12/17/24 revealed Resident #22 was ordered Sinemet (anti-Parkinson ' s medication) 1.5 tablets, 25-100 milligrams (mg) every three hours. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 had severe cognitive impairment. Review of the care plan dated 03/02/25 revealed Resident #22 had Parkinson's disease, with an approach to administer medications/treatments as ordered. Observation on 05/28/25 at 12:15 P.M. during medication administration with Licensed Practical Nurse (LPN) #14 revealed Sinemet located in a single-dose blister pod. To open the pod, LPN #14 used the tip of a pen retrieved from a stack of papers on the medication cart to create a U-shaped opening. The tablet was removed through the opening, and the pen was returned to the paper. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365416	A. Building B. Wing	05/29/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #136 revealed an admission date of 05/20/25 with diagnoses including Parkinson's disease, lack of coordination, cognitive communication deficit, difficulty walking, and history of falls. Review of physician orders dated 05/20/25 revealed Resident #136 was ordered Sinemet 25-100 milligrams (mg) one tablet three times daily at 8:00 A.M., 1:00 P.M., and 8:00 P.M. Review of Resident #136's care plan dated 05/27/25 revealed a diagnosis of Parkinson's disease, with an approach to administer medications/treatments as ordered. Observation on 05/28/25 at 12:21 P.M. during medication administration with Licensed Practical Nurse (LPN) #14 revealed Sinemet located in a single-dose blister pod. To open the pod, LPN #14 used the tip of a pen retrieved from a stack of papers on the medication cart to create a U-shaped opening. The tablet was removed through the opening, and the pen was returned to the paper. Interview on 05/28/25 at 12:31 P.M. with LPN #14 confirmed that single-dose blister pods for Residents #22, #29, and #136 were opened with the tip of a pen that was located on the nurses cart during the entire medication administration. Additionally, the pen was left unattended and had never received sanitation. LPN #14 acknowledged the potential infection risk, confirming that the pills passed through the potentially contaminated opening before being placed into the medication cup. Interview on 05/29/25 at 10:00 A.M. with the Director of Nursing confirmed the potential infection risk associated with using a contaminated pen to open single-dose blister pods. Review of medication administration policy dated January 2025 revealed medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles, and practices. Additionally, during medication administration, staff should avoid touching any of the medication unless wearing gloves.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of the infection control log, and review of facility policy and procedure, the facility failed to follow its antibiotic stewardship protocol by administering antibiotics without meeting established clinical criteria. This affected two (Resident #17 and Resident #32) of three residents reviewed for antibiotic use. The facility census was 29. Findings include: 1. Review of the medical record for Resident #17 revealed an admission date of 02/21/25 with diagnoses including vascular dementia, dysphagia, cystitis, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the admission Minimum Data Set (MDS) dated [DATE] for Resident #17 showed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Resident #17 required substantial to maximal assistance with toileting hygiene and was documented as always incontinent of bowel and bladder. Review of the care plan dated 02/26/25 for Resident #17 identified bowel and bladder incontinence. Interventions included to encourage fluids, provide routine incontinence care, obtain labs and tests as ordered, and monitor for signs of infection. Review of the hospital record dated 05/01/25 for Resident #17 revealed a urinalysis showed no bacteria present in the residents urine. A diagnosis of cystitis with hematuria was documented, and antibiotics were prescribed. Review of a physician order dated 05/01/25 for Resident #17 revealed an order for Cephalexin 500 mg, to be administered twice daily for seven days for a diagnosis of urinary tract infection (UTI). Review of the facility's infection tracking log event report dated 05/01/25 for Resident #17 indicated a diagnosis of a UTI made at the hospital. The infection log stated a urine culture was performed, but results were unknown. Resident #17 was noted to have bloody urine, but did not exhibit additional symptoms required to meet McGeers' Criteria. The evaluation noted the resident completed antibiotic therapy and the Medical Director was aware McGeers' criteria was not met, but wanted to treat from hospitalization. Review of the May 2025 Medication Administration Record (MAR) for Resident #17 revealed Cephalexin was administered from 05/01/25 through 05/07/25. Interview conducted on 05/29/25 at 2:11 P.M. with the Director of Nursing (DON) confirmed Resident #17 did not meet McGeers' Criteria for treatment of a urinary tract infection. The DON stated that the physician was notified, but antibiotic therapy was continued based on the hospital diagnosis and physician decision. 2. Review of the medical record for Resident #32 revealed an admission date of 03/27/25 with diagnoses including osteopathic, obesity, constipation, diarrhea, reduced mobility, and nondirective gastroenteritis and colitis. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's infection tracking log event report dated 03/27/25 revealed a urine culture was completed for Resident #32. Culture results were noted as have not received results-completed in the hospital. Review of the McGeers' criteria indicated the questionnaire was incomplete, with the result noted as does not meet McGeers' criteria and a manual trigger marked yes for appropriate antibiotic usage. Review of physician orders dated 03/28/25 revealed sulfamethoxazole-trimethoprim (antibiotic medication) 800-160 milligrams was ordered to be administered twice daily, starting 03/29/25 through 04/02/25. Review of the Medication Administration Record (MAR) from 03/29/25 through 04/02/25 confirmed sulfamethoxazole-trimethoprim tablets were administered as ordered. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 was cognitively intact, was dependent on staff assistance for toileting, and was always continent of bowel and bladder. Review of the care plan dated 04/07/25 revealed that Resident #32 was at risk for bowel and bladder incontinence, placing the resident at risk for infection. Interventions included to provide routine incontinence care, assess for needs as they arise, perform labs and tests as ordered, and monitor for signs and symptoms of infection. Interview conducted with the Director of Nursing (DON) on 05/29/25 at 2:11 P.M. confirmed Resident #32 continued on the prescribed antibiotic following their readmission, despite the absence of documentation indicating the presence or confirmed identification of an organism in the urine. Additionally, the DON acknowledged that comprehensive data supporting McGeers' criteria had not been documented in the facility's infection tracking log event report. Review of the Antibiotic Stewardship policy, revised 09/14/23, revealed antibiotic treatment will only be considered if the suspected infection meets McGeers' criteria and if pathology strongly suggests a bacterial origin. For urinary tract infections without a catheter, both Criteria One and Two must be met. Criteria One includes symptoms such as acute flank or supra pain, increased incontinence, urgency or frequency, and fever. In the absence of a fever, at least two of the other listed symptoms must be present. Criteria Two requires a urine culture showing at least 100,000 colony forming units per milliliter (CU/ml) of no more than two species, or 100 CU/ml of any number of organisms if collected via straight catheter.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of personnel files and staff interview, the facility failed to ensure one staff completed at least 12-hours of education each year. This had the potential to affect all residents residing in the facility. The facility census was 29. Findings include Review of the personnel file for Certified Nursing Assistant (CNA) #5 revealed they began employment on 04/06/20. Review of the training logs revealed CNA #5 had completed several training's in 10/29/23. Since 10/29/23, the CNA had only completed 6.25 hours of continuing education. The educations included a medicaid waiver education on 06/24/24 for 0.25 hours, understanding dementia on 02/02/25 for one hour, communication on 02/02/25 for one hour, challenging behavior on 02/02/25 for one hour, activity on 02/04/25 for one hour, dining on 02/04/25 for one hour, and personal care on 02/04/25 for one hour. Interview on 05/29/25 at 10:50 A.M. with Human Resources #19 confirmed CNA #5 had not completed 12 hours of education in the previous 19 months. She reported the facility completed education on a rolling calendar from July to June and acknowledged this could allow staff to complete training at the beginning of one year and the end of another leading to over 12 months without required training being completed. Review of the facility policy titled, Training and Staff Development dated July 2024 revealed the facility shall encourage all employees to attend and participate in applicable training. The policy revealed training shall be completed from July 1st to June 30th each year. The policy did not include details of completing 12 hours of continuing education.