STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365379	A. BUILDING _____ B. WING _____	03/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LAURELS OF WALDEN PARK	5700 KARL ROAD COLUMBUS, OH 43229

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 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** Based on observation, record review and interview the facility failed to ensure residents (#174, #17 and #15) were provided with a dignified dining experience during the lunch meal on 03/02/20 and failed to ensure Resident #50, who had a [DIAGNOSES REDACTED]. This affected four residents (#174, #17, #15 and #50) of six residents reviewed for dignity. Findings include: 1. Review of Resident #174's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #174's Minimum Data Set (MDS) 3.0 assessment, dated 02/04/20 revealed Resident #174 was severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of three. The MDS further revealed Resident #174 required extensive assist with one to two persons assist for bed mobility, transfers, hygiene, bathing, dressing and toileting needs and required supervision with set up assistance with eating. Review of Resident #174's diet order, dated 02/07/20 revealed a no added salt diet, regular texture, thin consistency, small portions for weight loss. Review of Resident #17's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #17's MDS 3.0 assessment, dated 02/21/20 revealed Resident #17 was severely cognitively impaired with a BIMS score of zero. The MDS further revealed Resident #17 required total assistance with two persons assist for bed mobility, transfers, hygiene, bathing, and toileting needs and required total assistance with one person assist for dressing and eating. Review of Resident #15's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #15's MDS 3.0 assessment, dated 02/17/20 revealed Resident #57 was severely cognitively impaired with a BIMS score of zero. The MDS further revealed Resident #15 required extensive assist with two persons assist for bed mobility, transfer, toileting needs, extensive assist with one person assist for dressing, eating and personal hygiene and total assist with one person assist for bathing. Review of Resident #15's dietary orders dated 09/30/19 revealed an order for [REDACTED].#15's diet order dated 11/15/19 revealed an order for [REDACTED]. Observation on 03/02/20 at 12:23 P.M. of the lunch meal revealed Licensed Practical Nurse (LPN) #291 and Registered Nurse (RN) #359 began to serve lunch trays at this time. At the time the meal started, Resident #174, Resident #17 and Resident #15 were observed seated at the same table. Resident #174 was observed sitting in a wheelchair at the right table in the dining room on the far side, facing away from the window. Resident #17 was sitting in a specialized (Broda) chair across from Resident #174. And to the right of Resident #174 was Resident #15. On 03/02/20 at 12:25 P.M. Resident #15 was observed to be served the lunch meal. The tray was placed to the resident's left. Neither Resident #17 or Resident #174 received their meal tray immediately following Resident #15. On 03/02/20 at 12:37 P.M. a second food tray cart was observed to arrive to the area. As of 03/02/20 at 12:52 P.M. Resident #15 had made no attempts to eat and no staff had attempted to assist the resident. The meal tray remained to the resident's left. On 03/02/20 at 12:55 P.M. a speech therapist was observed assisting Resident #17 to eat. Resident #17 had completed the lunch meal before any staff assisted Resident #15 and before Resident #174 was even served a lunch tray. On 03/02/20 at 1:00 P.M. Resident #174 was served the lunch meal and encouraged by LPN #291 to take small bites. On 03/02/20 at 1:15 P.M. (50 minutes after the resident received the meal tray) a nursing assistant was observed to assist the resident to eat. On 03/02/20 at 1:30 P.M. interview with LPN #291 revealed Resident #15, Resident #17 and Resident #174 should have been served at the same time as they were seated at the same table to promote a more dignified dining experience. The LPN also verified the residents should have been provided more timely assistance with the meal. 2. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 50's significant change MDS 3.0 assessment dated [DATE] revealed Resident #50's speech was unclear, he sometimes understood, sometimes understands and his cognition was severely impaired. Resident # 50 had no indicators or [MEDICAL CONDITION], had physical behaviors one to three days that did not significantly impact the resident or other residents and he did not reject care. Resident # 50 required extensive assistance from two staff for bed mobility and to transfer. Observation of Resident #50 on 03/05/20 at 8:05 A.M. revealed he was in the common area, wearing a hospital gown. At the time of the observation, the resident's left hip and incontinent brief product were exposed and visible to other residents, staff and visitors. Resident #50 was observed at 9:00 A.M. with the same gown on and his hip exposed. Observation of Resident #50 at 2:50 P.M. revealed the resident was wearing the same gown and a sweatshirt. Interview with Licensed Practical Nurse (LPN) #294 on 03/05/20 at 2:51 P.M. revealed Resident #50 was wearing a gown because the resident's clothes were not back from laundry. LPN #294 confirmed the resident's hip and incontinent brief should not be exposed. Observation of Resident #50's closet with LPN #294 at the time of the interview revealed the resident did have a pair of basketball type shorts in the closet. This deficiency substantiates Complaint Number OH 812 and Complaint Number OH 564.
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** Based on observation, record review and interview the facility failed to ensure Resident #122 was informed of the arrival of her meal tray to accommodate the resident's ability to consume meals in a timely manner. This affected one resident (#122) of one resident reviewed for accommodation of needs. Findings include: Review of Resident #122's medical record revealed an initial admission date of [DATE] and a re-entry date of 10/29/19. [DIAGNOSES REDACTED]. Review of Resident #122's plan of care, dated 01/21/19 revealed the resident was at nutritional and/or dehydration risk related to consuming less than 75% of most meals. Interventions included providing assistance with meals as needed. The care plan did not provide any additional guidance as to the resident's meal preferences for delivery and/or set up. Review of Resident #122's annual Minimum Data Set (MDS) 3.0 assessment, dated 01/08/20 revealed the resident required supervision with set up help for eating. Record review revealed a physician's orders [REDACTED]. On 03/02/20 at 1:03 P.M. a meal tray was observed sitting on Resident #122's night stand. The meal tray was not set up for the resident, the foods were not cut/prepped and the tray was not available for her to eat (as it appeared out of her reach). An interview with the resident at the time of the observation revealed she was unaware staff had brought her lunch tray in and she thought the tray had been left over from breakfast. On 03/06/20 at 12:40 P.M. during a follow up interview with Resident #122, the resident voiced concerns that when staff brought her meal tray to her room, they would leave it on the night stand without telling her it was there. The resident revealed the way the privacy curtain was placed, she was not able to see the tray sitting there. The resident stated because of this there were times she did not eat the meal because it got cold or it had a dairy product and she was worried it has spoiled. The resident denied being offered a new meal tray from staff when this occurred. On 03/06/20 at 12:50 P.M. interview with Licensed Practical Nurse (LPN) #322 revealed it was Resident #122's request to have her meal

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

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.

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) trays placed on her night stand. LPN #322 revealed she had to provide verbal education to multiple staff members over the last few days to ensure the staff were telling Resident #122 when her meal tray arrived because it had been identified the resident was unaware staff were bringing the tray and just leaving it in the room without telling her it was there. This deficiency substantiates Complaint Number OH 564.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to honor Resident #109's choice/request to share a bed with his wife, Resident #143 with whom he shared a room and failed to ensure Resident #146's choice to not use a clothing protector was honored. This affected two residents (#109 and #146) of three residents reviewed for choices. Findings include: 1. Review of Resident #109's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #109's Minimum Data Set (MDS) 3.0 assessment, dated 01/13/20 revealed Resident #109 was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of eight. The MDS further revealed Resident #109 required supervision and/or staff assistance for all activities of daily living Review of the resident council meeting minutes from the meeting dated 02/11/20 revealed Resident #109 expressed a desire to have his and his wife's bed placed together so they could sleep next to each other. Review of the response and facility plan of correction dated 02/11/20 revealed no evidence this request was addressed. The administrator reviewed and dated the response on 02/12/20. Review of a progress note, dated 03/04/20 at 9:15 A.M., revealed Resident #109 requested to have his bed near his wife's bed. The note indicated the resident's power of attorney (POA) was made aware. Interview on 03/03/20 at 12:05 P.M. with Resident #109 revealed a concern that staff would not let him and his wife (Resident #143) share a bed. The resident reported they had been married for almost [AGE] years and he wanted to sleep next to his wife. The resident stated the staff had told him it was inappropriate. Interview on 03/04/20 at 8:39 A.M. with Staff #333 revealed she was unaware of any reason why Resident #109's request to share a bed with his wife could not be accommodated. Interview on 03/05/20 at 12:40 P.M. with Staff #134 verified Resident #109 had made a request to sleep next to his wife. The staff member revealed she had placed this request on the maintenance log, but never followed up to ensure the beds were moved next to each other. Observation on 03/03/20 at 10:30 A.M. revealed Resident #109's bed was on the right side of the room next to the wall and Resident #143's bed was located next to the window. There were two dressers between the resident's beds. 2. Review of Resident #146's medical record revealed the resident had a plan of care, dated 05/10/19 related to activities of daily living. The care plan revealed the resident preferred no clothing protector. On 03/04/20 at 9:05 A.M. during an observation of the breakfast meal, State tested Nursing Assistant (STNA) #146 was observed to place a clothing protector on Resident #146. At 9:06 A.M. STNA #146 began feeding the resident . At 9:07 A.M., STNA #146 got up from the table leaving Resident #146. At 9:09 A.M. Resident #146 was observed to pull the clothing protector off. On 03/05/20 at 10:25 A.M. interview with Licensed Practical Nurse (LPN) #294 confirmed Resident #146 did not like to wear a clothing protector.
F 0569 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.** Based on record review and staff interview the facility failed to provide spend down notifications to residents and/or resident representatives in a timely manner. This affected 12 residents (#15, #50, #62, #64, #66, #80, #82, #130, #140, #148, #159, and #192) of 12 residents reviewed for resident personal fund accounts. Findings include: Review of the resident personal fund account information revealed the following concerns: 1. Review of Resident #15's financial records revealed from 08/02/19 to 12/31/19, the balance was between $2010.19 and $2260.30 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from August 2019 to December 2019, indicating Resident #15's fund account was within $200 of the maximum allotted amount to have in the account. 2. Review of Resident #50's financial records revealed from 07/29/19 to 12/31/19, the balance was between $2523.00 and $2773.12 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from August 2019 to December 2019, indicating Resident #50's fund account was within $200 of the maximum allotted amount to have in the account. The facility also documented they did not have guardian contact information for Resident #50 (volunteer guardian) until late November 2019. 3. Review of Resident #62's financial records revealed from 08/02/19 to 12/13/19, the balance was between $2010.19 and $2260.30 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from August 2019 to December 2019, indicating Resident #15's fund account was within $200 of the maximum allotted amount to have in their account. In addition, review of Resident #62's financial records revealed from 12/13/19 to 12/31/19, the balance was between $6923.21 and $7067.21. There was no evidence a spend down letter/notification was sent for December 2019, indicating Resident #62's fund account was within $200 of the maximum allotted amount to have in their account. 4. Review of Resident #64's financial records revealed from 08/02/19 to 12/31/19, the balance was between $1807.09 and $2007.20 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from August 2019 to December 2019, indicating Resident #64's fund account was within $200 of the maximum allotted amount to have in their account. 5. Review of Resident #66's financial records revealed from 08/06/19 to 12/31/19, the balance was between $2249.46 and $2431.58 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from August 2019 to December 2019, indicating Resident #66's fund account was within $200 of the maximum allotted amount to have in their account. 6. Review of Resident #80's financial records revealed from 08/06/19 to 12/31/19, the balance was between $1898.28 and $2005.17 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from August 2019 to December 2019, indicating Resident #80's fund account was within $200 of the maximum allotted amount to have in their account. 7. Review of Resident #82's financial records revealed from 05/07/19 to 12/31/19, the balance was between $1800.70 and $4701.05 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent in August, October, and November 2019, indicating Resident #82's fund account was within $200 of the maximum allotted amount to have in their account. 8. Review of Resident #130's financial records revealed from 05/07/19 to 12/31/19, the balance was between $1837.04 and $2187.24 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent for September 2019 to December 2019, indicating Resident #130's fund account was within $200 of the maximum allotted amount to have in their account. 9. Review of Resident #140's financial records revealed from 05/07/19 to 12/31/19, the balance was between $1846.06 and $2196.25 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from September 2019 to December 2019, indicating Resident #140's fund account was within $200 of the maximum allotted amount to have in their account. 10. Review of Resident #148's financial records revealed from 04/02/19 to 12/31/19, the balance was between $2291.02 and $4268.46 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent for May 2019 or from August 2019 to December 2019, indicating Resident #148's fund account was within $200 of the maximum allotted amount to have in their account. 11. Review of Resident #159's financial records revealed from 05/07/19 to 12/31/19, the balance was between $1805.32 and $2205.52 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from August 2019 to December 2019, indicating Resident #159's fund account was within $200 of the maximum allotted amount to have in their account. 12. Review of Resident #192's financial records revealed from 11/30/19 to 12/31/19, the balance was between $2531.66 to $2526.68 (fluctuations when cost of care payment came in and was debited from the account). There was no evidence spend down letters/notifications were sent from November 2019 to December 2019, indicating Resident #192's fund account was within $200 of the maximum allotted amount to have in their account. Interview with Business Office Manager (BOM) #216 on 03/05/20 at 2:21 P.M. confirmed there was no evidence to support the spend down letters/notifications being sent to the residents and/or representatives identified above.

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F 0569 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2)
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.** Based on observation and interview the facility failed to implement effective housekeeping and/or maintenance services to ensure the environment on the 100 unit was maintained in a clean and comfortable manner. This affected four residents (#162, #54, #102 and #135) and had the potential to affect all 49 residents who resided on the 100 unit. Findings include: Intermittent observations from 03/02/20 at 10:00 A.M. until 03/04/20 at 9:00 A.M. revealed all three hallway floors of the 100 unit were sticky. While walking on the floor, there was a cracking and suction cup noise from the shoes of those walking down each hallway. It also made the same sounds when residents would be going down the hallway in their wheelchairs; the wheels made the same sticky noises. During the same time period, a persistent/chronic bowel movement/urine/body odor was identified throughout all the hallways of the 100 unit. On 03/03/20 at 9:23 A.M. interview with Resident #162 and on 03/03/20 at 9:46 A.M. interview with Resident #54 revealed environmental concerns. Both resident indicated they did not feel the facility did a great job of cleaning. Both residents confirmed when they were maneuvering down the hallways, the floor was sticky and unclean. The residents shared they had not seen facility staff actually clean the hallway floors in a very long time and had both told the nursing staff about this but nothing had changed. The residents also confirmed the odors in the facility hallways were persistent and indicated it makes them sick. They wished the facility staff could do something about this. On 03/03/20 interview with State tested Nursing Aide (STNA) #109 at 12:12 P.M. and Licensed Practical Nurse (LPN) #350 at 3:45 P.M. confirmed the presence of odors in the 100 unit hallway. Both staff stated they see the housekeeping staff cleaning the hallways and rooms, but there was a constant odor in the 100 unit. Also, they both confirmed the floor was very sticky and indicated it had not been cleaned/mopped in a while. Intermittent observations between 03/02/20 and 03/03/20 of Resident #102 and Resident #135's bathroom revealed there were blood spots on the floor, near the toilet. There was a fifty cent piece size blood stain on the bathroom floor of the room on 03/02/20 that was present from 10:30 A.M. to 2:45 P.M. When observing the bathroom again on 03/02/20 at 3:30 P.M., the bathroom floor had been cleaned. However, on 03/03/20 from 9:30 A.M. to 12:00 P.M., the bathroom had two dime sized drops of blood on the floor near the toilet. At approximately 1:00 P.M., their bathroom had been cleaned and the blood stains were gone. Interview with Resident #102 and Resident #135 on 03/02/20 at 12:15 P.M. and again on 03/03/20 at 9:45 A.M. revealed concerns that the facility staff do not clean their bathroom on a routine basis. Resident #102 revealed the fifty cent sized blood stain had been on the floor for a couple days. He stated he had told the facility staff about both blood stains, but no one seemed to care to get it cleaned up immediately. This deficiency substantiates Complaint Number OH 812 and Complaint Number OH 377.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to ensure a comprehensive and thorough investigation was completed following an allegation of sexual abuse involving Resident #20. This affected one resident (#20) of one resident reviewed for abuse. Findings include: Record review revealed Resident #20 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 02/26/20 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated she was moderately cognitively impaired. Review of the facility Self Reported incident (SRI), tracking number 6, dated 02/27/20 revealed Resident #20 made a sexual abuse allegation against State tested Nursing Assistant (STNA) #174. The resident reported the STNA molested her by touching her breasts (over her shirt) while she was sitting in her wheelchair. The facility immediately suspended STNA #174 and started an investigation. In review of the investigation documentation, the facility interviewed multiple residents and other staff, but failed to obtain a statement from STNA #174 (the alleged perpetrator) or the activity assistant, who was the staff member identified to be first told about the alleged incident. Interview with Resident #20 on 03/20/20 at 4:00 P.M. confirmed she made an allegation of sexual abuse against STNA #174. Interview with the Administrator on 03/06/20 at 9:45 A.M. confirmed he did not obtain written statements regarding the incident from the activity staff person who was first notified of the incident or from STNA #174 the alleged perpetrator. The administrator revealed he had verbal information from both employees and included that in a summary of the incident that was completed.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were accurate for Resident #207 related to discharge and for Resident #70 related to pressure ulcers. This affected two residents (#207 and #70) of 40 residents whose MDS assessments were reviewed. Findings include: 1. Review of Resident #207's closed electronic medical record revealed an admission date of [DATE] and a discharge date of [DATE]. The resident had [DIAGNOSES REDACTED]. external causes, hypertension, [DIAGNOSES REDACTED] unspecified [MEDICAL CONDITION] of liver. Review of the Discharge MDS 3.0 assessment, dated 12/14/19 revealed the resident's discharge was planned to an acute hospital. However, review of the progress notes, dated 12/13/19 and 12/14/19 revealed the resident discharged home with her son on 12/14/19 and was not hospitalized . Interview with the Director of Nursing (DON) on 03/05/20 at 12:16 P.M. confirmed Resident #207 discharged home from the facility and was not hospitalized . The DON confirmed the resident's MDS 3.0 assessment, dated 12/14/19 was inaccurate. 2. Review of the medical record for Resident #70 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a skin and wound assessment completed 10/15/19 revealed no evidence of any skin breakdown. Review of a nursing progress note, dated 10/21/19 at 2:00 P.M. revealed a new area to the left lateral ankle was noted. The physician was notified and a new treatment order was obtained. The treatment of [REDACTED]. Review of a skin and wound evaluation form completed 10/23/19 revealed Resident #70 developed an unstageable pressure ulcer containing slough and/or eschar on the left lateral malleolus (ankle) on 10/21/19. (Slough is non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. An unstageable ulcer is defined as obscured full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If slough or eschar is removed, a stage three or four pressure ulcer will be revealed). The area measured 2.5 centimeters (cm) long by 2.5 cm wide with depth documented as not applicable. It stated the wound had 60 percent slough with moderate serous exudate. (Exudate is defined as fluid that has been forced out of the tissue or its capillaries because of inflammation or injury). It was identified as a new wound. Review of a wound evaluation report by the wound physician on 10/23/19 revealed the resident had a Stage IV pressure wound of the left lateral ankle for at least one day duration. (A Stage IV pressure ulcer is defined as full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer). There was moderate serous exudate. The area measured 3.1 cm by 3.8 cm by 0.5 cm. and had 20 percent slough, 60 percent granulation tissue, and 20 percent bone. The area was debrided (damaged tissue removed from the wound) on 10/23/19. The wound continued and was measured weekly. The most recent MDS 3.0 assessment, dated 01/08/20 revealed the resident had no pressure ulcers. Review of a wound evaluation summary by the wound physician on 03/03/20 revealed Resident #70 had a Stage IV pressure wound of the left lateral ankle for at least 126 days duration. There was moderate serous exudate. The area measured 0.6 cm long by 0.4 cm wide by 0.2 cm deep. The wound was described as 90 percent granulation tissue with 10 percent slough. Observation on 03/04/20 at 7:20 A.M. revealed Resident #70 to have a 0.6 cm wide by 0.4 cm long by 0.1 cm deep superficial open area. The center of the wound was primarily pink tissue with a small area of white tissue. Interview with Licensed Practical Nurse #304 on 03/04/20 at 11:02 A.M. confirmed the MDS completed on 01/08/20 was inaccurate as Resident #70 developed an unstageable/Stage IV pressure ulcer in October 2019 which the resident still had.

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** Based on record review and interview the facility failed to develop a comprehensive plan of care for Resident #183 related

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) to a pacemaker. This affected one resident (#183) of 40 residents whose Minimum Data Set (MDS) 3.0 assessments and care plans were reviewed. Findings include: Review of Resident #183's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of hospital discharge paperwork, dated 06/08/19 revealed under the section titled history and physical it noted pacemaker with some unidentifiable numbers behind it in parentheses. Review of Resident #183's MDS 3.0 assessment, dated 02/19/20 revealed the resident had mild cognitive impairment with a Brief Interview of Mental Status (BIMS) score of ten. Interview with Resident #183 on 03/02/20 at 11:00 A.M. revealed he had a pacemaker and it had been five years since it was checked. He reported he had notified nursing staff about his pacemaker needing checked but they had not done anything with it. Review of Resident #183's current plan of care (initiated 01/27/20) revealed no plan of care had been developed related to the resident's pacemaker. Interview with MDS #334 and the director of nursing (DON) on 03/05/20 at 8:35 A.M.verified the facility failed to develop a comprehensive and individualized plan of care for Resident #183 related to his pacemaker.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to implement timely and necessary interventions, including the use of adaptive equipment for Resident #83 and Resident #146 who exhibited limitations to self-feeding. This affected two residents (#83 and #146) of six residents reviewed for nutrition. Findings include: 1. Review of Resident #83's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 83's annual Minimum Data Set (MDS) 3.0 assessment, dated 11/27/19 revealed the resident's speech was unclear, she usually understands, usually was understood, her short and long term memory were impaired, the resident recalled her room location and that she was in a nursing home and her cognition was moderately impaired. Resident # 83 had no behaviors, no indicators of [MEDICAL CONDITION] and rejected care daily. Resident #83 required supervision of two staff for bed mobility, supervision of one staff to transfer, supervision with set up help to eat. Resident #83 had no swallowing problems was 66 inches, weighed 110 pounds, had no significant weight changes and was on a therapeutic diet. Review of Resident #83's quarterly MDS 3.0 assessment, dated 01/03/20 revealed the resident understands, was understood and her cognition was moderately impaired. Resident #83 required supervision of one staff for bed mobility and to transfer. Resident #83 received a mechanically altered diet. Review of Resident #83's therapy notes dated 03/03/20 identified self-feeding needs, but no recommendations were made at that time. Observation of Resident #83 on 03/03/20 at 8:43 A.M. revealed the resident received thickened juice and water, pureed cereal, pureed omelet, pureed muffin and pureed fruit on a regular plate and had a plastic spoon. Resident #83 was feeding herself but she had difficulty getting the utensils and beverage containers to her mouth due to involuntary movements the resident was having. Resident #83 had spillage of her food and drink during the meal. Interview with Rehabilitation Director #321 on 03/05/20 on 2:31 P.M. revealed Resident #83 was evaluated by therapy and she had a self-feeding deficit, but her self-feeding deficit was not addressed. Rehabilitation Director #321 revealed the therapist identified Resident #83's ataxia was more pronounced and Rehabilitation Director #321 indicted the resident would need to be evaluated related to self-feeding needs. 2. Review of Resident #146's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 146's MDS 3.0 assessment, dated 01/21/20 revealed the resident's speech was unclear, sometimes she understood, sometimes she understands, her short and long term memory were impaired, she recalled the location of her room, recalled staff names and faces and had moderately impaired decision making skills. Resident #146 had no indicators of [MEDICAL CONDITION], had physical behaviors, verbal behaviors and other behaviors one to three days and did not reject care. Resident #146 required extensive assistance of two staff for bed mobility, to transfer and required extensive assistance of one staff to eat. Resident #146 received no therapy and no restorative programs. Record review revealed Resident #146 did not have any recommendations for adaptive self-feeding equipment. Review of Resident #146's March 2020 physician's orders [REDACTED].#146 on 03/02/20 at 1:44 P.M. revealed the resident received a pureed meal. The food was served on a regular plate and she had regular flatware. Resident #146 had involuntary movements making it difficult to scoop food from the plate and she had spillage from her spoon into her lap. Observation of Resident #146 on 03/04/20 at 8:56 A.M. during the breakfast meal revealed the resident received a plastic spoon, a regular plate and a bowl. Resident #146 received pureed eggs, pureed cereal, pureed sausage, pureed toast, apple sauce and pudding. Resident #146 was attempting to feed herself. She drank the pureed cereal from the bowl. Resident #146 had involuntary movements that made self-feeding difficult. Resident #146 had food spillage from her spoon during the observation. Interview with Licensed Practical Nurse (LPN) #294 on 03/05/20 at 10:25 A.M. revealed when food was put bowls the resident did better with eating. Interview with Rehabilitation Director #321 on 03/05/20 at 11:47 A.M. revealed Resident #146 had nothing triggered for self-feeding. Rehabilitation Director #321 stated Resident #146 would be screened for therapy needs related to self feeding today. This deficiency substantiates Complaint Number OH 564.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to develop and implement a comprehensive and individualized activities program to meet the total care needs of all residents. This affected four residents (#48, #50, #83 and #43) of seven residents reviewed for activities. Findings include: 1. Review of Resident #43's medical record revealed an admission date of [DATE] with the admitting [DIAGNOSES REDACTED]. Review of the resident's plan of care, dated 08/20/19 revealed the resident had the potential for impaired social interaction related to impaired communication. She preferred to watch television and was on one on one programming. The care plan revealed the resident preferred music therapy, hand massages and painted nails. Interventions included to provide an activity calendar, one to one bedside/in room visits and activities if unable to attend out of room events and assist/escort to activity functions. Review of the resident's comprehensive MDS 3.0 assessment, dated 12/13/19 revealed the resident had no speech, rarely/never understands, rarely/never made herself understood and had a severe cognitive deficit. The assessment indicated a staff interview was conducted for the activity preferences. The staff reported listening to music, keeping up with the news, doing things with group activities and participating in her favorite activities were her activity preferences. Review of the resident's monthly physician's orders [REDACTED]. Review of the resident's activity reevaluation dated 02/10/20 revealed the activity staff had added the resident to the one on one activity program. The assessment did not identify the resident's activity preferences. Review of the resident's monthly activity attendance log for December 2019 revealed the resident was provided an activity five days out of 31 days. Review of the resident's monthly activity attendance log for January 2020 revealed the resident was provided an activity four days out of 31 days. Review of the resident's monthly activity attendance log for February 2020 revealed the resident was provided an activity 21 days out of 29 days. Review of the resident's monthly activity attendance log for March 2020 revealed the resident was provided an activity two days out of five days. On 03/05/20 10:43 AM observation of the resident revealed she was in bed with her eyes closed. The television located on the wall between the beds was playing. The resident was positioned towards the door away from the television. On 03/05/20 11:59 AM interview with Registered Nurse (RN) #147 verified the resident did not have an individual activity program to meet her needs. 2. Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #48's activity reevaluation, dated 05/09/19, revealed the resident preferred snacks and music events. There was no assessment of Resident #48's music preferences and the assessment did not identify his past or current activity interests. Review of Resident #48's plan of care, dated 05/17/19 revealed the resident attended activities, loved Motown music, attended happy hour, karaoke, sing-a- longs, and Cleveland Browns football. Review of Resident #48's significant change Minimum Data Set (MDS) 3.0 assessment, dated 12/17/19 revealed the resident's speech was unclear, he usually understood, he usually understands, and his cognition was severely impaired. Resident #48 had behaviors not directed toward others that did not significantly affect him or other residents and he did not reject care. Review of Resident # 48's activity preferences revealed it was not very important for him to have reading material, it was very important to listen to music, it was somewhat important for him to be around animals and to keep up on the news, and very important to be in group activities, to do favorite activities and to participate in religious practices. Resident # 48 required extensive assistance of two staff for bed mobility and to transfer. Review of Resident #48's activity progress

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	365379	A. BUILDING _____ B. WING _____	03/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LAURELS OF WALDEN PARK	5700 KARL ROAD COLUMBUS, OH 43229

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) note, dated 12/17/19 revealed the resident resided on a secure unit for dementia. Resident #48 preferred to sit in common areas and listen to Motown music, attends happy hour, sings karaoke, socializes with other guest and staff and attends sing-a-longs. The note revealed the resident declined the need for activity supplies such as crossword puzzles and coloring sheets. The activity staff would continue to encourage him to engage in activities as tolerated. Review of Resident #48's activity participation logs revealed for December 2019 he participated in exercise once, happy hour twice, independent activities six times and television/movies twice. In January 2020 Resident #48 participated in conversation once, independent activities eight times, sing-along twice and social one time. In February 2020 Resident #48 listened to music twice, pamper me once, party/special event twice, sing-along/karaoke four times, television/movies eight times, conversing with others seven times, cooking club twice, exercise once, games four times, and happy hour once. From 03/01/20 to 03/04/20 Resident #48 participated in games twice, music once, puzzles/word games once, sing-along/karaoke once, special interests once and television music once. Observation of Resident #48 on 03/02/20 at 10:30 A.M. revealed he was asleep in his wheelchair. The television was on but no other activity was occurring even though review of the activity calendar revealed a church service was scheduled at that time. On 03/02/20 at 3:55 P.M. Resident #48 was in his wheelchair in the common area asleep. The television was on, music was playing and Activity Aide (AA) #133 was talking to residents. Review of the activity calendar revealed the scheduled activity at that time was supposed to be karaoke. Observation of Resident #48 on 03/03/20 at 10:23 A.M. revealed Resident #48 was asleep in the common area. The television was on, music was playing, and four other residents were playing corn hole. On 03/03/20 at 2:57 P.M. Resident #48 was in the common area. The television was on The Talk but Resident #48 was not watching it. The activity calendar revealed horse racing was scheduled for that time. Observation on 03/03/20 from 4:15 P.M. until 4:26 P.M. revealed the window coverings were closed, the lights were out and Activity Director (AD) #131, in a loud voice, was repeatedly telling the residents it was time to relax and unwind time. Resident #59 asked for the lights to be turned on. The environment was not calm and relaxing. On 03/04/20 from 10:13 A.M. until 10:44 A.M. Resident #48 was observed seated in the common area with no activity occurring and no resident or staff interaction. Four other residents were bowling. Observation on 03/04/20 from 2:07 P.M. until 2:48 P.M. revealed Resident #48 was sitting in the common area with no activity while five other residents played charades with AA #133. Interview with AD #131 on 03/05/20 at 2:27 P.M. revealed Resident #48 did not actively participate in activities but rather sits in the common area. AD #131 confirmed the resident slept a lot in the common area. The AD verified the resident was not actively engaged in activities of interest or that he preferred during the observations made above. Interview with AD #131 on 03/05/20 at 2:27 P.M. revealed the daily listed activities consisted of: brush-up which was morning grooming, morning news which was the television on a news station (and sometimes later activity staff talked about the news), tea time which was activity staff taking residents to the common area after a meal for the nursing assistants, daily living which was getting ready for a meal, relax and unwind which was shutting the window covers; turning out the lights and putting on soft music, music and meal prep which was taking residents to the dining room for meal, snack and chat pass which was the evening snacks and talking to residents as snacks were passed. The AD was unable to explain why the activities listed on the calendar did not occur as planned based on the observations made. Interview with Licensed Practical Nurse (LPN) #294 on 03/06/20 at 2:18 P.M. revealed Resident #48 had a short attention span and he did not converse with others, mostly he just repeated a word or two. 3. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #50's plan of care, dated 07/08/19 revealed he preferred games like bingo, whammy and to watch television in his room independently. Review of Resident #50's significant change MDS 3.0 assessment, dated 12/20/19 revealed Resident #50's speech was unclear, he sometimes understood, he sometimes understands, and his cognition was severely impaired. Resident # 50 had no indicators or [MEDICAL CONDITION], had physical behaviors one to three days that did not significantly impact the resident or other residents and he did not reject care. Review of the staff assessment of activity preferences revealed Resident #50 did not want reading material, he listened to music, liked being around animals, like keeping up with news, liked doing things with groups of people, liked favorite activities, liked spending time outdoors, and did not participate in religious activities. Resident # 50 required extensive assistance from two staff for bed mobility and to transfer. Review of Resident #50's activity participation logs revealed for December 2019 he participated in independent activities three times, conversing once, and television/movies three times. In January 2020 Resident #50 participated in independent activities nine times, sing-along once, mail once, and social twice. Review of Resident #50's activity reevaluation, dated 02/02/20, revealed the resident participated in social activities, sat in the common area throughout the day and liked games and exercise. The reevaluation indicated the resident declined the need for activity supplies such as crossword puzzles and coloring sheets. The activity staff would continue to engage him in activities as tolerated. There were no assessment of Resident #50's past or current activity interests. In February 2020 Resident #50 participated in busy hands three times, listened to music once, pamper me once, party/special event twice, sing-a-long/karaoke three times, and television/movies five times, conversing with others three times, cooking club twice, games four times, independent activities once, and radio/music once. From 03/01/20 to 03/04/20 Resident #50 participated in games twice, music once, sing-along/karaoke once, special interests once and television music once. Observation of Resident #50 on 03/02/20 at 10:30 A.M. revealed he was asleep in his wheelchair; the television was on and no other activity was occurring even though the activity calendar revealed a church service was scheduled. On 03/02/20 at 3:55 P.M. Resident #50 was in his wheelchair in the common area asleep. The television was on, music was playing and Activity Aide (AA) #133 was talking to residents. Review of the activity calendar revealed the scheduled activity was supposed to be karaoke at that time. Observation of Resident #50 on 03/03/20 at 10:23 A.M. revealed he was asleep in the common area, the television was on, music was playing, and four other residents were playing corn hole. On 03/03/20 at 2:57 P.M. Resident #50 was in the common area and the television was on The Talk. Resident #50 was not watching it. The activity calendar called for horse racing at that time. Observation on 03/03/20 from 4:15 P.M. until 4:26 P.M. revealed the window coverings were closed, the lights were out and AD #131, in a loud voice, was repeatedly telling the residents it was time to relax and unwind time. Resident #59 asked for the lights to be turned on. The environment was not calm and relaxing. On 03/04/20 from 10:13 A.M. until 10:44 A.M. Resident #50 was seated in the common area with no activity and no other resident or staff interactions occurring. Four other residents were bowling. Observation on 03/04/20 from 2:07 P.M. until 2:48 P.M. revealed Resident #50 was sitting in the common area with no activity while five other residents played charades with AA #133. Observation of Resident #50's room on 03/04/20 at 2:50 P.M. revealed he did not have a television or radio in his room. Interview with AD #131 on 03/05/20 at 2:27 P.M. confirmed Resident #50 did not actively participate in activities and he mostly just sat in the common area. AD #131 revealed the resident liked to watch television in his room. However, after making this statement, observation with AD #131 confirmed there was no television or radio in the resident's room. The AD was unable to explain why the activities listed on the calendar did not occur as planned based on the observations made. Interview with LPN #294 on 03/06/20 at 12:01 P.M. revealed Resident #50 talks but he does not make sense when he talks. 4. Review of Resident #83's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #83's activity reevaluation dated 03/20/19 revealed there was no assessment of the resident's activity interests past or present. Review of Resident #83's care plan dated 04/26/19 revealed she liked independent activities in her room such as watching television and listening to music. Review of Resident #83's annual MDS 3.0 assessment, dated 11/27/19 revealed her speech was unclear, she usually understands, she usually was understood, her short and long term memory were impaired, she recalled her room location and that she was in a nursing home and her cognition was moderately impaired. Resident #83 had no behaviors, no indicators of [MEDICAL CONDITION], and rejected care daily. Review of Resident #83's self-assessment for activities reveled she liked to have reading materials, it was very important to listen to music, somewhat important to be around animals, to keep up with the news, do things with groups of people, to do favorite activities, go outside for fresh air, and participate in religious activities. Resident #83 required supervision of two staff for bed mobility and supervision of one staff to transfer. Review of Resident #83's quarterly MDS 3.0 assessment revealed the resident's speech was clear, she understands, she was understood and her cognition was moderately impaired. Resident #83 had no behaviors and did not reject care. Resident #83 required supervision of one staff for bed mobility and to transfer. Observation of Resident #83 on 03/02/20 at 10:30 A.M. revealed she was sitting in the common area not paying attention to the television that was on and no other activity was occurring at that time even though the activity calendar revealed a church service was scheduled. At 3:55 P.M. Resident #83 was in a chair in the common area. The television was on, music was playing and AA #133 was talking to residents. Review of the activity calendar revealed the scheduled activity was karaoke. Observation of Resident #83 on 03/03/20 at 10:23 A.M. revealed she was in her room and there was no television or music was playing. On

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) 03/03/20 at 2:57 P.M. Resident #83 was in the common area and the television was on The Talk. Resident #83 was not watching it. The activity calendar called for horse racing. Observation on 03/03/20 from 4:15 P.M. until 4:26 P.M. revealed the window coverings were closed the lights were out and AD #131, in a loud voice, was repeatedly telling the residents it was time to relax and unwind time. Resident #59 asked for the lights to be turned on. The environment was not calm and relaxing. Observation on 03/04/20 from 10:13 A.M. until 10:44 A.M. revealed Resident #83 was in her room and there was no television or music playing. Observation on 03/04/20 from 2:07 P.M. until 2:48 P.M. revealed Resident #83 was sitting in the common area with no activity while five other residents played charades with AA #133. Interview with AD #131 on 03/04/20 at 4:23 P.M. revealed once Resident #83 moved to the secure unit she refused one to one visits. AD #131 stated Resident #83 was socializing more and out of her room almost all day. AD #131 stated Resident #83 used to look out the window, watch television, or came to music activities, but not now. However, no changes had been made to her activity plan. Interview with Resident #83 on 03/05/20 at 7:34 A.M. revealed she liked to watch television and listen to music in her room but did not have a TV or radio. Resident #83 stated mostly she liked to stay in her room. This deficiency substantiates Complaint Number OH 812.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of the facility policy on skin management the facility failed to prevent the development of a pressure ulcer to Resident #70's left lateral ankle and failed to ensure interventions were in place to promote pressure ulcer healing. Actual harm occurred on 10/21/19 when Resident #70, who had a [DIAGNOSES REDACTED].e. turning/repositioning program and pressure relieving heel devices). This affected one resident (#70) of five residents reviewed for pressure ulcers. Findings include: Review of the medical record for Resident #70 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 07/24/19 revealed the resident had severely impaired cognition and required extensive assistance from two staff for bed mobility and transfers. Review of a plan of care initiated 08/14/19 revealed Resident #70 was at risk for impaired skin integrity/pressure injury related to impaired bed mobility and incontinence of bowel and bladder. Review of interventions to minimize the risk of pressure injury indicated to cue the resident to reposition self as needed. There was no evidence of a turning/repositioning program in place for staff to turn/reposition the resident, even though the resident was identified as requiring assistance from two staff with bed mobility. The plan of care also included interventions of air mattress as ordered and soft heel cut out boots as tolerated. Review of a pressure ulcer risk assessment dated [DATE] revealed Resident #70 was identified as high risk for the development of pressure ulcers. Review of a skin and wound assessment completed 10/15/19 revealed no evidence of any skin breakdown. Review of a nursing progress note, dated 10/21/19 at 2:00 P.M. revealed a new area to the left lateral ankle was noted. The physician was notified and a new treatment order was obtained. The treatment to cleanse left lateral ankle with normal saline, apply calcium alginate with silver, and cover with dry dressing was started on 10/22/19. Review of a skin and wound evaluation form completed 10/23/19 revealed Resident #70 developed an unstageable pressure ulcer containing slough and/or eschar on the left lateral malleolus (ankle) on 10/21/19. (Slough is non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed; An unstageable ulcer is defined as obscured full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If slough or eschar is removed, a stage three or four pressure ulcer will be revealed). The area measured 2.5 centimeters (cm) long by 2.5 cm wide with depth documented as not applicable. It stated the wound had 60 percent slough with moderate serous exudate. (Exudate is defined as fluid that has been forced out of the tissue or its capillaries because of inflammation or injury). It was identified as a new wound. Review of a wound evaluation report by the wound physician, dated 10/23/19 revealed the resident had a Stage IV pressure wound of the left lateral ankle for at least one day duration. (A Stage IV pressure ulcer is defined as full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer). There was moderate serous exudate. The area measured 3.1 cm by 3.8 cm by 0.5 cm. and had 20 percent slough, 60 percent granulation tissue, and 20 percent bone. The area was debrided (damaged tissue removed from the wound) on 10/23/19. After the development of the pressure ulcer on the left lateral ankle on 10/21/19, the plan of care was revised to include actual skin impairment of Stage IV pressure. However, the plan still indicated to cue the resident to reposition self as needed. An MDS 3.0 assessment, dated 10/21/19 revealed the resident had severely impaired cognition and required extensive assistance from two staff for bed mobility and transfers. There was no evidence of a turning/repositioning program in place for staff to turn/reposition the resident. An MDS 3.0 assessment, dated 01/08/20 revealed the resident had severely impaired cognition and required extensive assistance from two staff for bed mobility and transfers. Record review revealed Resident #70 had physician's orders, dated 01/14/19 for an air mattress to the bed and 03/18/19 for soft cut out boots to both feet as tolerated every shift. Observations on 03/02/20 at 12:11 P.M., 12:45 P.M., 1:22 P.M., 4:08 P.M. and 5:25 P.M. revealed Resident #70 was in bed on his left side. Observations on 03/03/20 at 7:17 A.M. revealed Resident #70 was in bed on his left side. The air mattress had a low pressure light on and the mattress alarm was sounding by beeping loudly. The door to the resident's room was closed with no staff in the room. On 03/03/20 at 7:43 A.M. the air mattress alarm was still beeping and the resident was still on his left side. On 03/03/20 at 7:49 A.M. the resident was still on his left side but the air mattress alarm was no longer beeping and State tested Nursing Assistant (STNA) #118 was in the room delivering the resident's breakfast tray. On 03/03/20 at 7:58 A.M. the resident was on his left side in bed and the air mattress was flat with the resident sunken down in the middle of the mattress. On 03/03/20 at 9:20 A.M. the resident was in bed on his left side and the air mattress was still flat. On 03/03/20 at 10:07 A.M. the resident was on his left side in bed but the air mattress was inflated and the low air pressure light was off. On 03/03/20 at 12:56 P.M. and 3:20 P.M. the resident was in bed on his left side. Interview on 03/04/20 at 7:30 A.M. with the Licensed Practical Nurse (LPN) #291 who cared for Resident #70 on 03/03/20 revealed she was not aware of any issues with the air mattress on 03/03/20. She stated the air mattress beeps if it is flat. Interview on 03/04/20 at 7:45 A.M. with the STNA #118, who cared for Resident #70 on 03/03/20, revealed she was not aware of any issues with the air mattress on 03/03/20. Interview on 03/04/20 at 7:50 A.M. with Unit Manager #324 revealed she was not aware of any issues with the air mattress on 03/03/20. She stated the hospice aide and nurse were in on 03/03/20 and maybe they reset the air mattress. Interview with Hospice Aide #402 on 03/04/20 at 10:00 A.M. revealed she arrived on 03/03/20 at around 8:30 A.M., provided care for Resident #70, and left around 9:00 A.M. She stated she did not notice anything wrong with the air mattress. Interview with Hospice Nurse #400 on 03/04/20 at 11:45 A.M. revealed he arrived on 03/03/20 at 10:00 A.M. He stated he was with Resident #70 for approximately 15 minutes. (However, no staff were observed in the room on 03/03/20 at 10:07 A.M.) He stated he did not notice anything wrong with the air mattress. He also stated the resident was on his left side when he arrived and when he left. He stated he would have to check with the facility to see if the resident was supposed to be turned/repositioned by staff. He stated the hospice care plan said to assist with repositioning but did not include a frequency. Review of a wound evaluation summary by the wound physician on 03/03/20 revealed Resident #70 had a Stage IV pressure wound of the left lateral ankle for at least 126 days duration. There was moderate serous exudate. The area measured 0.6 cm long by 0.4 cm wide by 0.2 cm deep. The wound was described as 90 percent granulation tissue with 10 percent slough. Observation on 03/04/20 at 7:20 A.M. revealed Resident #70 had a 0.6 cm wide by 0.4 cm long by 0.1 cm deep superficial open area. The center of the wound was primarily pink tissue with a small area of white tissue. At that time, the resident was not observed to have a pressure relieving boot to his right foot. Interview with STNA #118 on 03/04/20 at 10:35 A.M. confirmed Resident #70 was unable to turn himself and was dependent upon staff for turning/repositioning. She stated she turned the resident every two hours and he was usually cooperative with turning. She stated on 03/03/20 she had placed the resident on his left side at 8:00 A.M. (However, the resident was observed on his left side at 7:17 A.M., 7:43 A.M., 7:49 A.M., and 7:58 A.M.). She also stated she placed the resident on his right side at 3:00 P.M. (However, the resident was observed on his left side at 3:20 P.M.). She further stated she was not aware of any boots for the resident to wear on his feet and did not ever put them on. Interview with LPN #291 on 03/04/20 at 10:40 A.M. confirmed Resident #70 was unable to turn himself and required assistance from two staff for turning/repositioning. She stated staff were to turn him every two hours and he was cooperative with turning. She stated he should be repositioned from left side to right side to back every two hours. She stated Resident #70 was unable to stay on his back much in bed but was able to be on his back when he was up in a chair. She stated residents usually get up every day unless they refuse. She stated they did not ask Resident #70 to get up on 03/02/20 or 03/03/20. She stated she was not aware Resident #70 was not repositioned every two hours on 03/02/20 or

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) 03/03/20. She stated the nursing assistants were responsible to apply the pressure relieving boots to the resident's feet. Interview with LPN #293 on 03/04/20 at 11:00 A.M. confirmed she was Resident #70's nurse. She confirmed he was to have pressure relieving boots on both feet. She was not aware the resident did not have one on the right foot on 03/04/20 at 7:20 A.M. Interview with Wound Physician #401 on 03/04/20 at 12:00 P.M. revealed Resident #70 was at high risk for the development of pressure ulcers. He stated the resident should be turned/repositioned every two hours and should wear the pressure relieving boots on both feet. He stated the pressure ulcer on the left ankle was currently healing as long as the pressure was kept off of the area. Review of the facility policy titled Skin Management dated 10/2019 revealed the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. Residents with pressure ulcers and those at risk for skin compromise were identified, evaluated and provided appropriate treatment to promote prevention and healing. It further stated appropriate preventative measures would be implemented on residents identified at risk and the interventions documented on the care plan. Interview with the Director of Nursing on 03/04/20 at 2:20 P.M. revealed appropriate treatment meant what ever fit the resident. She stated a turning/repositioning program would be appropriate for Resident #70. Interview with the Director of Nursing and Corporate Nurse #147 on 03/05/20 at 8:25 A.M. confirmed Resident #70 did not have a preventative turning/repositioning program in place prior to or after developing the Stage IV pressure ulcer on the ankle. The lack of a turning and repositioning program likely contributed to the area on the left lateral ankle being first identified by staff as an unstageable/Stage IV pressure ulcer.
F 0689 **Level of harm -** Minimal harm or potential for 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** Based on observation, record review and interview the facility failed to ensure Resident #109's assistive devices were properly maintained to prevent accidents and failed to ensure fall safety interventions were implemented for Resident #83 to prevent falls/accidents. This affected two residents (#109 and #83) of eight residents reviewed for accidents. Findings include: 1. Review of Resident #109's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #109's Minimum Data Set (MDS) 3.0 assessment, dated 01/13/20 revealed Resident #109 was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of eight. The MDS further revealed Resident #109 required total assistance with one person for bathing, extensive assist with one person for transfers, supervision assist from one person for bed mobility and toileting and limited assistance from one person for dressing and personal hygiene. Review of Resident #109's physician's orders [REDACTED]. Review of Resident #109's care plan dated 01/27/20 revealed the resident required assistance with activities of daily living (ADL's) and mobility with interventions including the use of an enabler bar (to the bed). Review of the Maintenance log, dated 02/17/20 through 03/03/20 revealed on 03/02/20 and 03/03/20 a request was made for Resident #109's bed to be fixed. On 03/03/20 the log indicated the bed was fixed. Review of Resident #109's Treatment Administration Record (TAR) from 03/01/20 through 03/05/20 revealed staff were documenting every shift the enabler bar was in place. Interview on 03/02/20 at 1:35 P.M. with Licensed Practical Nurse (LPN) #291 revealed Resident #109's enabler bar was broken and was laying on the floor. She reported it had been there for a while. She furthermore verified the resident's wheelchair brake on the left side was not holding. The LPN revealed she would contact maintenance. On 03/03/20 at 10:15 A.M. Resident #109 was heard telling maintenance staff his wheelchair was not working. Observation on 03/03/20 at 10:31 A.M. revealed Resident #109 had a broken bed rail, which was on the floor and the resident's wheelchair left brake was not holding. On 03/03/20 at 1:35 P.M. Resident #109 was heard telling Registered Nurse (RN) #324 his garb bar and wheelchair were broken. Registered Nurse (RN) #324 informed Resident #109 maintenance was notified and they would come and fix them. Interview on 03/05/20 at 4:30 P.M. with RN #324 revealed Resident #109 used the enabler bar to assist with getting in and out of bed. She stated he used the wheelchair for long distance only. She further verified the TAR dated 03/01/20 through 03/05/20 contained documentation the enabler bar was in place every shift as staff were signing the record indicating the enabler bar was in place, when in fact the bar was not and had been on the floor of Resident #109's room (from at least 03/02/20 through 03/05/20 based on the surveyors observations). 2. Review of Resident #83's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 83's annual Minimum Data Set (MDS) 3.0 assessment, dated 11/27/19 revealed her speech was unclear, she usually understands, usually was understood, her short and long term memory was impaired, she recalled her room location, that she was in a nursing home, and her cognition was moderately impaired. Resident #83 had no behaviors, no indicators of [MEDICAL CONDITION] and rejected care daily. Resident # 83 required supervision of two staff for bed mobility, supervision of one staff to transfer, supervision with set up help to walk and for locomotion. The assessment also revealed the resident had functional limitations in range of motion and used no mobility devices. Resident # 83 had no falls. Resident # 83 used no bed rails, no alarms and no restraints. Review of Resident #83's quarterly MDS assessment, dated 01/03/20 revealed the resident understands, was understood, and her cognition was moderately impaired. Resident # 83 required supervision of one staff for bed mobility and to transfer, she required supervision with set up help to walk, limited assistance of one staff for locomotion on the unit and supervision with set up help for locomotion off the unit. Review of Resident #83's progress notes revealed on 02/27/20 the resident had spontaneous bruising and hipsters were ordered. Resident #83 reported she banged into things in her room. Review of Resident #83's incident report revealed she had a 9 centimeter (cm) by 7 cm bruise on her left buttock, a 15 cm by 9 cm bruise on her right buttock, a 6 cm by 6 cm bruise on her left thigh, a 4cm by 3 cm bruise on her right calf, and multiple smaller bruises on her left calf. Review of Resident #83's March 2020 physician's orders [REDACTED]. Further review of Resident #83's progress notes revealed on 03/02/20 at 10:20 A.M. the resident was laying on her left side on the floor of the Unit 3 dining room. Resident #83 was asked what happened and she was unable to explain. A new intervention was implemented to sit in a chair against the wall at meals. Observation of Resident #83 on 03/03/20 at 7:15 A.M. revealed she was laying in bed with the right side of the bed up to the wall and her left side rail down. Observation at 7:45 A.M. revealed Resident #83 was on the floor on her back trying to pull herself up using the foot board of the bed. This was reported to the nurse. Observation at 1:50 P.M. revealed the resident was moved to a room closer to the nurse's station. Resident #83's was in bed, the bed was by the window, not against the wall and the side rail was down. Review of Resident #83's progress note, dated 03/03/20 at 7:55 A.M. revealed the resident was laying on the floor on her back. Resident #83 stated she was going to the bathroom. A new intervention was to move Resident #83 closer to the nurse's station. Observation of Resident #83 on 03/04/20 at 7:20 A.M. revealed the resident was in bed with the bed not against the wall and her side rail not up. Resident #83's wheelchair and overbed table were across the room and not within her reach. At 10:17 A.M. Resident #83 was in bed, the bed was closer to the door and it was not against the wall. At 12:49 P.M. and 1:59 P.M. the resident was observed in bed, the bed was not against the wall and the side rail was down. Interview with Licensed Practical Nurse (LPN) #280 on 03/04/20 at 4:15 P.M. revealed Resident #83 had two falls; one on Monday and one on Tuesday, so she was moved closer to nurse's station. LPN #280 revealed the resident used a wheelchair, her bed was supposed to be near the wall and she used one side rail. Interview with Resident # 83 on 03/05/20 at 7:34 A.M. revealed she liked her bed moved so she could see out the window and she used her side rail to turn and to get out of bed. Resident #83 stated the bruises on her bottom and legs were from were from bumping into the dressers and other items in room. Interview with Registered Nurse (RN) #326 on 03/05/20 at 7:37 A.M. confirmed the resident's bed rail was not up at this time and it was supposed to be. RN #326 also confirmed the bed was supposed to be against the wall and on 03/04/20 it was not. Interview with the Director of Nursing (DON) on 03/05/20 at 9:42 A.M. revealed she put the hipsters in place to pad the resident's hips when bumping into things. The DON stated she did not identify what could have caused the bruises to Resident #83's buttocks and legs and she did not put anything in place to help prevent or minimize the bruising.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** Based on observation, record review and interview the facility failed to maintain Resident #125's indwelling urinary

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) (Foley) catheter in a manner to prevent the risk of contamination and urinary tract infection. This affected one resident (#125) of nine residents reviewed for infection control. Findings include: Review of Resident #125's medical record revealed an initial admission date of [DATE] and a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #125's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/17/20 revealed the resident had severely impaired cognition and required total dependence from two staff members for bed mobility, transfers and assistance from one staff member for toilet use. Resident #125 was noted to have impairments to his bilateral upper and lower extremities and required the use of an indwelling catheter for bladder elimination. Review of Resident #125's plan of care, dated 01/17/20 revealed the resident was at risk for urinary tract infections related to the use of an indwelling catheter and [MEDICAL CONDITION]. Interventions included to ensure to position the catheter bag and tubing below the level of bladder and to provide catheter care per policy. Review of a current physician's orders [REDACTED].M. of Resident #125 revealed the resident's Foley catheter bag was laying directly on the floor beside the resident's bed. Interview on 03/02/20 at 10:43 A.M. with Licensed Practical Nurse (LPN) #348 confirmed Resident #125's Foley bag was laying on the floor and not attached to a non-movable part of the bed. Review of the facility undated policy titled Indwelling Urinary Catheter revealed the Foley bag was to be kept off the floor to reduce the risk of contamination. This deficiency substantiates Complaint Number OH 377.
F 0692 **Level of harm -** 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** Based on observation, record review and interview the facility failed to implement effective and timely nutritional interventions to prevent one resident (Resident #83) from sustaining a significant weight loss and failed to ensure ordered interventions, including whole milk and double protein portions were provided. Actual Harm occurred on 02/26/20 when Resident #83, who had a [DIAGNOSES REDACTED]. This affected one resident (#83) of six residents reviewed for nutrition. Findings include: Review of Resident #83's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 83's annual Minimum Data Set (MDS) 3.0 assessment, dated 11/27/19 revealed the resident's long and short term memory were impaired and she exhibited moderately impaired cognition. Resident # 83 had no behaviors, no indicators of [MEDICAL CONDITION] and rejected care daily. Resident # 83 required supervision of two staff for bed mobility, supervision of one staff to transfer, supervision from staff with set up help to eat. Resident # 83 had no swallowing problems was 66 inches tall, weighed 110 pounds, was on a therapeutic diet and had no significant weight changes during the assessment reference period. Review of the 11/29/19 nutrition assessment revealed the resident's usual body weight was 120 pounds. Resident #83's weight on 11/26/19 was 109.8 pounds, and her body mass index (BMI) was 17.7, indicating she was underweight. Resident #83 refused any medications to stimulate her appetite or nutritional supplements. Resident #83's diet was a regular diet, regular texture, thin consistency liquids with eight ounces of whole milk at each meal. The nutrition goal was to maintain current weight. No new nutritional recommendations were made at that time. Review of Resident #83's progress note, dated 12/18/2019 at 1:20 P.M. revealed the resident appeared to be choking with mucus coming out of her mouth. The resident was sent to the emergency department (ED) of a local hospital. Resident #83 returned the same day from the ED Review of the progress note, dated 12/19/19 revealed Resident #83's was at risk for choking and her diet was downgraded to a puree diet with eight ounces whole milk each meal. Review of Resident #83's quarterly MDS 3.0 assessment dated [DATE] reflected the resident continued to exhibit cognitive impairment and received a mechanically altered diet. Review of Resident #83's dietary note, dated 0[DATE] revealed on 02/20/20 her weight was 101.8 pounds which reflected a weight loss of 6.8 pounds (6.2%) in two months. The recommendation was to ensure Resident #83 eats well at meals and eats enough to maintain her weight. No new nutritional recommendations were made at that time. Review of the dietary note, dated 03/02/20 revealed on 02/26/20 Resident #83 weighed 98.2 pounds which was assessed/documented to be a severe weight loss of 9.5 % in one month. A new recommendation for double protein portions at all meals was made at that time. Observation of Resident #83 on 03/02/20 at 1:44 P.M. revealed she received a chicken salad sandwich, pasta salad, scalloped apples, juice and water. Resident #83 did not receive whole milk and her food was not pureed. Interview with Licensed Practical Nurse (LPN) #267 confirmed the food was not pureed and the resident did not receive milk. Observation of Resident #83 on 03/03/20 at 8:43 A.M. revealed she received thickened juice and water, pureed cereal, pureed omelet, pureed muffin and pureed fruit. She did not receive whole milk and she did not receive double protein portions. Interview with LPN #294 confirmed her portions looked like everyone else's and she received thickened juice and water. Observation of Resident #83 on 03/05/20 at 9:25 A.M. revealed she did not receive milk with the breakfast meal. Interview with LPN #294 at that time confirmed Resident #83 did not receive milk. Interview with Registered Dietitian (RD) #212 on 03/05/20 at 10:53 A.M. revealed Resident #83 should have received whole milk and she would make sure more was sent out with the meals. RD #212 revealed Resident #83 would only accept certain items if too many food items were sent then she would have a behavior. RD #212 was asked why no recommendations were made on 0[DATE] and she replied she would have to investigate it and get back with the surveyor. Interview with RD #212 on 03/06/20 at 11:33 A.M. revealed she forgot to document on 0[DATE] the recommendation for family to bring in a treat the resident liked when they visited. When asked how often the family visited, she stated about one time a week. Interview with State tested Nursing Assistant (STNA) #150 on 03/06/20 at 11:58 A.M. revealed she had not seen Resident #83's family visit. Interview with LPN #294 on 03/06/20 at 12:01 P.M. revealed she had not seen Resident #83's family visit. Interview with Registered Nurse (RN) #326 on 03/06/20 at 12:04 P.M. revealed she had not seen Resident #83's family visit.
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** Based on observation, record review, interview and policy review the facility failed to date and label oxygen administration tubing and failed to place signage on doors indicating oxygen in use in resident rooms. This affected three residents (#123, #81 and #457) of five residents reviewed for respiratory care. Findings include: 1. Review of Resident #123's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED].#123's physician's orders revealed an order dated 11/08/19 for oxygen administration via nasal cannula at two liters per minute as needed for oxygen saturation less than 90% and as needed for shortness of breath (SOB). Review of Resident #123's care plan, dated 01/24/20 revealed the resident was at risk for respiratory complications and to administer medications and treatments per physician orders. Review of Resident #123's Minimum Data Set (MDS) 3.0 assessment, dated 01/08/20 revealed the resident was severely cognitively impaired with a Brief Interview of Mental Status score of five. The MDS further revealed Resident #123 required total assistance of two persons for bed mobility, to transfer, dressing, eating, toileting and hygiene needs. Observation of Resident #123 on 03/02/20 at 1:37 P.M. revealed the resident had a nasal cannula and oxygen concentrator in her room. The oxygen tubing did not contain a label or date. (Dating oxygen tubing is a standard practice to prevent contamination and spreading of bacteria). Interview with Maintenance Supervisor #314 on 03/03/20 at 3:00 P.M. verified Resident #123's oxygen tubing and nasal cannula were unlabeled and undated, and there was no signage on the door indicating oxygen was in use. 2. Review of Resident #81's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #81's MDS assessment, dated 01/03/20 revealed Resident #81 had a Brief Interview of Mental Status (BIMS) score of eight and moderate cognitive impairment. The MDS further revealed Resident #81 required extensive assistance from one to two persons for bed mobility, transfers, hygiene, bathing, dressing and toileting and required staff supervision with eating. Review of Resident #81's physician's orders revealed an order dated 02/28/20 for oxygen administration 2 liters as needed (PRN) for shortness of breath; maintain saturation levels at 90% or greater every shift. Observation of Resident #81 on 03/02/20 at 11:25 A.M. revealed Resident #81 did not have an oxygen in use sign on her door. Interview with Maintenance supervisor #314 on 03/03/20 at 3:05 P.M. verified Resident #81 did not have any signage on the door indicating oxygen was in use. 3. Review of Resident #457's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #457's physician's orders revealed an order, dated 02/12/20 for continuous positive airway pressure ([MEDICAL CONDITION]) with a pressure of 15 at bedtime every shift for sleep apnea. The order indicated to clean tubing with soap and water, rinse with water and let air dry once every seven days. The resident also had an order for [REDACTED].#457's care plan revealed the resident was at risk for respiratory complications and to administer medications and treatments per physician orders. Review of Resident #457's MDS 3.0 assessment, dated 02/19/20 revealed Resident #457 was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15. The MDS further revealed Resident #457 required the extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene and toileting needs and required supervision assistance of setup help only for eating. Observation of Resident #457 on 03/02/20 at 11:30 A.M. revealed the resident had a [MEDICAL CONDITION] machine beside her bed on the nightstand and an oxygen concentrator on the floor next to

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) her bed. The [MEDICAL CONDITION] machine tubing and the oxygen concentrator nasal cannula tubing were unlabeled and undated. Furthermore, there was no signage on the outside of the door identifying oxygen was in use. Interview with Maintenance Supervisor #314 on 03/03/20 at 3:25 P.M. verified Resident #457's oxygen tubing on the [MEDICAL CONDITION] machine and oxygen concentrator were not labeled or dated and there was no signage on the door indicating oxygen was in use. Review of the facility policy titled Use of Oxygen, dated 09/2019 revealed for safe oxygen administration the oxygen cannula or mask should be changed weekly and dated.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #55 was only administered as needed narcotic pain medication for severe pain as ordered to ensure the medication was necessary for the resident. This affected one resident (#55) of of six residents reviewed for unnecessary medication use. Findings include: Review of Resident #55's medical record revealed an initial admission date of [DATE] with a current readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #55's annual Minimum Data Set (MDS) 3.0 assessment, dated 12/26/19 revealed the resident had intact cognition, required supervision only for activities of daily living and was on a scheduled pain medication regimen. The assessment revealed the resident also either received as needed pain medications or was offered as needed pain medication and it was declined. The resident noted frequent pain that limited day to day activities at an intensity level of a six out of ten (on a zero to 10) pain scale. Review of Resident #55's physician's orders [REDACTED]. Review of the Medication Administration Records (MARs) for Resident #55 revealed [MEDICATION NAME] HCL was administered to Resident #55 ten times in January 2020 and 26 times in February 2020 for pain levels rated from 0 to 3 on a pain scale from 0 to 10, where 10 was the highest level of pain. Interview with Resident #55 on 03/03/20 at 8:09 A.M. revealed the resident was taking [MEDICATION NAME] and [MEDICATION NAME] for pain. The resident confirmed [MEDICATION NAME] was an as needed (PRN) pain medication that he received every six hours for pain. Interview with Licensed Practical Nurse #240 on 03/04/20 at 11:16 A.M. revealed a PRN pain medication for severe pain would be administered to a resident if the resident indicated he/she experienced a pain level of five or higher on a pain scale from 0 to 10, where 10 was the highest level of pain. Interview with the Director of Nursing (DON) on 03/04/20 at 12:59 P.M. confirmed the pain level documented on the top of the MAR indicated [REDACTED]. The DON confirmed Resident #55 received PRN pain medication when his pain level did not indicate the resident was having pain or the resident was having a low level of pain. The DON confirmed the physician order [REDACTED].
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure the necessary use of [MEDICAL CONDITION] medications including monitoring for symptoms for which the [MEDICAL CONDITION] medications were given and completion of gradual dose reduction attempts. This affected four residents (#50, #48, #102 and #67) of six residents reviewed for unnecessary medication use. Findings include: 1. Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #48's significant change Minimum Data Set (MDS) 3.0 assessment, dated 12/17/19 revealed the resident's speech was unclear, he usually understood, usually understands, and his cognition was severely impaired. Resident #48 had behaviors not directed toward others that did not significantly affect him or other residents and he did not reject care. Resident # 48 required extensive assistance of two staff for bed mobility and to transfer. Resident # 48 received antipsychotic medication, antianxiety medication, and antidepressant medication seven of the seven days during the assessment period and no gradual dose reduction had been attempted. Review of Resident #48's pharmacy review revealed on 12/17/19 a recommendation to attempt a dose reduction of Resident #48's [MEDICAL CONDITION] medications was made by the pharmacist. On 12/24/19 the physician declined a dose reduction but failed to give a rational as to why a dose reduction was clinically contraindicated. Review of Resident #48's physician's orders [REDACTED]. Review of Resident #48's plan of care dated 01/29/20 revealed target behaviors were related to the resident yelling, screaming out, hypersexuality, agitation, blowing kisses to staff, being verbally aggressive and difficulty with rational problems solving. However, the only target behavior the facility was monitoring was inappropriate sexual behavior toward females. Observation of Resident #48 on 03/02/20 at 11:09 A.M., and 3:58 P.M. revealed he was asleep in his wheelchair in the common area. At 1:02 P. M. after lunch the resident was awake. Interview with Activities Director (AD) #131 on 03/05/20 at 2:27 P.M. revealed Resident #48 slept a lot in the common area and she was not aware of him having any behaviors. Interview with Licensed Practical Nurse (LPN) #247 on 03/06/20 at 2:18 P.M. revealed Resident #48 did not usually have any behaviors. LPN #247 stated Resident #48 liked to talk to girls but that was about all. Interview with the Director of Nursing on 03/06/20 at 3:10 P.M. confirmed the facility was not monitoring all of Resident #48's behaviors and confirmed the physician did not give a rational why a gradual dose of the resident's [MEDICAL CONDITION] medication was contraindicated. 2. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #50's significant change MDS 3.0 assessment, dated 12/20/19 revealed Resident #50's speech was unclear, he sometimes understood, sometimes understands and his cognition was severely impaired. Resident #50 had no indicators or [MEDICAL CONDITION], had physical behaviors one to three days that did not significantly impact the resident or other residents and he did not reject care. Resident #50 required extensive assistance from two staff for bed mobility and to transfer. Resident #50 received antipsychotic medication, antianxiety medication and antidepressant medication, seven of the seven days during the assessment period and no gradual dose reduction was attempted. Review of Resident #50's pharmacy reviews revealed on 02/17/20 a recommendation to attempt a dose reduction of Resident #50's [MEDICAL CONDITION] medications was made by the pharmacist. On 02/21/20 the physician declined a dose reduction but failed to give a rational as to why a dose reduction was clinically contraindicated. Review of Resident #50's March 2020 physician's orders [REDACTED]. Resident #50's plan of care identified target behaviors of wandering without purpose and delusions. The only target behavior the facility was monitoring wandering and in the past 30 days no episodes of wandering were documented to have occurred. Observation of Resident #50 on 03/04/20 from 10:13 A.M. to 10:44 A.M. and from 2:05 P.M. until 2:48 P.M. revealed he was seated in a wheelchair in a common area asleep. Interview with State tested Nursing Assistant (STNA) #150 on 03/06/20 at 11:58 A.M. revealed Resident #50 had no behaviors. Interview with LPN #294 on 03/06/20 at 12:01 P.M. revealed Resident #50 did not have a lot of behaviors mostly he talked but did not make sense. Interview with the Director of Nursing on 03/06/20 at 3:10 P.M. confirmed the facility was not monitoring all of Resident #48's behaviors and confirmed the physician did not give a rational why a gradual dose was contraindicated for the resident's [MEDICAL CONDITION] medications. 3. Review of Resident #102's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #102's annual MDS 3.0 assessment, dated 01/07/2020 revealed Resident #102's speech was clear, he understands, was understood and his cognition was intact. Resident #102 had no behaviors and did not reject care. Resident #102 was independent with set up help for bed mobility and required supervision with set up help to transfer. The assessment revealed the resident received an antipsychotic medication, antianxiety medication and an antidepressant medication on seven of the seven days in the assessment period and no gradual dose reduction was attempted. Review of Resident #102's March 2020 physician's orders [REDACTED].#102's plan of care did not identify specific target behaviors for which he was receiving the psychoactive medication. And there was no evidence any behaviors were being monitored for the resident. Interview with STNA #146 on 03/04/20 at 8:36 A.M revealed sometimes Resident #102 refused care, his sheets to be changed or a shower. STNA #146 stated Resident #102 had no physical or verbal behaviors and he had no hallucinations or delusions. Interview with LPN #292 on 03/04/20 at 8:47 A.M. revealed the resident only refused showers sometimes and he had no hallucinations or delusions. Interview with LPN #322 on 03/04/20 at 9:49 A.M. confirmed Resident #102's target behaviors were not identified on his plan of care and there was no evidence of the facility was monitoring behaviors to ensure the psychoactive medications were necessary for the resident.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) 4. Review of Resident #67's medical record revealed an admitted on 09/14/19 with [DIAGNOSES REDACTED]. Review of Resident #67's physician's orders [REDACTED].#67's care plan, dated 09/14/19 revealed the resident had potential for fluctuations in mood and behaviors related to cognitive communication deficit, mood disorder, [MEDICAL CONDITION], cerebral infarction, depression, and [MEDICAL CONDITION]. Interventions included a quarterly [MEDICAL CONDITION] medication regimen review, attempted gradual dose reductions and behavior monitoring. Review of Resident #67's quarterly Minimum Data Set assessment dated [DATE] showed the resident had mild cognitive impairment and required extensive assistance from staff to complete activities of daily living (ADLs). Resident #67 received daily antipsychotic medication. Review of Resident #67's Psychoactive Medication Quarterly Evaluation assessment, dated 01/07/20 revealed the resident was taking Aripiprazole ([MEDICATION NAME]) 10 mg daily for dementia and major [MEDICAL CONDITION]. The behaviors associated with using the medication included: increased anxiety, depression, frustration while trying to find the appropriate words, and agitation. The assessment did not indicate any target behaviors that Resident #67 displayed to justify the usage of a [MEDICAL CONDITION] medication. Review of Resident #67's behavior monitoring task for the past 30 days revealed the resident had not displayed any behaviors during this time period. Interview with Registered Nurse (RN) #325 on 03/05/20 at 12:56 P.M. revealed Resident #67 was transferred to the 200 unit from the secured unit in October 2019. RN #325 stated Resident #67 had not displayed any behaviors toward staff or other residents. RN #325 stated Resident #67 did self-isolate and required encouragement to accept care. Interview with the Director of Nursing (DON) on 03/05/20 at 3:01 P.M. confirmed they facility had no evidence or documentation to support specific behaviors for Resident #67 during the given quarterly review period. The DON would expect the nursing staff (aides and nurses) to document in the electronic record when there was a behavior so they could accurately assess and monitor Resident #67's behaviors and continued medication justification.
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.** Based on observation, record review and staff interview the facility failed to ensure fire door assemblies were annually inspected, tested , and maintained in accordance with NFPA 101 - 2012 edition Section 7.2.1.15, 8.5.4, NFPA 80 5.2.4, and NFPA 105 - 2010 Edition Section 4.1.1 and 5.2.1. This had the potential to affect all 197 residents residing in the facility. Findings include: Record review on 03/02/2020 between 11:00 A.M. to 2:30 P.M. revealed the fire door inspection report dated 01/09/2020 did not list all of the 90 minute and greater doors found in the facility during the tour. Also, the report only checked for latch, gap, and proper closing. It's did not check the 11 required elements of the requirement. Observation during facility tour on 03/02/2020 between 2:30 P.M. and 5:00 P.M. and on 03/03/2020 between 9:15 A.M. and 2:00 P.M. revealed there were basement doors, stairwell doors, attic hatches and fire doors that had not have the annual fire door inspection completed. Interview with Maintenance Director at the time of discovery during tour verified the above findings. NFPA 101 - 2012 Edition 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. 7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. 7.2.1.15.5 Functional testing of door assemblies shall be performed by individuals who can demonstrate knowledge and understanding of the operating components of the type of door being subjected to testing. 7.2.1.15.6 Door assemblies shall be visually inspected from both sides of the opening to assess the overall condition of the assembly. 7.2.1.15.7 As a minimum, the following items shall be verified: (1) Floor space on both sides of the openings is clear of obstructions, and door leaves open fully and close freely. (2) Forces required to set door leaves in motion and move to the fully open position do not exceed the requirements in 7.2.1.4.5. (3) Latching and locking devices comply with 7.2.1.5. (4) Releasing hardware devices are installed in accordance with 7.2.1.5.10.1. (5) Door leaves of paired openings are installed in accordance with 7.2.1.5.11. (6) Door closers are adjusted properly to control the closing speed of door leaves in accordance with accessibility requirements. (7) Projection of door leaves into the path of egress does not exceed the encroachment permitted by 7.2.1.4.3. (8) Powered door openings operate in accordance with 7.2.1.9. (9) Signage required by 7.2.1.4.1(3), 7.2.1.5.5, 7.2.1.6, and 7.2.1.9 is intact and legible. (10) Door openings with special locking arrangements function in accordance with 7.2.1.6 (11) Security devices that impede egress are not installed on openings, as required by 7.2.1.5.12. 8.5.4 Opening Protectives. 8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3?4 in. (19 mm). 8.5.4.2 Where required by Chapters 11 through 43, doors in smoke barriers that are required to be smoke leakage-rated shall comply with the requirements of 8.2.2.4. 8.5.4.3 Latching hardware shall be required on doors in smoke barriers, unless specifically exempted by Chapters 11 through 43. 8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1. 8.5.4.5 Fire window assemblies shall comply with 8.3.3. NFPA 80 2010 Edition - Fire Doors 5.2.4 Swinging Doors with Builders Hardware or Fire Door Hardware. 5.2.4.1 Fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. 5.2.4.2 As a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. 5.2.5 Horizontally Sliding, Vertically Sliding, and Rolling Doors. 5.2.5.1 Fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. 5.2.5.2 The following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Slats, endlocks, bottom bar, guide assembly, curtain entry hood, and flame baffle are correctly installed and intact. (3) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (4) Curtain, barrel, and guides are aligned, level, plumb, and true. (5) Expansion clearance is maintained in accordance with manufacturer's listing. (6) Drop release arms and weights are not blocked or wedged. (7) Mounting and assembly bolts are intact and secured. (8) Attachments to jambs are with bolts, expansion anchors, or as otherwise required by the listing. (9) Smoke detectors, if equipped, are installed and operational. (10) No parts are missing or broken. (11) Fusible links, if equipped, are in the location; chain/cable, s-hooks, eyes, and so forth, are in good condition (i.e., no kinked or pinched cable, no twisted or inflexible chain); and links are not painted or coated with dust or grease. (12) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (13) No field modifications to the door assembly have been performed that void the label. 5.2.12 Lubrication and Adjustments. 5.2.12.1 Guides and bearings shall be kept well lubricated to facilitate operation. 5.2.12.2 Chains or cables on biparting, counterbalanced doors shall be checked, and adjustments shall be made, to ensure latching and to keep the doors in proper relation to the opening. 5.2.13 Prevention of Door Blockage. 5.2.13.1 Door openings and the surrounding areas shall be kept clear of anything that could obstruct or interfere with the free operation of the door. 5.2.13.2 Where necessary, a barrier shall be built to prevent the piling of material against sliding doors. 5.2.13.3 Blocking or wedging of doors in the open position shall be prohibited. 5.2.14 Maintenance of Closing Mechanisms. 5.2.14.1 Self-closing devices shall be kept in working condition at

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 10) all times. 5.2.14.2 Swinging doors normally held in the open position and equipped with automatic-closing devices shall be operated at frequent intervals to ensure operation. 5.2.14.3 All horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. 5.2.14.3.1 Resetting of the automatic-closing device shall be done in accordance with the manufacturer's instructions. 5.2.14.3.2 A written record shall be maintained and shall be made available to the AHJ. 5.2.14.3.3 When the annual test for proper operation and full closure is conducted, rolling steel fire doors shall be droptested twice. 5.2.14.3.4 The first test shall be to check for proper operation and full closure. 5.2.14.3.5 A second test shall be done to verify that the automatic-closing device has been reset correctly. 5.2.14.4 Fusible links or other heat-actuated devices and release devices shall not be painted. 5.2.14.5* Paint shall be prevented from accumulating on any movable part.
F 0802 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.** Based on observation, record review and interview the facility failed to provide sufficient staffing to ensure residents received their meals in a timely manner. This had the potential to affect 186 of 186 residents who received meal trays with the exception of 11 residents (#56, #121, #123, #145, #42, #43, #49, #94, #69, #24, and #159) who received nothing by mouth. The facility census was 197. Findings include: 1. Review of the facility established mealtimes revealed breakfast was supposed to be served at 8:00 A.M., lunch in the dining room was supposed to be served at 12:00 P.M. On 03/02/20 at 2:19 P.M. observation on the 100 unit received the lunch meal cart and meals were delivered and meal service started at this time. Interview with Licensed Practical Nurse (LPN) #293 and LPN #350 on 03/02/20 at 2:14 P.M. confirmed meal served in this hallway varies (quite often) since it was the last hallway served. The LPNs revealed they were unsure why it took so long for the meal carts to be brought back, but nursing worked to get meals out as quickly as they could once the cart arrived. On 03/03/20 at 8:57 A.M., breakfast was observed being served to the residents on the 100 unit. The front hallway was completed at 9:03 A.M. and the back hallway was starting to be served. On 03/03/20 interview with Resident #162 at 9:23 A.M. and interview with Resident #54 at 9:46 A.M. revealed meals were always served later than scheduled. Both residents indicated they wished meals came sooner/on time because they get hungry. The residents also shared food items were sometimes cold when meals were served late and indicated they had both asked nursing staff about this previously. Interview with Dietary Manager #211 and Dietary Aide #204 on 03/04/20 at 11:41 A.M. revealed the reason the dining room meal service was late was because kitchen staff were dependent on the State tested nursing assistants (STNA) to serve the food when they come from they units. When the STNAs were late coming, the meal service was late and that spiraled out to the other hallways. They stated they will email the STNAs when they notice they are late. On 03/05/20 at 2:45 P.M., there were three residents being served their lunch in the common/dining area in the 100 unit. These residents had not received their lunch prior to this. 2. Observation of the main dining room on 03/02/20 at 11:56 A.M. revealed 16 residents were in the dining room waiting to be served. At 12:02 P.M. coffee was served. At 12:13 P.M. soup was served and at 12:19 P.M. entres were served. As of 12:41 P.M., Resident #183, Resident #112, Resident t#35, and Resident #150, and Resident #37 were not served. Interview with STNA #180 revealed the STNA was not aware these residents had not been served as another staff was supposed to serve them. Observation of the 300-hall meal cart on 03/02/20 revealed the first cart did not arrive until 1:29 P.M. and the second cart arrived at 1:42 P.M. Observation of the breakfast meal in the dining room on 03/03/20 at 8:05 A.M. revealed the ice cart and beverage carts were out at this time. At 8:12 AM 21 residents were in the dining room and two STNAs were passing beverages and one STNA was passing condiments. At 8:24 A.M. packaged bowls of cereal were passed. At 8:27 A.M. the breakfast meal was passed. Review of the facility established mealtimes revealed breakfast was supposed to be served at 8:00 A.M., lunch in the dining room was supposed to be served at 12:00 P.M., and lunch on 300 halls was supposed to arrive at 12:55 P.M. and 1:10 P.M. Interview with Dietary Manager (DM) #500 on 03/04/20 at 11:41 A.M. revealed on 03/02/20 the trays were late due to staff calling off and the dietary aide on the line had family problems. DM #500 revealed the reason the dining room was served late was the kitchen staff were dependent on the STNA staff from the units to serve the food. DM #500 stated when the STNA's were late the meal service was late.
F 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, record review and interview the facility failed to ensure the written menu for pureed diets was followed. This had the potential to affect eight residents (#15, #23, #149, #83, #50, #147, #139 and #146) who received pureed meal trays. Findings include: Review of the spreadsheet for the lunch meal on 03/20/20 revealed a #10 scoop was to be used to serve pureed green beans, a #20 scoop was to be used for the pureed bread and pureed macaroni and cheese was on the menu. Observation of tray line on 03/04/20 from 10:50 A.M. until 11:15 A.M. revealed staff were using a #8 scoop (instead of a #10 scoop) for the pureed green beans. Staff were using a #16 scoop (instead of a #20 scoop) for the pureed bread and there was no pureed macaroni and cheese on tray line. Interview with Dietary Aide #204 confirmed the pureed foods (beans and bread) had the wrong scoop sizes compared with the size listed on the menu/spreadsheet. Interview with Cook #210 at the time of tray line revealed she missedthe macaroni and cheese for the pureed diets. Interview with Dietary Staff #192 revealed she was going to serve the residents who had orders for pureed diets mashed potatoes instead of the pureed macaroni and cheese. The facility identified eight residents, Resident #15, #23, #149, #83, #50, #147, #139 and #146 who received pureed meal trays.
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, record review and interview the facility failed to ensure food served was appealing, appetizing and served at the proper temperature. This affected seven residents (#54, #162, #109, #6, #189, #457 and #183) and had the potential to affect all 186 of 186 residents who received meal trays with the exception of 11 residents (#56, #121, #123, #145, #42, #43, #49, #94, #69, #24, and #159) who received nothing by mouth. The facility census was 197. Findings include: 1. Interview with Resident #54 on 03/02/20 at 1:58 P.M. revealed dietary concerns. The resident indicated most meals were served late and when served they were often cold (no longer hot/warm enough). The resident revealed she tells the staff this and at times they will warm the meal up. Interview with Resident #162 on 03/02/20 at 3:26 P.M. revealed dietary concerns. The resident revealed meals were served to his room extremely late, and by the time it gets to his room, the food was cold. The resident revealed he will sometimes ask for it to be warmed up, and it typically will be; but there were times he doesn't say anything because he doesn't believe anything will be fixed. He definitely wanted his food to be much warmer when served to him. Observation of food service and test tray temperature on 03/04/20 from 1:17 P.M. to 1:46 P.M. revealed it too 29 minutes from the point the food was served onto the test tray plate, to when it was served to take the food temperatures. The temperature of the ham was 101.7 degrees Fahrenheit (F). When tasting the ham, it was luke warm, not warm enough for a preference for food to be served warm/hot. The temperature of the ham was confirmed by Dietary Aide #204. During a follow up interview with Resident #54 on 03/04/20 at 2:12 P.M. the resident revealed the ham she received for lunch on this date was not warm enough for her preference when it was served to her. 2. On 03/02/20 at 1:35 P.M. Resident #109 was heard telling Registered Nurse (RN) #324 his food was not prepared correctly. Interview on 03/03/20 at 12:00 P.M. with Resident #109 revealed dietary concerns. The resident stated the food was horrible, there was no taste to it and it looked like cat food. The resident then reported fresh citrus fruits were rarely offered but sometimes you might get a banana. Observation on 03/03/20 at 12:00 P.M. revealed Resident #109 was served ground up chicken or turkey (could not be identified) with brown gravy, peas and carrots and mashed potatoes with gravy. The resident indicated the meal was not any good. On 03/02/20 at 10:44 A.M. an interview with Resident #183 revealed dietary concerns. The resident stated the food was horrible, everything was always served cold. The resident stated if you want anything else to eat (other than what was served) it takes a very long time for the substitution to come. The resident

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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 11) stated the meat was tough and many times you can't tell what vegetables you are eating because they all look the same and taste the same; no taste at all. 3. On 03/05/20 at 11:30 A.M. during a resident council group meeting, revealed four of the five residents present at the meeting voiced dietary concerns. The residents revealed food was often served late and cold. Resident #6 revealed the orange juice was never cold and actually hot when served. He further stated the hot items were served cold and the cold items were served hot. Resident #189 stated when Styrofoam was used, the residents were served cold meals like deli sandwiches. The problem was when they placed other things on the plate the bun or bread gets soaking wet and the sandwich turns to mush due to the runoff of the liquids from the sides. Resident #457 reported she refuses to drink the juice any longer do to it being sour and making her sick in the past.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review the facility failed to ensure residents received therapeutic diets as ordered. This affected one resident (#83) of six residents reviewed for nutrition and two residents (#62 and #109) of 31 residents reviewed for dining. Findings include: 1. Review of Resident #83's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #83's annual Minimum Data Set (MDS) 3.0 assessment, dated 11/27/19 revealed the resident's speech was unclear, she usually understands, usually was understood, her short and long term memory was impaired, recalled her room location and that she was in a nursing home and her cognition was moderately impaired. Resident #83 had no behaviors, no indicators of [MEDICAL CONDITION] and rejected care daily. Resident #83 required supervision of two staff for bed mobility, supervision of one staff to transfer and supervision from staff with set up help to eat. Resident #83 had no swallowing problems, was 66 inches and weighed 110 pounds. The assessment revealed the resident had no significant weight changes and was on a therapeutic diet. Review of Resident #83's quarterly MDS 3.0 assessment, dated 01/03/20 revealed Resident #83 understands, was understood and her cognition was moderately impaired. Resident #83 required supervision from one staff for bed mobility and to transfer. Resident #83 received a mechanically altered diet. Review of Resident #83's progress notes, dated 12/18/2019 at 1:20 P.M. revealed the resident appeared to be choking with mucus coming out of her mouth. The resident was sent to the emergency department (ED) of a local hospital. Resident #83 returned the same day from the ED Review of the progress note, dated 12/19/19 revealed Resident #83's was at risk for choking and her diet was downgraded to a puree diet with eight ounces whole milk each meal. Review of Resident #83's March 2020 physician's orders revealed her diet was a regular pureed texture diet. Observation of Resident #83 on 03/02/20 at 1:44 P.M. revealed she received a chicken salad sandwich, pasta salad, scalloped apples, juice and water. None of the food items were observed to be pureed. Interview with Licensed Practical Nurse (LPN) #267 confirmed the resident's food items were not pureed as ordered. 2. Review of the medical record for Resident #109 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of physician's orders revealed an order dated 07/05/19 for a low concentrated sweets, mechanical soft texture diet. A dietary note, dated 12/04/19 stated the writer would consult speech therapy to see if Resident #109's diet texture could be upgraded to regular per his request. A Minimum Data Set (MDS) 3.0 assessment, dated 01/13/20 revealed the resident required supervision only for eating. The plan of care stated the resident could tolerate a mechanical soft diet. Observations of the lunch meal on 03/02/20 at 12:40 P.M. revealed Resident #109 had a diet card on his meal tray that stated mechanical soft, low concentrated sweets diet. However, during the meal observation, the resident received a regular chicken salad croissant and pureed pasta salad. Interview with Resident #109 on 03/02/20 at 12:40 P.M. revealed he was upset and stated he could not eat the pureed pasta salad because it looked so bad. Observations on 03/02/20 at 1:45 P.M. revealed State tested Nursing Assistant #117 picked up Resident #109's lunch tray. She confirmed he did not eat any of his lunch. Interview with Speech Therapist #333 on 03/03/20 at 11:15 A.M. revealed she had spoken to Resident #109 after 12/04/19 and he wanted to stay on a mechanical soft diet. She stated that a mechanical soft diet meant the meat was ground but everything else was regular texture. She stated a mechanical soft diet would include regular texture pasta salad. Review of the facility policy titled Mechanically Altered Diets, dated 04/2010 revealed mechanically altered diets shall be prepared and served as prescribed by the physician. Guests shall be provided with the least restrictive diet to optimize nutritional status and to promote overall satisfaction with meals. All guests with physician's orders for mechanical soft diets shall receive foods of nearly regular textures with the exception of very hard, sticky, or crunchy foods. All guests with a physician's order for a pureed diet shall receive pureed, homogenous, and cohesive foods. Foods shall be pudding like. Interview with Dietary Manager #500 on 03/04/20 at 11:41 A.M. revealed the chicken salad should have been ground for a mechanical soft diet. She further stated the pasta salad should have been regular texture and not pureed for a mechanical soft diet. 3. Review of the medical record for Resident #62 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #62 had a physician's order, dated 08/28/19 for a mechanical soft, low concentrated sweets diet. A dietary note on 11/08/19 stated the resident was on a mechanical soft, low concentrated sweets diet. May have regular texture sausage but limit to three days per week. Meal intakes mostly 76-100%. A Minimum Data Set (MDS) 3.0 assessment, dated 01/01/20 revealed the resident required supervision only with eating. Observations on 03/02/20 at 12:55 P.M. revealed Resident #62 had her lunch meal. The diet card on the meal tray indicated mechanical soft, low concentrated sweets diet. The resident received a pureed sandwich, pureed pasta salad, a regular texture side salad, and regular texture fruit cocktail. The resident ate less than 25% of her meal. Review of the facility policy titled Mechanically Altered Diets, dated 04/2010 revealed mechanically altered diets shall be prepared and served as prescribed by the physician. Guests shall be provided with the least restrictive diet to optimize nutritional status and to promote overall satisfaction with meals. All guests with physician's orders for mechanical soft diets shall receive foods of nearly regular textures with the exception of very hard, sticky, or crunchy foods. All guests with a physician's order for a pureed diet shall receive pureed, homogenous, and cohesive foods. Foods shall be pudding like. Interview with Dietary Manager #500 on 03/04/20 at 11:41 A.M. revealed the chicken salad only should have been ground for a mechanical soft diet. She further stated the pasta salad should have been regular texture and not pureed for a mechanical soft diet.
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 and staff interview the facility failed to store, prepare and distribute food under sanitary conditions to prevent contamination and potential food borne illness. This had the potential to affect 186 of 186 residents who received meal trays with the exception of 11 residents (#56, #121, #123, #145, #42, #43, #49, #94, #69, #24, and #159) who received nothing by mouth. The facility census was 197. Findings include: Initial tour of the kitchen on 03/02/20 from 8:30 A.M. to 08:45 A.M. revealed the following concerns: The plate warmer had bread crumbs on it. A plate with egg residue on the plate was in the plate warmer. Two covers for the plate warmers were dirty, one had bread crumbs in it and the other had dried food on it. The floor of the fridge under the shelves was dirty and lids to drinks (4) were on the floor. The storeroom floor under the rack and shelves was dirty with food packet and lids. Observation of the service hallway outside the kitchen revealed three serving carts in service hall with old food trays. The above observations were confirmed by Dietary Manager (DM) #500 during the initial tour. In addition DM #500 revealed the trays were from the evening before and would be washed this morning. There was dried juice on the floor. The floor had the same areas of dried juice on the service hall floor which DM #500 confirmed on 03/03/20 at 11:00 A.M.
F 0840 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #183 had timely follow up and care related to a pacemaker. This affected one resident (#183) of one resident reviewed for specialized medical appointments. Findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365379	A. BUILDING _____ B. WING _____	03/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LAURELS OF WALDEN PARK	5700 KARL ROAD COLUMBUS, OH 43229

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

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F 0840 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 12) include: Review of Resident #183's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #183's hospital discharge record, dated 06/08/19 revealed under surgical/procedure history, it identified pacemaker with some unidentifiable numbers in parentheses. Review of Resident #183's Minimum Data Set (MDS) 3.0 assessment, dated 02/19/20 revealed Resident #183 had mild cognitive impairment with a Brief Interview of Mental Status (BIMS) score of ten. The MDS further revealed Resident #183 required extensive assist from one to two persons for bed mobility, transfers, hygiene, bathing, dressing and toileting needs and required supervision with setup assistance from staff for eating. Review of Resident #183's progress note, dated 01/13/20 revealed Resident #183 informed the nurse he wanted his pacemaker checked. The nurse contacted the local hospital for information regarding resident's pacemaker. The hospital advised the nurse to contact the resident's cardiologist since the hospital did not have any records of the resident having a pacemaker. The nurse attempted to contact the resident's daughter regarding information on cardiologist. Review of the facility grievance log from 01/2020 revealed on 01/14/20 Resident #183 reported he had a pacemaker issue. The grievance log indicated the resolution was Certified Nurse Practitioner (CNP) and hospital follow-up. Review of a progress note, dated 01/15/20 revealed the nurse spoke with the resident's daughter and she reported that her father did not have a pacemaker or defibrillator. The nurse then contacted a different hospital for records as the resident thought the procedure had been completed at this hospital. The nurse contacted the hospital medical records and they advised the nurse to fax over a request for medical records. Review of Resident #183's physician's progress note, dated 01/15/20 revealed pacemaker was documented under surgical history. Review of Resident #183's physician note, dated 01/19/20 revealed the resident reported to nursing staff his pacemaker needed checked as it had been some time since it was (last checked). He reported he was not having any chest pain or other concerns, just worried it had been some time since it was checked. The physician note revealed the physician completed a record review of the resident's hospital record from 06/2018 which reflected a pacer/ICD wire on imaging. Interview with Resident #183 on 03/02/20 at 11:00 A.M. revealed he had a pacemaker and it had been five years since it was checked. The resident revealed he had informed the nurse (some time ago) that it needed checked but stated nothing had been done about it. Interview with Staff #333 on 03/04/20 at 5:08 P.M. revealed the facility had not located the cardiologist who completed the pacemaker surgery. She further verified the hospital discharge paperwork, dated 06/08/19 revealed the resident had a pacemaker with an unidentifiable number in parentheses. Interview with Registered Nurse (RN) #324 on 03/04/20 at 5:26 P.M. revealed she had been trying since 01/2020 to find out who the cardiologist was that completed the pacemaker surgery. She reported she called one hospital and they reported they had no information on the resident for a pacemaker. She reported she called the same hospital again today and asked for the cardiology department. She reported they were able to verify the resident was a patient there three to four years ago and had not been seen since then. She reported the cardiology department would call her back if they could set an appointment for the resident. Interview with Registered Nurse (RN) #324 on 03/05/20 at 11:30 A.M. revealed Resident #183 now had an appointment with a Heart and Vascular specialist on 03/09/20 at 10:30 A.M. This deficiency substantiates Complaint Number OH 564.
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, record review and interview the facility failed to maintain adequate infection control practices for Resident #42 related to contact isolation for a ,[MEDICAL CONDITION]. Difficle (C Diff) infection, for Resident #122 related to droplet isolation precautions for possible influenza and for Resident #70 related to a pressure ulcer dressing change to prevent the spread of infection. This affected three residents (#122, #70 and #42) of nine residents reviewed for infection control. Findings include: 1. Review of Resident #42's medical record revealed an initial admission date of [DATE] and a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of a physician's order for Resident #42 revealed an order, dated 02/27/20 for the resident to be placed in contact isolation until 03/09/20 related to the[DIAGNOSES REDACTED] infection. Also noted was an order, dated 02/27/20 for [MEDICATION NAME] (an antibiotic) suspension, give 125 milligrams (mg) four times a day for[DIAGNOSES REDACTED] for 11 days. Review of Resident #42's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/27/20 revealed the resident required total dependence from two staff members for bed mobility, transfers and dependence on one staff member for eating via gastrostomy tube/eternal feeding. Review of Resident #42's plan of care, dated 02/28/20 revealed the resident was on contact isolation precautions related to the [DIAGNOSES REDACTED]. Observation on 03/02/20 at 12:24 P.M. of the Resident #42's room revealed there was no isolation equipment outside of the room nor was there a sign to inform visitors to see the nurse before entering the room. Interview on 03/03/20 at 9:11 A.M. with Registered Nurse #323 revealed Resident #42 was not presently in contact isolation. However, the resident had an order and care plan in place for isolation which began on 02/27/20 due to positive[DIAGNOSES REDACTED] results. Review of the facility policy titled Contact Precautions, revised September 2019 revealed it was the intent of the facility to use contact precautions in addition to Standard Precautions for guest/residents known or suspected to have serious illnesses easily transmitted by direct guest/resident contact or by contact with items in the guest's/resident's environment. 2. Review of Resident #122's medical record revealed the resident was placed on droplet isolation precautions on 03/02/20 at 1:21 P.M. due to the possibility of her having influenza. On 03/02/20 at 1:29 P.M. Licensed Practical Nurse (LPN) #270 and Laundry Staff #234 were observed to walk into Resident #122 room without any personal protective equipment (PPE). Resident #122 had a sign on her door for visitors to see the nurse prior to entering the resident's room, and a plastic tote of PPE outside of her door. Interview with LPN #270 and Laundry Staff #234 on 03/02/20 at 1:35 P.M. revealed they knew Resident #122 was on droplet isolation precautions and each time they go into her room they were supposed to put a gown, gloves, and a mask on prior to entering. Both staff verified they had gone in the resident's room jut prior to this interview and had not used any PPE and should have. On 03/03/20 at 8:25 A.M. LPN #247 was observed to enter Resident #122's room and did not apply any PPE equipment prior to entering the room. On 03/03/20 at 8:30 A.M. interview with LPN #247 verified she entered Resident #122's room without utilizing any PPE and the resident was in isolation for a possible influenza infection. Review of facility Droplet Precaution policy, dated September 2019 revealed healthcare personnel were to wear surgical masks for close contact in addition to standard precautions. 3. Review of the medical record for Resident #70 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a wound evaluation summary by the wound physician on 03/03/20 revealed Resident #70 had a Stage IV pressure wound of the left lateral ankle for at least 126 days duration. There was moderate serous exudate. The area measured 0.6 centimeters (cm) long by 0.4 cm wide by 0.2 cm deep. The wound was described as 90 percent granulation tissue with 10 percent slough. The resident had a physician's order for a treatment of [REDACTED]. Observation of the treatment on 03/04/20 at 7:20 A.M. revealed Licensed Practical Nurse (LPN) #304 washed her hands and applied clean gloves. She then used her gloved hand to move a mat out of the way that was on the floor and then move the trash can closer to the resident's bed. She then removed the soiled gloves and, without washing her hands, applied clean gloves. She then removed the soiled dressing from Resident #70's left ankle. She then cleansed the wound with normal saline. The resident was observed to have an open area on the left ankle measuring 0.6 centimeters wide by 0.4 centimeters long by 0.1 centimeters deep. LPN #304 then removed her gloves, washed her hands, and applied clean gloved prior to applying the clean dressing. Review of the facility policy titled Hand Hygiene, dated 9/2019 revealed staff were to either wash their hands or use alcohol based hand sanitizer after glove removal. Interview with LPN #304 on 03/04/20 at 11:02 A.M. confirmed staff were to wash their hands each time after removing gloves. This deficiency substantiates Complaint Number OH 377. This deficiency is also a recite to the complaint survey completed on 01/28/20.

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 and interview the facility failed to implement an effective antibiotic stewardship program to ensure the appropriate use of antibiotics for Resident #25. This affected one resident (#25) of six residents reviewed for unnecessary medication use. Findings include: Record review revealed Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 02/25/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Review of Resident #25's medical record revealed she was prescribed [MEDICATION NAME] 100 milligrams (mg) twice daily for 14 days (starting 02/29/20) related to infection. There was no documentation to support the justification of an infection or what the specific

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F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 13) infection was. Also, there was no documentation to support Resident #25 had signs or symptoms of an infection or the need for an anti-biotic prior to being it prescribed. Finally, the facility did not have documentation (after the antibiotic was prescribed) to support whether the medication was effective. There were no signs or symptoms documented after the medication was prescribed as to what the antibiotic was combating. Interview with Regional Clinical Consultant (RCC) #147 on 03/05/20 at 2:06 P.M. confirmed there was no justification for the use [MEDICATION NAME] until 03/05/20 because the medical professional who assessed Resident #25 was out of town. She revealed the medical director came in to the facility on [DATE] and documented the antibiotic was for acute [MEDICAL CONDITION]. Interview with Director of Nursing (DON) on 03/05/20 at 2:24 P.M. confirmed there was no documentation to support signs and symptoms were observed prior to the antibiotic being prescribed. She also confirmed there was no on-going monitoring for signs and symptoms related to whether antibiotic was effective. Review of the facility Antibiotic Stewardship policy, dated May 2016 and Antibiotic Use policy, dated June 2017 revealed facility staff will document in the medical record signs and symptoms of an infection. The policy revealed the facility would follow the McGeer's criteria to determine if an antibiotic was necessary/needed. Then, after three days of antibiotic use, the facility would review and speak with the doctor about the effectiveness and needed for continued use. This deficiency substantiates Complaint Number OH 377.
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.** Based on observation and interview the facility failed to ensure resident rooms and bathrooms on the 300 and 400 units were maintained in a safe, sanitary and comfortable manner. This affected 13 residents (#183, #103, #175, #109, #143, #70, #23, #176, #6, #7, #201, #8 and #182) residing on the 400 unit, ten residents (#107, #146, #59, #142, #48, #87, #86, #50, #130 and #160) residing on the 300 unit and had the potential to affect all 82 residents who resided on the 300 and 400 units. Findings include: 1. On 03/02/20 at 10:38 A.M. a tour of the 400 unit revealed the following concerns: In Resident #183's room, the bathroom floor had a heavy buildup of a black substance especially around the edge of the room (six to eight inches wide) and the floors were sticky. In Resident #103 and Resident #175's room, the toilet was sitting sideways exposing a dark brown golden yellow thick rusty ring on floor. There was a heavy buildup of dirt around the edge of bathroom floor. In Resident #109 and Resident #143's room, the bathroom floor had a dark brown golden yellow thick rusty ring build up around the base of the toilet. There was a white towel folded in half on floor in front of toilet and was stuck to floor. There were multiple scrapes on wall behind the B bed approximately three to four-foot area in diameter. In Resident #70's room, the area around the toilet had a dark brown golden yellow thick rusty ring build up around the base of the toilet. The dresser in the room had the top layer of veneer chipping off exposing the rough wood underneath. In Resident #23's room, the call light had a broken clip, so it was unable to be secured to ensure the light kept from falling to the floor. There was brown matter splattered on the wall beside the toilet. There was a broken electric cover on the wall behind the B bed. In Resident #176's room, the bathroom floor had a buildup of black material. In Resident #6 and Resident #7's room, the bathroom floor was dirty with dark brown golden yellow thick rusty ring around the toilet on the floor. There was a two-foot piece of molding missing near floor under sink. In Resident #201's room, the dresser in the room had the top layer of veneer chipping off exposing rough wood underneath. The bathroom floor had a dark brown golden yellow thick rusty ring around the toilet and the floor was dirty. In Resident #8 and Resident #182's room, had a brown substance on the left side of toilet seat with an elevated toilet seat over top of it. The bathroom floor was dirty with a dark brown golden yellow thick rusty ring build up around the base of the toilet. In the 400 shower room, the toilet had dried fecal matter covering the left side of the inside of the toilet bowel. The light above the back-shower stall does not work leaving the shower stall area dark. A fan and a ceiling vent in the shower room covered with dust build up. The back shower had low water pressure coming out of the handheld shower wand. The entire shower room floor had dirt and paper scattered all over. On 03/03/20 from 2:50 P.M. through 3:40 P.M. a second tour of the 400 unit was conducted with Maintenance Supervisor #314. The areas identified by the facility tour at the 10:38 A.M., were still there during the second tour. The Maintenance Supervisor #314 verified all the areas of concern during the tour. The Maintenance Supervisor furthermore verified there were live wires behind the missing electric cover in Resident #23's room because the room use to be the ventilator room. 2. On 03/03/19 from 3:50 P.M. to 4:05 P.M. a tour of the 300 unit with Maintenance Supervisor #314 revealed the following: Observation of Resident #107 and #146's room revealed the wall by the door was patched but not painted, the telephone outlet cover did not cover the outlet. Observation of Resident #59 and #142's room revealed the floor in the bedroom floor was stained and the wall by the closet had cracked and missing dry wall patch. Observation of Resident #48 and #87's bathroom floor revealed it was dirty and the flooring had about a half inch gap around the edge which was dirty with a buildup of debris. Observation of Resident #86 and 50's bathroom revealed cove molding and tiles missing off the wall under the sink. Observation of Resident #130 and #160's room revealed cove molding and tiles missing off the wall under the sink. Maintenance Supervisor #314 verified the above findings at the time of the observations. The carpeting in the common area by the nurses' station had stains that were red and beige in color on all of the carpeting. This deficiency substantiates Complaint Number OH 812 and OH 377.