

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365829	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/13/2025
NAME OF PROVIDER OR SUPPLIER  Villa Springfield Rehabilitation and Healthcare Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Villa Road Springfield, OH 45503	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the medical record, staff interviews, and policy review, the facility failed to ensure the resident's physician and/or provider was notified timely when residents developed significant weight loss. This affected two Residents (#31 and #48) of the twelve residents reviewed for significant weight loss. The facility census was 93.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #31 revealed an admission date of 05/11/20. Diagnoses included cirrhosis of liver, thrombocytopenia, and major depressive disorder.</p> <p>Review of the monthly weight records for Resident #31 revealed the following dates and weights:</p> <p>a) On 07/01/24, the resident was recorded at 132.1 pounds (lbs.).</p> <p>b) There was no documented weight recorded for August 2024.</p> <p>c) There was no documented weight recorded for September 2024.</p> <p>d) On 10/03/24: the resident was recorded at 114 lbs.</p> <p>e) On 10/15/24: the resident was recorded at 110 lbs.</p> <p>Review of the care plan for Resident #31 dated 07/14/24, revealed Resident #31 was at risk for altered nutritional status related to dementia, depression, hypertension, and psychosis. Interventions included to administer medication and/or vitamin/mineral supplements per physician order, monitor meal percentage intake for changes in eating habits, periodically obtain weight, evaluate, and report to the Registered Dietician (RD), physician, and family of significant weight changes, and provide feeding and dining assistance as needed.</p> <p>Review of Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #31 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. This resident was assessed to require setup with eating.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Nurse Practitioner (NP) #211 on 02/13/25 at 8:18 A.M., verified she was never notified of Resident #31's significant weight loss by the facility, nor did she receive any notification from RD #210.</p> <p>Review of the medical record for Resident #31 revealed there was no documentation regarding notification to the physician and/or provider in relation to the resident's significant weight loss.</p> <p>2) Review of the medical record for Resident #48 revealed an admission date of 08/13/24. Diagnoses included depression, malignant neoplasm of prostate, and metabolic encephalopathy.</p> <p>Review of the weight records for Resident #48, revealed the following dates and weights:</p> <ul style="list-style-type: none"> <li>a) On 08/13/24, the resident weighed 204 lbs.</li> <li>b) On 09/12/24, the resident weighed 196 lbs.</li> <li>c) There was no documented weight recorded for October 2024.</li> <li>d) On 11/11/24, the resident weighed 193 lbs.</li> <li>e) On 12/06/24, the resident weighed 188 lbs.</li> <li>f) On 01/03/25, the resident weighed 177.6 lbs.</li> <li>g) On 01/23/25, the resident weighed 171.6 lbs.</li> <li>h) On 02/05/25, the resident weighed 163.2 lbs.</li> <li>i) On 02/11/25, the resident weighed 161 lbs.</li> </ul> <p>Review of the most recent MDS assessment dated [DATE], revealed Resident #48 had intact cognition as evidenced by a BIMS score of 15. This resident was assessed to require setup with eating, substantial assistance with toileting, bathing, and dressing, and partial assistance with transfers.</p> <p>Review of the care plan for Resident #48 dated 12/02/24, revealed the resident was at risk for altered nutritional status related to depression, hypertension, and abnormal lab values. Interventions included to administer medications and/or vitamin/mineral supplements per physician orders, monitor meal percentage intake for changes in eating habits, periodically obtain weight, evaluate, and report to the RD, physician, and family of significant weight changes.</p> <p>Interview on 02/12/25 at 1:28 P.M. with RD #210, revealed she was tasked with completing a monthly notification to the physician and/or providers for residents with significant weight loss.</p> <p>Interview with NP #211 on 02/13/25 at 8:18 A.M., revealed she was never notified of Resident #48's significant weight loss by the facility, nor did she receive any notification from RD #210.</p> <p>Review of the medical record for Resident #48, revealed there was no documentation regarding notification to the physician and/or provider in relation to the resident's significant weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Physician Notification, dated September 2021, revealed physicians were immediately informed of resident changes in condition that required immediate notification, resulting in the resident receiving prompt medical intervention. Non-immediate notification revealed the physician should be informed of the problem or event during office hours and generally no later than the next regular office day. The physician may be notified at any time via facsimile communication.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2) Review of the medical record of Resident #53 revealed an admission date of 11/15/24. Diagnoses included mild dementia with mood disturbance, anxiety, depression, and psychosis.</p> <p>Review of the quarterly MDS for Resident #53 dated 01/06/25, revealed the resident had severely impaired cognition. The resident exhibited wandering, fluctuating inattention and disorganized thinking during the assessment period. The resident required supervision with eating, partial/moderate assistance with bed mobility, and substantial/maximal assistance with toileting, showering, and transfers.</p> <p>Review of a progress note for Resident #53 dated 11/19/24 at 3:04 P.M., revealed the resident's daughter was provided with a copy of the baseline care plan on 11/18/24.</p> <p>Review of the care plans for Resident #53, revealed the care plan was created on 11/19/24.</p> <p>Interview with SSD #105 on 02/12/25 at 9:57 A.M., verified Resident #53 was admitted on [DATE] and a care plan was created on 11/19/24. SSD #105 stated a baseline care plan should be created within 48 hours of admission.</p> <p>Review of the facility policy titled, Baseline Care Plan, dated September 2021, indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. To ensure the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission. The resident and their representative would be provided a summary of the baseline care plans that included but was not limited to the initial goals of the resident, summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility and any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure baseline care plans were developed within 48 hours of admission. This affected two Residents (#15 and #53) of the 11 residents reviewed for baseline care plans. The facility census was 93.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #15 revealed an admission date of 08/09/24. Diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), hyperlipidemia, atherosclerotic heart disease (ASHD), hypothyroidism, and congestive heart failure.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #15 dated 11/21/24, revealed the resident had moderate cognitive impairment and required supervision with toilet hygiene and transfers, and partial/moderate assist with bathing and was independent with bathing.</p> <p>Review of the medical record for Resident #15 revealed all baseline care plans were created on 08/13/24, except for a smoking care plan which was dated 08/12/24.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Interdisciplinary Team (IDT) note for Resident #15 dated 08/12/24 at 8:55 A.M., revealed the resident was presented with a list of medications, therapy orders, dietary instructions given with explanation and a copy of baseline care plans.</p> <p>Review of an Interdisciplinary Team (IDT) note for Resident #15 dated 08/20/24 at 4:55 A.M. revealed Resident #15's son was presented with a copy of baseline care plans, resident medication list, therapy orders, and dietary instructions.</p> <p>Interview on 02/12/25 at 9:56 A.M. with Social Service Director (SSD) #105, verified Resident #15 was admitted on [DATE] and verified Resident #15's baseline care plans were not created until 08/13/24. SSD #105 verified there was an IDT note dated 08/12/24 indicating Resident #15 was given a copy of baseline care plans on 08/12/24. SSD #105 verified Resident #15's son was given a copy of baseline care on 08/20/24.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 5) Review of medical record for Resident #51 revealed the resident was admitted to the facility on [DATE]. Diagnoses included COPD, dysphasia, hypokalemia, sepsis, chronic kidney disease, hypothyroidism, essential primary hypertension, gout, major depressive disorder, and adjustment disorder.</p> <p>Review of the most recent MDS assessment dated [DATE], revealed Resident #51 was cognitively intact.</p> <p>Review of a care conference note revealed Resident #51 had a care conference on 08/20/24. There was no other documented care conference for Resident #51.</p> <p>Interview with SSD #105 on 01/12/25 at 10:25 A.M., verified Resident #51 had a care conference on 08/20/24 and there was no other care conferences held for the resident in the past year.</p> <p>Review of the facility policy titled, Care Conference, dated 09/01/21, revealed the facility will hold regular interdisciplinary care conferences to provide residents and families with the opportunity to participate in the plan of care. Further review of the facility revealed each resident shall be invited to participate.</p> <p>2) Review of the medical record for Resident #20 revealed an admission date of 02/21/23. Diagnoses included heart failure, acute pulmonary edema, type two diabetes mellitus, and cirrhosis of the liver.</p> <p>Review of the most recent MDS assessment dated [DATE], revealed Resident #20 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12.</p> <p>Review of the care conferences for the last 12 months revealed Resident #20 did not receive any care conferences.</p> <p>Interview with SSD #105 on 02/12/25 at 9:58 A.M., verified care conferences were not completed for Resident #20 for the last 12 months.</p> <p>3) Review of the medical record for Resident #31 revealed an admission date of 05/11/20. Diagnoses included cirrhosis of liver, thrombocytopenia, and major depressive disorder.</p> <p>Review of most recent MDS assessment dated [DATE], revealed Resident #31 had moderate cognitive impairment as evidenced by a BIMS score of nine.</p> <p>Review of the care conferences for the last 12 months, revealed Resident #31 had one care conference on 06/11/24.</p> <p>Interview with SSD #105 on 02/12/25 at 9:58 A.M., verified care conferences were not completed for Resident #31 for the last 12 months besides on 06/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4) Review of the medical record for Resident #33 revealed an admission date of 01/05/23. Diagnoses included COPD, type two diabetes mellitus, and PVD.</p> <p>Review of the most recent assessment dated [DATE], revealed Resident #33 had intact cognition as evidenced by a BIMS score of 15.</p> <p>Review of the care conferences for the last 12 months revealed Resident #33 did not receive any care conferences.</p> <p>Interview with SSD #105 on 02/12/25 at 9:58 A.M., verified care conferences were not completed for Resident #33 for the last 12 months.</p> <p>Based on medical record reviews, staff interviews, and policy review, the facility failed to conduct care conferences as required. This affected five residents (#15, #20, #31, #33, and #51) of the 19 residents reviewed for care conferences. The facility census was 93.</p> <p>Findings included:</p> <p>1) Review of the medical record for Resident #15 revealed an admission date of 08/09/24. Diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), hyperlipidemia, atherosclerotic heart disease (ASHD), hypothyroidism, and congestive heart failure.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #15 dated 11/21/24, revealed the resident had moderate cognitive impairment.</p> <p>Review of the medical record for Resident #15, revealed no documented evidence the facility conducted quarterly care conferences with the resident or the resident's representative or members of the Interdisciplinary Team (IDT).</p> <p>Interview with Social Service Director (SSD) #105 on 02/12/25 at 9:56 A.M., verified the facility had not conducted quarterly care conferences for Resident #15 which included resident representative or member of the IDT since admission care conference on 08/12/14.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on medical record review, staff and resident interviews, and policy review, the facility failed to ensure showers were provided as scheduled. This affected one Resident (#15) of the four residents reviewed for showers/baths. The facility census was 93.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #15 revealed an admission date of 08/09/24. Diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), hyperlipidemia, atherosclerotic heart disease (ASHD), hypothyroidism, and congestive heart failure.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 11/21/24, revealed the resident had moderate cognitive impairment and required supervision with toilet hygiene and transfers, and partial/moderate assist with bathing and was independent with bathing.</p> <p>Review of the shower schedule for Resident #15, revealed the resident was to receive a shower/bath on Wednesdays and Saturdays between 7:00 A.M. to 3:00 P.M.</p> <p>Review of Resident #15's shower documentation, revealed showers were received on 12/21/24, 12/28/24, 01/03/25, 01/10/25, 01/15/25, 01/22/25, 01/26/25, 02/05/25, and 02/12/25.</p> <p>Interview with Resident #15 on 02/11/25 at 11:39 A.M., revealed the resident does not receive showers as scheduled. Resident #15 stated she may get one shower weekly.</p> <p>Interview with Director of Nursing (DON) on 02/12/25 at 1:24 P.M., verified Resident #15 did not receive two showers per week as scheduled in December 2024, January 2025, and February 2025. The DON verified the medical record for Resident #15 did not contain documentation to support Resident #15 refused any showers/baths on her scheduled days.</p> <p>Review of the facility policy titled, Activities of Daily Living (ADLs), stated residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The residents who are unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The staff would provide appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care), mobility (transfers and ambulation), elimination (toileting), dining (meals and snacks) and communication (speech, language, and any functional communication systems).</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the medical record, staff interviews, and policy review, the facility failed to adequately monitor weights and implement appropriate interventions in a timely manner. This affected two Residents (#31 and #48) of the twelve residents reviewed for significant weight loss. The facility census was 93.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #31 revealed an admission date of 05/11/20. Diagnoses included cirrhosis of liver, thrombocytopenia, and major depressive disorder.</p> <p>Review of the care plan for revealed Resident #31 dated 07/14/24, revealed the resident was at risk for altered nutritional status related to dementia, depression, hypertension, and psychosis. Interventions included to administer medication and/or vitamin/mineral supplements per physician order, monitor meal percentage intake for changes in eating habits, periodically obtain weight, evaluate, and report to Registered Dietician (RD), physician, and family of significant weight changes, and provide feeding and dining assistance as needed.</p> <p>Review of the monthly weight records for Resident #31 revealed the following dates and weights:</p> <p>a) On 07/01/24, the resident was recorded at 132.1 pounds (lbs.)</p> <p>b) There was no documented weight recorded for August 2024.</p> <p>c) There was no documented weight recorded for September 2024.</p> <p>d) On 10/03/24, the resident was recorded at 114 lbs.</p> <p>e) On 10/15/24, the resident was recorded at 110 lbs.</p> <p>Review of the physician order for Resident #31 dated 10/15/24, revealed the resident was ordered a super donut breakfast one time a day for weight loss.</p> <p>Review of the nutritional assessment for Resident #31 dated 11/23/24, revealed the resident had not had a weight loss in the last three months and was at risk for malnutrition.</p> <p>Review of Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #31 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. This resident was assessed to require setup with eating, substantial assistance with toileting and bathing, partial assistance with dressing, and supervision with transfers.</p> <p>Review of the physician order for Resident #31 dated 12/20/24, revealed the resident was ordered a health shake with lunch and dinner.</p> <p>Observations of the lunch meal service on 02/12/25 and 02/13/25 revealed Resident #31 was able to feed self and ate 25-50 percent of meals.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RD #210 on 02/12/25 at 1:28 P.M., verified all residents should be weighed monthly unless weights needed to be monitored more often. RD #210 verified Resident #31 did not get weighed in August and September 2024, and Resident #31 was noted to have an 18-pound weight loss when weighted in October 2024, which was a 13.7 percent weight loss in 90 days. RD #210 also verified residents, who had a significant weight loss, were weighed more frequently than monthly to ensure weights were stabilizing after interventions were put into place.</p> <p>2) Review of the medical record for Resident #48 revealed an admission date of 08/13/24. Diagnoses included depression, malignant neoplasm of prostate, and metabolic encephalopathy.</p> <p>Review of the weight records for Resident #48 revealed the following dates and weights:</p> <p>a) On 08/13/24, the resident weighed 204 lbs.</p> <p>b) On 09/12/24, the resident weighed 196 lbs.</p> <p>c) There was no documented weight recorded for October 2024</p> <p>d) On 11/11/24, the resident weighed 193 lbs.</p> <p>e) On 12/06/24, the resident weighed 188 lbs.</p> <p>f) On 01/03/25, the resident weighed 177.6 lbs.</p> <p>g) On 01/23/25, the resident weighed 171.6 lbs.</p> <p>h) On 02/05/25, the resident weighed 163.2 lbs.</p> <p>i) On 02/11/25, the resident weighed 161 lbs.</p> <p>Review of the MDS assessment dated [DATE], revealed Resident #48 had intact cognition as evidenced by a BIMS score of 15. This resident was assessed to require setup with eating, substantial assistance with toileting, bathing, and dressing, and partial assistance with transfers.</p> <p>Review of the care plan for Resident #48 dated 12/02/24, revealed the resident was at risk for altered nutritional status related to depression, hypertension, and abnormal lab values. Interventions included to administer medications and/or vitamin/mineral supplements per physician orders, monitor meal percentage intake for changes in eating habits, periodically obtain weight, evaluate, and report to registered dietician, physician, and family of significant weight changes.</p> <p>Review of the physician order dated 01/27/25, revealed Resident #48 was ordered a health shake two times a day for risk of malnutrition 120 cubic centimeters (cc).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nutritional assessment for Resident #48 dated 02/10/25, revealed the resident had a weight loss greater than 6.6 lbs. in the last three months. The nutritional assessment also revealed Resident #48 had not had a decrease in food intake. After reviewing the meal intake records for Resident #48 since admission in August 2024 revealed Resident #48 had been refusing breakfast consistently since December 2024. After reviewing meal intakes, Resident #48 was only eating around 50 percent of meals for lunch and dinner, which had changed since admission.</p> <p>Interview with RD #210 on 02/12/25 at 1:46 P.M., verified Resident #48 had a significant weight loss since admission, which was 21 percent in the six months. RD #210 reported that the resident was ordered a health shake on 01/27/25 to consume with lunch and dinner. RD #210 reported Resident #48 had been eating 75 percent of his meals in December, but as of recently, he was averaging about 45 percent of meal intakes. RD #210 reported the resident was out to the hospital from [DATE] through 01/22/25, which could have played a role in some of his weight loss. RD #210 explained Resident #48 was on diuretic therapy, which could have pertained to some weight loss as well.</p> <p>Observations of lunch meal services on 02/12/25 and 02/13/25 for Resident #48 revealed the resident was dependent on staff for meals and ate about 25 percent of meals.</p> <p>Interview with Nurse Practitioner (NP) #211 on 02/13/24 at 8:18 A.M., revealed she was unaware of the weight loss of Resident #48. NP #211 reported RD #210 had not notified her of any significant weight changes for Residents #31 or #48. NP #211 also explained residents with significant weight changes should be monitored more often than monthly to ensure residents were not continuing to lose weight and to identify and implement appropriate interventions.</p> <p>Review of the facility policy titled, Weight Assessment and Intervention, dated September 2021 revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff would measure resident weights on admission, and at least monthly unless otherwise ordered by the physician. The dietician would review the weights to follow individual weight trends over time. Negative trends would be evaluated by the treatment team whether or not the criteria for significant weight change had been met. Interventions for undesirable weight loss should be based on careful considering of the following: nutrition and hydration needs of the resident, chewing and swallowing abnormalities and the need for diet modifications, the use of supplementation and/or feeding tubes, and end of life decisions and advance directives.</p>		

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NAME OF PROVIDER OR SUPPLIER  Villa Springfield Rehabilitation and Healthcare Ce		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Villa Road Springfield, OH 45503	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observations, staff interviews, and policy review, the facility failed to ensure insulin vials were stored properly. This affected four Residents (#09, #186, #188, and #191) who received insulin. The facility identified nine residents received insulin. The facility census was 93.</p> <p>Findings include:</p> <p>Observations of the Skilled One medication cart on 02/11/25 at 7:35 A.M. with the Director of Nursing (DON), revealed Resident #09's insulin glargine (hormone that regulates blood sugar levels) vial 100 units per milliliter (ml) was opened and not dated. Resident #186's insulin glargine vial 100 units per ml was new, unopened and not being stored in the refrigerated. Interview with DON at the same time, verified Resident #09's insulin vial was opened and not dated and Resident #186's insulin vial should have been refrigerated since it had not been opened yet.</p> <p>Observations of the Skilled Two medication cart on 02/11/25 at 7:50 A.M. with Registered Nurse (RN) #192, revealed Resident #191's insulin Lispro vial 100 units per ml was new, unopened, and not refrigerated. Resident #188's Lantus SoloStar insulin 100 units per ml pen-injector was new, unopened and stored in the refrigerator. Interview with RN #192 at the same time, verified both Resident #191's insulin vial and Resident #188's insulin pen-injector should have been refrigerated since neither had been opened.</p> <p>Review of the facility policy titled, Storage of Medication, dated 09/01/21, revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy stated the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals and stated all drugs shall be returned to the dispensing pharmacy or destroyed. The policy continued to state medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurse's station or other secured location. Medications must be stored separately from food and must be labeled accordingly.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the medical record, staff interviews, observations, and policy review, the facility failed to ensure supplements were served in a manner appropriate for consumption. This affected one Resident (#48) of the 37 residents on supplements. The facility census was 93.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #48 revealed an admission date of 08/13/24. Diagnoses included depression, malignant neoplasm of prostate, and metabolic encephalopathy.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #48 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require setup with eating.</p> <p>Review of the care plan dated 12/02/24, revealed Resident #48 was at risk for altered nutritional status related to depression, hypertension, and abnormal laboratory (lab) values. Interventions included: administer medications and/or vitamin/mineral supplements per the physician orders, monitor meal percentage intake for changes in eating habits, periodically obtain weight, evaluate, and report to Registered Dietician (RD), physician, and family of significant weight changes.</p> <p>Review of the physician order dated 01/27/25, revealed Resident #48 was ordered a health shake two times a day for risk of malnutrition 120 cubic centimeters (cc).</p> <p>Observation on 02/13/25 at 12:04 P.M , revealed Certified Nursing Assistant (CNA) #181 reported the health shake on Resident #48's lunch tray was frozen as she attempted to assist him to drink it.</p> <p>Interview on 02/13/25 at 12:06 P.M. with Resident #48 revealed he was unable to drink the health shake because it was frozen.</p> <p>Interview on 02/13/25 at 12:15 P.M. with CNA #181, revealed the health shake for Resident #48 was frozen, so she was unable to provide the supplement to him. CNA #181 verified the health shakes had been frozen for the last few weeks, which made consumption for residents during feeds difficult.</p> <p>Review of the facility policy titled, Facility Nutrition Program, dated September 2021 revealed direct care staff assisted by the facility's clinical dietician, would evaluate each individual's physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. A facility dietician would help assess the nutritional needs and risks of all residents in the facility and help the facility assure that it provided appropriate meals and other nutritional interventions.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure food was stored in a manner to prevent the potential spread of foodborne illness. This had the potential to affect 91 of 93 residents in the facility. The facility identified two Residents (#44 and #52) who did not receive food from the facility. The facility census was 93.</p> <p>Findings include:</p> <p>Observation of the Memory Care Unit refrigerator and freezer on 02/13/25 at 10:58 A.M. with Certified Nursing Assistant (CNA) #144, revealed the following:</p> <ol style="list-style-type: none"> <li>1. A health shake carton opened but not labeled or dated.</li> <li>2. A 3-compartment plastic protein pack containing lunch meat chunks and cheese, which was opened and partially consumed, was not labeled nor dated.</li> <li>4. An insulated container containing fruited gelatin, covered but not labeled nor dated</li> <li>5. A bag of bacon bits, which was open but did not have a label nor date</li> <li>6. A pitcher of an unidentified liquid, approximately 1/4 full, with no label nor date</li> <li>7. A brown bag from subway, containing food, with no label nor date</li> <li>8. A container of yogurt, uncovered and open to air, not labeled, frozen solid</li> <li>9. A brown streak of an unidentified substance on the back panel of the inside of the refrigerator, extending from the top shelf into the lower drawers.</li> </ol> <p>Interview at the same time, with CNA #144, verified the findings in the MCU refrigerator and freezer.</p> <p>Observation of the [NAME] Unit utility room's refrigerator and freezer on 02/13/25 at 11:04 A.M. with Licensed Practical Nurse (LPN) #131, revealed the following:</p> <ol style="list-style-type: none"> <li>1. An insulated bowl, loosely covered with clear plastic wrap, containing unidentifiable contents, which were covered in a black and white fuzzy substance, with no label nor date</li> <li>2. An insulated bowl, containing pudding, which was not labeled nor dated</li> <li>3. A pitcher of lemonade which was not labeled nor dated.</li> <li>4. A plastic container of prune juice which was opened and without label or date</li> <li>5. A 12-ounce bottle of coke, which was approximately 1/4 full, without a label or date</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>6. A slice of pie on a Styrofoam plate, covered in clear plastic wrap, with no label nor date</p> <p>7. A carton of thickened water, opened, with a date of 10/24</p> <p>8. Two pints of ice cream, opened, covered, labeled with a resident's name but no date</p> <p>Interview at the same time with LPN #131 verified the findings in the [NAME] Unit utility room's refrigerator and freezer. LPN #131 verified the items should be labeled and dated. LPN #131 was unsure how long the thickened water was to be stored once opened.</p> <p>Review of the facility policy titled, Refrigerators and Freezers, undated, revealed the facility would ensure safe refrigerator and freezer sanitation and will observe food expiration guidelines. All food shall be appropriately dated to ensure proper rotation by expiration dates. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. Supervisors will be responsible for ensuring food items in refrigerators and freezers are not expired or past perish dates. Refrigerators and freezers will be kept clean and free of debris.</p> <p>Review of the facility policy titled, Foods Brought by Family/Visitors, dated 09/01/21, revealed food brought by family/visitors that is left with the resident to consume later will be labeled with the resident's name and the date. Nursing and/or food service staff will discard any food prepared for the residents that show obvious signs of potential foodborne danger (for example, mold growth and past due package expiration dates).</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the medical record and interviews, the facility failed to maintain adequate documentation of meal intakes. This affected three Residents (#20, #31, and #48) of the nineteen residents reviewed for documentation. The facility census was 93.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #20 revealed an admission date of 02/21/23. Diagnoses included heart failure, acute pulmonary edema, type two diabetes mellitus (DM II), and cirrhosis of the liver.</p> <p>Review of the meal intake records from November 2024 through February 2025, revealed Resident #20 had missing documentation for meal intakes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #20 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12. This resident was assessed to require supervision with eating.</p> <p>Interview on 02/13/25 with the Director of Nursing (DON), reported staff should be documenting all meal intakes in the medical record. The DON also verified Resident #20's meal intakes documentation was incomplete.</p> <p>2) Review of the medical record for Resident #31 revealed an admission date of 05/11/20. Diagnoses included cirrhosis of liver, thrombocytopenia, and major depressive disorder.</p> <p>Review of the meal intake records from November 2024 through February 2025, revealed Resident #31 had missing documentation for meal intakes.</p> <p>Review of the most recent MDS assessment dated [DATE], revealed Resident #31 had moderate cognitive impairment as evidenced by a BIMS score of nine. This resident was assessed to require setup with eating.</p> <p>Review of the care plan dated 07/14/24, revealed Resident #31 was at risk for altered nutritional status related to dementia, depression, hypertension, and psychosis. Interventions included: to administer medication and/or vitamin/mineral supplements per physician order, monitor meal percentage intake for changes in eating habits, periodically obtain weight, evaluate, and report to registered dietician (RD), physician, and family of significant weight changes, and provide feeding and dining assistance as needed.</p> <p>Interview on 02/13/25 with the DON, reported staff should be documenting all meal intakes in the medical record. The DON also verified Resident #31's meal intakes documentation was incomplete.</p> <p>3) Review of the medical record for Resident #48 revealed an admission date of 08/13/24. Diagnoses included depression, malignant neoplasm of prostate, and metabolic encephalopathy.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the most recent MDS assessment dated [DATE], revealed Resident #48 had intact cognition as evidenced by a BIMS score of 15. This resident was assessed to require setup with eating.</p> <p>Review of the meal intake records from November 2024 through February 2025, revealed Resident #48 had missing documentation for meal intakes.</p> <p>Review of the care plan dated 12/02/24, revealed Resident #48 was at risk for altered nutritional status related to depression, hypertension, and abnormal lab values. Interventions included: to administer medications and/or vitamin/mineral supplements per physician orders, monitor meal percentage intake for changes in eating habits, periodically obtain weight, evaluate, and report to registered dietician, physician, and family of significant weight changes.</p> <p>Interview on 02/13/25 at 11:35 A.M. with the DON, reported staff should be documenting all meal intakes in the medical record. The DON also verified Resident #48's meal intakes documentation was incomplete.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, staff interview, record review, employee file review, and facility policy review, the facility failed to track employee call offs related to personal illness as part of the facility surveillance program for infectious diseases. This had the potential to affect all 93 residents who resided in the facility. The facility also failed to ensure annual employee Tuberculosis (TB) screenings were completed. This affected seven employees (Housekeeping Supervisor #103, Licensed Practical Nurses [LPNs] #136, 137 and #154, Certified Nursing Assistants [CNA] #153 and #173, and [NAME] #190) of the seven employee files reviewed but had the potential to affect all residents. The facility census was 93.</p> <p>Findings include:</p> <p>1) Review of the facility's infection control surveillance logs and the corresponding facility's map of infections, the facility did not have any documented information related to the employee calls offs related to personal illness recorded on the surveillance logs.</p> <p>Interview with Human Resource Manager (HRM) #127 on 02/12/25 at 2:03 P.M., revealed the Human Resource Department does not track when employees call off for personal illnesses.</p> <p>Interview with the Administrator and Director of Nursing (DON) on 02/12/25 at 2:24 P.M. verified the facility does not track employee call offs for personal illness as part of the facility's infection control surveillance program.</p> <p>Review of the facility policy titled, Infection Prevention and Control Program, dated September 2022, revealed the facility surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications.</p> <p>2) Review of employee personnel file for Housekeeping Supervisor #103, revealed a hire date of 12/22/22. Review of the file revealed no documentation to support an annual TB screening was completed in 2024.</p> <p>Review of the employee personnel file for Certified Nursing Assistant (CNA) #136, revealed a hire date of 11/11/21. Review of the file revealed no documentation to support an annual TB screening was completed in 2024.</p> <p>Review of the employee personnel file for Licensed Practical Nurse (LPN) #137, revealed a hire date of 05/30/19. Review of the file revealed no documentation to support an annual TB screening was completed in 2024.</p> <p>Review of the employee personnel file for CNA #153, revealed a hire date of 05/30/19. Review of the file revealed no documentation to support an annual TB screening was completed in 2024.</p> <p>Review of the employee personnel file for LPN #154, revealed a hire date of 05/03/13. Review of the file revealed no documentation to support an annual TB screening was completed in 2024.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the employee personnel file for CNA #173, revealed a hire date of 02/21/23. Review of the file revealed no documentation to support an annual TB screening was completed in 2024.</p> <p>Review of the employee personnel file for [NAME] #190, revealed a hire date of 09/20/23. Review of the file revealed no documentation to support an annual TB screening was completed in 2024.</p> <p>Interview on 02/13/25 at 10:37 A.M. with the DON, revealed all employees who have been employed more than one year are required to have an annual TB screening completed. The DON verified the facility did not have documentation to support the aforementioned employees had annual TB screenings completed in 2024.</p> <p>Review of the facility TB Risk assessment dated [DATE], revealed the facility was low risk for TB and an annual screening of symptoms would be completed.</p> <p>Review of the facility policy titled, TB plan, dated 09/2021, stated employees with negative skin test history would have an annual Mantoux if indicated by the facility's TB Risk assessment. The policy stated facilities categorized as low risk on the annual facility TB Risk Assessment do not have to do annual Mantoux but stated an annual assessment for symptoms would be completed.</p>		

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<p>F 0885</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Report COVID19 data to residents and families.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview, review of online guidance from Centers for Medicare and Medicaid Services (CMS), the facility failed to notify the resident's representatives and /or families of the facility's Coronavirus 2019 (COVID-19) status during an outbreak. This had the potential to affect all residents at the facility. The facility census was 93.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #48 revealed the resident was admitted to the facility on [DATE]. Diagnoses included COVID-19, hereditary and idiopathic neuropathy, essential primary hypertension, mixed hyperlipidemia, metabolic encephalopathy, obstructive and reflux uropathy, hypomagnesemia, hypokalemia, and vitamin D deficiency.</p> <p>Review of Minimum Data Set (MDS) assessment for Resident #48, dated 01/14/25, revealed the resident was cognitively intact.</p> <p>Review of the physician orders dated 02/04/25, for Resident #48 revealed an order for the resident to be in droplet isolation until 02/13/25 for COVID-19.</p> <p>Review of the medical record for Resident #62, revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus (DM), metabolic encephalopathy, disorders of magnesium metabolism, essential primary hypertension, chronic obstructive pulmonary disease (COPD), anemia, and vascular dementia.</p> <p>Review of the MDS assessment dated [DATE], revealed Resident #48 had impaired cognition.</p> <p>Review of a physician order dated 02/04/25 for Resident #63, revealed an order for the resident to be in droplet isolation until 02/13/24 for COVID-19.</p> <p>Interview with the Administrator on 02/12/25 at 2:24 P.M. revealed the facility was not aware of the need to notify the residents' representatives and/or families during a COVID-19 outbreak other than posting a sign on the front door. The Administrator verified the facility was not notifying the residents' representatives and/or families by 5:00 P.M. the next calendar when a COVID-19 outbreak was identified in the facility.</p> <p>Review of a CMS Quality Safety and Oversight Memorandum (QSO memo) titled QSO-20-29- NH, dated 05/06/20, revealed the facility would inform residents, their representatives, and families of those residing in facilities by 5:00 P.M. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must not include personally identifiable information; include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and include any cumulative updates for residents, their representatives, and families at least weekly or by 5:00 P.M. the next calendar day following the subsequent occurrence of either each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.</p>		