STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365435	a. building _____ b. wing _____	**11/13/2020**

name of provider or supplier	street address, city, state, zip code
EMBASSY OF LOGAN	**300 ARLINGTON AVENUE LOGAN OH, 43138**

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F 0000	INITIAL COMMENTS 05/14/21 - Amended due to the results of the Independent Informal Dispute Resolution. PARTIAL EXTENDED SURVEY COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00117118 COMPLAINT NUMBER OH00117115 COMPLAINT NUMBER OH00117087 COMPLAINT NUMBER OH00117075 COMPLAINT NUMBER OH00117045 COMPLAINT NUMBER OH00116914 COMPLAINT NUMBER OH00116553 COMPLAINT NUMBER OH00116434 COVID- 19 FOCUSED INFECTION CONTROL SURVEY ADMINISTRATOR: Donna Garza, #4035 CERTIFIED BED CAPACITY: 135 CENSUS IN HOUSE: 126 The following deficiencies are based on the COVID 19 Focused Infection Control Survey and Complaint investigation completed on 11/13/20. The facility remains out of compliance from the survey dated 10/06/20.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

ASHLEY.GORTNER | 06/02/2021

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F 0561	Continued From page 1	F 0561		
F 0561 SS=D	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This STANDARD is not met as evidenced by: Based on observations, staff interview, medical record review, and resident	F 0561	F 561 Resident #61, 90 and 125 were interviewed/reviewed by corporate dietician and social worker on 11/25/2020 and had no negative effect from not honoring their choices. Cognitively able Residents who can make their needs known were interviewed and had their tray tickets updated with choices by the dietician on 11/30/2020. In order to ensure that residents have their food preferences honored, Food Service Staff will educated by the Corporate Dietician/designee by 12/4/2020 regarding the importance and process for reading tray cards. In order to ensure resident choices and preferences are honored, 3-5 residents will be audited 3-5 times/week by the Administrator/designee to validate food preferences were honored. In order to ensure that resident choices and preferences are honored, 3-5 resident trays will be audited 3-5 times/week by the Administrator/designee to validate tray accuracy. Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. *The administrator/designee will monitoring tray line for accuracy	12/07/2020

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F 0561	Continued From page 2 interviews, the facility failed to ensure residents had the right to make choices about aspects of his or her life in the facility that were significant to the resident in the area of food choices. This affected three of 126 residents (Residents #61, #90, and #125). Findings include: 1. Review of the medical record for Resident #61 revealed an admission date of 07/24/18. Review of the Minimum Data Set Assessment completed 10/05/20 revealed the resident was independent with daily decision making. Review of physician's orders revealed an order dated 09/13/18 for the resident to receive a peanut butter and jelly sandwich instead of lunch and dinner entree per resident preference. Review of the plan of care revealed a goal for the resident to maintain nutritional status with meal intakes greater than 75% of at least 2-3 meals daily. An intervention on 09/10/20 stated the resident would like to receive cottage cheese and applesauce three times a day with meals. The plan of care stated to honor the resident's food preferences as able. Observations on 11/09/20 at 12:55 P.M. revealed Resident #61 to have her lunch tray in her room. The resident received meat, sweet potatoes, and cauliflower. The resident was not observed to receive a	F 0561		

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F 0561	Continued From page 3 peanut butter and jelly sandwich, cottage cheese, or applesauce. Review of the diet card on the meal tray revealed it stated Resident #61 was to receive a peanut butter and jelly sandwich for lunch entree, cottage cheese and applesauce. Interview with Resident #61 on 11/09/20 at 12:55 P.M. revealed she is supposed to receive a peanut butter and jelly sandwich, cottage cheese, and applesauce with her lunch meal but she did not get any of the items. She stated she likes these items and wants to get them. Interview with State Tested Nursing Assistant #223 on 11/09/20 at 1:00 P.M. revealed it happens a lot that residents do not get what they are supposed to on their meal trays. 2. Interview with Resident #90 on 11/05/20 at 3:30 P.M. revealed she fills out a menu of what she wants to eat but the facility loses it and just sends her anything they want to. 3. Interview with Resident #125 on 11/05/20 at 4:00 P.M. revealed he stated he did not think the kitchen staff could read because they don't send him the items he requests on his meal trays. This deficiency substantiates Complaint	F 0561		

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F 0561	Continued From page 4 Number OH00116434.	F 0561		

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F 0563	Continued From page 5	F 0563		
F 0563 SS=J	483.10(f)(4)(ii)-(v) Right to Receive/Deny Visitors §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.	F 0563	F 563 On 11/12/20 at 12:00pm IDT meeting was held to review identified concerns with team, current policies – action items developed. IDT Members included DON/Admin, Medical Director, Corporate members, Chief Nursing Officer, Vice President of Operations, Chief Operating Officer, Regional QA Nurse, Regional Director of Operations. The IDT reviewed policies including Visitation and compassionate care. The team determined that our policies were appropriate as written and followed based on interviews with staff. • On 11/12/20 at 12:00 pm the IDT conducted a review of residents/conditions, and determined no other requests for visitation made at this time. • On 11/12/20 at 1:00pm Root Cause analysis initiated by the Regional QA nurse to identify cause of not providing visitation, and was completed by 3:00 PM • On 11/12/20 at approximately 5:00 pm the Regional QA Nurse sent Immediate education to families via mass messaging call and email system related to Facility Visitation policy along with compassionate care visitation guidelines and who to contact if needed for discussing visitations and compassionate care • On 11/12/20 at 6 PM The DON and Administrator were educated by the QA Nurse and RDO on Visitation Policy and Compassionate care visitation. • On 11/13/20 at 6:30pm the Regional QA Nurse educated staff in all facility departments that Social Services Director and Director of Nursing are to be called with any change of condition to assist in notifying family and offering compassionate care visit as described in CMS guidance. • On 11/13/20 at	11/13/2020

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F 0563	Continued From page 6 This STANDARD is not met as evidenced by: Based on medical record review, observations, family interview, staff interview, review of the facility policy on visitation, and review of a Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memo, the facility failed to permit family visitation for one resident (Resident #118) experiencing a significant decline in condition. This resulted in Immediate Jeopardy on 11/08/20 when a family member requested visitation with their mother who was experiencing a significant decline in health status and the family member was not permitted to visit. This resulted in the likelihood of serious psychosocial harm when Resident #118 expired on 11/10/20 without visitation from her daughter. This affected one of 126 residents (Resident #118). The facility census was 126. On 11/12/20 at 11:25 A.M. the Director of Nursing and Corporate Registered Nurse #200 were notified Immediate Jeopardy began on 11/08/20 when a family member requested visitation with their mother (Resident #118) who was experiencing a significant decline in health status and the family member was not permitted to visit. Resident #118 expired on 11/10/20 without visitation from her daughter. As of 11/13/20 the Immediate Jeopardy	F 0563	4:00 pm the Regional QA Nurse developed an Audit tool to review progress notes, huddle meeting forms, change in condition, and family notifications to identify any change of conditions that may meet Compassionate care guidelines. The audits will be completed daily x 14 days and as needed, to ensure compliance based off of results and compliance per supplemental staff to include: Sister facility clinical managers and corporate staff. • On 11/13/2020 at 4:15 pm the Regional QA Nurse initiated education for all facility staff regarding compassionate care guidelines. The education was completed on 11/13/2020. • Effective 11/19 all audit results will be reviewed by Regional Quality Assurance Nurse weekly with re-education or audit changes made as needed. Audits to be reviewed include change in condition, compassionate care visits, and family notification. • Effective with the November QAPI meeting and ongoing, all audit results will be reviewed by the Facility QAPI for prompt resolution. Next QAPI scheduled for November 18, 2020. *All education for compassionate care by Regional QA Nurse completed by 12/4/20	

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F 0563	Continued From page 7 remains ongoing. Findings include: Review of the Department of Health and Human Services, CMS Memo (QSO 20-39 NH) dated 09/17/20 revealed facilities should use the COVID-19 county positivity rate, found on the COVID-19 Nursing Home Data site as additional information to determine how to facilitate indoor visitation: • Low (<5%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits) • Medium (5% - 10%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits) • High (>10%) = Visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:	F 0563		

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F 0563	Continued From page 8 • A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support. • A resident who is grieving after a friend or family member recently passed away. • A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration. • A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past). Allowing a visit in these situations would be consistent with the intent of, "compassionate care situations." However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). Review of the closed medical record for Resident #118 revealed a Minimum Data Set 3.0 (MDS) assessment completed on 08/19/20 which indicated the resident required supervision only with eating. It	F 0563		

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F 0563	Continued From page 9 further stated the resident required limited assistance from one staff for personal hygiene, toileting, bed mobility, transfers, walking, and dressing. Observations on 10/27/20 at 3:15 P.M. revealed Resident #118 to be walking with a wheeled walker by herself in the hallway. Review of nurse's notes dated 10/30/20 at 9:24 A.M. noted a rapid COVID test being positive. Review of nurse's notes dated 10/30/20 at 8:07 P.M. revealed the resident was noted lying on the floor next to the bed with her upper back and head leaning against the wall. The resident was complaining of severe bilateral hip pain. The physician was notified, and the resident was sent to the hospital for evaluation. The resident returned on 10/31/20 at 12:45 A.M. On 11/03/20 at 2:35 P.M. it was documented the X-rays at the hospital had no findings of acute fracture. On 11/03/20 at 5:10 P.M. the note stated the daughters were updated on new orders for IV fluids. On 11/03/20 at 6:00 P.M. the physician was updated on the resident's condition and the daughters request to change the resident to a do not resuscitate/ comfort care status (DNR-CC). On 11/04/20 at 1:19 P.M. it was noted the daughter was updated on the resident's	F 0563		

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F 0563	Continued From page 10 status. Observations on 11/09/20 at 2:47 P.M. revealed Resident #118 laying on her right side in bed, resting quietly with her eyes closed. Resident #118's bilateral feet and knees were noted to have a red/purple marbled appearance. Interview on 11/09/20 at 2:50 P.M. with State Tested Nurse Aide (STNA) #523 revealed Resident #118 use to walk up and down the halls with a wheeled walker. STNA #523 confirmed Resident #118 had a decline and was no longer ambulatory and was dependent on staff for all care. STNA #523 confirmed the red/purple marbled appearance to Resident #118's bilateral feet and knees. Review of the medical record for Resident #118 revealed a nurse's progress note on 11/10/20 at 12:03 P.M. stating that at 7:30 A.M. the aides called the nurse to the resident's room. The resident was found unresponsive with no respirations and no pulse. The physician was notified. An order was received to release the body to the funeral home. The resident's daughter was notified of the resident's death. Interview on 11/10/20 at 11:30 A.M. with Resident #118's daughter (Daughter #224) revealed she contacted a nurse (Registered Nurse (RN) #225) at the facility two days ago and asked about visiting her	F 0563		

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F 0563	Continued From page 11 mother. She stated she thought she might be able to get her mother to eat if she was able to visit. She stated the nurse told her she could not permit her to visit and she would need to contact the Director of Nursing (DON) on 11/09/20. Daughter #224 stated she called the DON on 11/09/20 but was unable to reach her. She stated she left a voicemail for the DON on 11/09/20 asking about visiting her mother. She stated the DON did not return her call. She stated her mother died on the morning of 11/10/20 without her being able to visit. Interview with RN #225 on 11/10/20 at 2:45 P.M. revealed Resident #118's daughter (Daughter #224) had called in to the facility on 11/08/20 between 5:00 P.M.-7:00 P.M. She stated she spoke with her and Daughter #224 asked to visit her mother and try to get her to eat. RN #225 stated she told Daughter #224 she would have to contact the DON or Administrator on Monday 11/09/20 as she was not sure if the daughter was allowed to visit as the resident was residing on a COVID unit. RN #225 stated Resident #118's condition on 11/07/20 and 11/08/20 included not getting out of bed, not eating, not taking medications, and agitated with care. She stated she felt the resident would have benefited from hospice due to her decline in mobility, eating, and taking medications in the past two weeks. RN #225 stated she did not attempt to contact any	F 0563		

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F 0563	Continued From page 12 administrative staff regarding Daughter #224's request to visit. Interview on 11/10/20 at 3:30 P.M. with STNA #521 revealed Resident #118 was her grandmother. STNA #521 revealed her mother, which was Resident #118's Emergency Contact #1 and Power of Attorney for Healthcare (POA), had been trying to contact someone at the facility for days to see about coming in to visit Resident #118 and attempt to assist the resident with mealtime. STNA #521 stated she saw Resident #118 prior to a fall on 10/30/20. She stated, at that time, Resident #118 was still walking and appeared to be at her normal baseline. STNA #521 claims that after the resident's fall on 10/30/20, Resident #118 had a quick decline to where she was no longer walking, required assistance with toilet use, and was no longer eating or drinking. STNA #521 stated she had worked different units than what Resident #118 was residing on and did not have a chance to visit her again until after the resident's decline (date not given). Interview on 11/10/20 at 3:35 P.M. with Regional Director of Operations #501 revealed the visitation policy provided by the facility did not address visits for compassionate care situations except to say they could continue to occur with county COVID-19 positivity rates >10%.	F 0563		

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F 0563	Continued From page 13 Interview on 11/10/20 at 4:45 P.M. with the DON revealed her office was on the COVID unit so she was not going to it, plus she had not had time to listen to her voice mails for the past week. She stated she was not aware of Resident #118's daughter wanting to visit. At the request of the surveyor, the DON went and listened to her voice mails. She confirmed she had received a call (she did not have dates or times) from Resident #118's daughter (Daughter #224). She stated Daughter #224 stated she felt they were going to let the resident lay there and die. She stated she could come in and help give her mother her medications. Daughter #224 stated she did not want the run around. The facility provided no evidence of a clinical or safety reason to prohibit the visitation by Resident #118's daughter. Review of the facility policy titled Outdoor/Indoor Visitation dated 07/20/20 and revised 09/28/20 and 10/16/20 revealed the facility would offer and assist residents with scheduled outdoor visitation in accordance with the established guidelines and safety practices starting 07/20/20. The visitations are in an effort to positively impact quality of life outcomes and avoid a prolonged loss of personal connection which can have an effect on an individual's physical, mental, and psychosocial well-being. The policy stated that for a county COVID- 19 positivity rate	F 0563		

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F 0563	Continued From page 14 of High (>10%) visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies. The policy stated the facility reserves the right to restrict visitation due to reasonable clinical or safety cause, the COVID- 19 county positivity rate, the facility's COVID-19 status, and a resident's COVID-19 status, visitor symptoms, lack of adherence to the proper infection control practices, or other relevant factor related to the COVID-19 PHE. This deficiency substantiates Complaint Number OH00117115.	F 0563		

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F 0565	Continued From page 15	F 0565		
F 0565 SS=E	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 0565	F 565 Resident #21, 81, and 126 are no longer in the facility. Resident # 8, 27,30,19,31,49,12,101,108, 124,100,102, 90,30 were interviewed/assessed and provided reassurance that their concerns will be followed up on effectively immediately by the Administrator/designee on 11/30/2020. Residents experienced no negative effects. A resident council meeting was held on 11/30/2020 by the Administrator/designee to verify concerns were identified and resolved. In order to ensure that resident concerns are followed up on, all staff received education on the timely passing of snacks and Ice water, concern form process, resident rights and grievance policy by the Regional Quality Assurance Nurse by 12/4/2020. Water and snack pass is routinely delivered by STNAs.The Administrator and Activity Director received education on the Resident Council follow up tool by the Regional QA nurse on 11/30/2020. In order to ensure follow up to resident council meeting concerns and concern forms, 3-5 residents will be audited 3-5 times/week by the Administrator/designee. Timely passing of snacks and ice water will be audited for 3-5 residents, 3-5 times/week by the Administrator/designee. Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. On-going compliance with resident satisfaction with passing/variety of snacks and ice water passing, will be monitored via the resident council meeting minutes and routine facility rounds.	12/07/2020

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F 0565	Continued From page 16 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This STANDARD is not met as evidenced by: Based on review of resident council meeting minutes, observations, staff interview, and resident interview, the facility failed to act promptly on grievances voiced by residents regarding resident care and life in the facility. This affected 14 residents who attended resident council meetings (Residents #8, #12, #19, #21, #27, #30, #31, #49, #81, #100, #102, #108, #124, and #126) and had the potential to affect any of the 126 residents residing in the facility while specifically affecting Residents #90 and #101. Findings include: 1. Review of Resident Council Meeting Minutes from 08/21/20 revealed residents voiced concerns as follows: a. Residents on 200, 300, and 700 units stated that snacks have not been getting passed and the aides stated there are no snacks to pass. b. Residents on 200 and 700 units stated that ice has not been getting passed regularly without the residents asking for it. c. Residents on 200, 300, and 700 units stated their rooms have been going without	F 0565		

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F 0565	Continued From page 17 being cleaned/trash emptied daily. Residents stated housekeeping has told them they are short staffed right now. Review of the facility responses for the concerns voiced at the 08/21/20 meeting revealed the following: a. All snacks are placed daily and filled as needed. Evening aide fills them nightly and puts them in the nutrition room. b. Instruction to management staff to speak to residents about these issues. c. Discussed issue with staff; educated staff on housekeeping protocols and responsibilities. Making multiple rounds to ensure cleanliness. 2. Review of Resident Council Meeting Minutes from 09/17/20 revealed residents voiced concerns as follows: a. Residents requested to have a larger variety/different snacks to choose from and more available. b. Residents state that ice water is still not being passed regularly. c. Residents state their rooms are still not being cleaned regularly or the trash emptied. Review of the facility responses for the concerns voiced at the 09/17/20 meeting revealed the following: a. We provide a variety of snacks daily. b. Staff education reviewed. Staff reminders. c. Making multiple rounds to ensure	F 0565		

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F 0565	Continued From page 18 cleanliness. 3. Review of Resident Council Meeting Minutes from 10/22/20 revealed residents voiced concerns as follows: a. Residents not receiving a variety of snacks. b. Residents stated ice water not being passed regularly. c. Resident stated bathrooms not being cleaned thoroughly. Toilets, sinks, mirrors, and counters not cleaned. Floors not swept or mopped. Review of the facility responses for the concerns voiced at the 10/22/20 meeting revealed the following: a. A list of snacks provided was listed. However, there was no evidence of any follow up to determine if the snacks were actually being passed or if enough was provided for all residents who wanted one. b. Staff education initiated. c. Re-educated staff. 4. Observation on 11/04/20 at 11:20 A.M. revealed Resident #101 asking staff for some ice water because her water pitcher was empty. State tested nursing assistants (STNA) #524 and STNA #220 were both observed telling Resident #101 that they would get her some fresh water in a few minutes. STNA #524 proceeded to enter another resident's room to obtain vital signs and STNA #220 entered another resident's room while holding a meal tray	F 0565		

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F 0565	Continued From page 19 to assist with feeding. Continued observation revealed Resident #101 did not receive fresh ice water until 12:30 P.M. Interview with STNA #220 confirmed they were not able to get Resident #101's ice water in a timely manner due to not having enough time to meet everyone needs nor having enough staff to help out. 5. Interview with Resident #90 on 11/05/20 at 3:30 P.M. revealed she does not always get ice water every day and did not get any as of 3:30 P.M. on 11/05/20. 6. Interview on 11/09/20 at 12:10 P.M. with Resident #81 revealed when asked if she was the President of the resident council she said, "I guess." Resident #81 claimed when the council meets and discusses any concerns they may have, a staff member who is in attendance takes notes and documents the concerns. The concerns are supposed to be presented to the facility management for reviews and correction. Then the concerns are to be discussed with the council president. Resident #81 confirmed any concerns the resident council has had has not been discussed with her and there has been no resolution to the council's complaints. 7. Observation on 11/13/20 at 2:30 P.M. of the 300 unit revealed a small trash can placed in the hallway outside of room 311. Used isolation gowns were noted to be	F 0565		

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F 0565	Continued From page 20 overflowing out of the top of the trash can onto the floor. Room 309 was noted to have food on the floor next to A bed and a plastic silverware wrapper by the foot of the A bed on the floor. Noted in the hallway between room 307 and the soiled linen room was an empty medication package and what appeared to be spilled milk and cereal. Also noted on the floor was dirt and small pieces of paper. Room 302 was noted to have a yellow colored substance by the door entrance. There was no evidence of any further actions taken to attempt to resolve the repeated concerns voiced by residents at three straight monthly resident council meetings. Repeated requests to the facility for any additional follow up on resident concerns went unanswered. The last request on 11/09/20 at 2:38 P.M. to Corporate Nurse #200 went unanswered.	F 0565		

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F 0600	Continued From page 21	F 0600		
F 0600 SS=J	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This STANDARD is not met as evidenced by: Based on staff interview, review of the medical record, facility policy and procedure for abuse, facility Self-Reported Incident (SRI), and facility investigation, the facility failed to ensure one female resident (Resident #2) assessed with severe cognitive impairment, was free from sexual abuse from one male resident (Resident #115) who was known to have sexually inappropriate behavior towards female residents. This resulted in Immediate Jeopardy and the likelihood of serious harm on 11/08/20 at 8:30 P.M., when Resident #115 entered into Resident #2's room and fondled the resident's bare breast while self-stimulating with his hand.	F 0600	F 600 Resident #2 is no longer in the facility. Resident #2's BIMS was 0 and was not able to benefit from psychosocial counseling. Social worker visited resident 11/16/2020 and resident voiced she feels safe and does not was not worried about anything. Resident was free of evidence of psychosocial harm. On 11/8/2020 approximately 8:30pm residents #2 and # 115 were separated by STNA. On 11/8/20 approximately 8:30pm Event was reported to RN Supervisor and Director of Nursing. On 11/8/2020 approximately 8:35 pm resident #115 moved to common area per STNA statement, and per statement kept in view and on 15 min checks. On 11/8/2020 approximately 8:40pm resident #2 was assisted with hygiene and cleaned up by STNA. 11/9/2020 resident#2 assessed per Director of Nursing RN at 5:00pm due to statement of crying and whimpering. During assessment on 11/9/2020 resident was not tearful and no s/s of distress. On 11/9/2020 7:00 pm resident #115 placed on 1:1 observation per Director of Nursing. Resident remained on 1:1 supervision until discharge on 11/19/2020. Psychological services were ordered on 11/11/2020. There were no other residents with inappropriate sexual behaviors in the facility. On 11/9/20 8:00 pm resident #115 and resident#2 assessed by Director of Nursing. On 11/9/20 – 8:45 pm Initiated by Regional QA Nurse RN: All staff, including ancillary staff educated on Abuse policy – which discusses documentation of adverse events and interventions to put into place for protection of residents. On 11/9/20 9:00 pm	12/07/2020

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F 0600	Continued From page 22 Resident #2 was completely wet in the front of her gown with yellow tinged liquid that appeared to be urine. This affected one of nine female residents residing in the Dementia Unit. The facility census was 126. On 11/09/20 at 5:25P.M., the Director of Nursing (DON) and Regional Director of Operations #501 were notified Immediate Jeopardy began on 11/08/19 at 8:30 P.M. when Resident #115, who was admitted on 01/22/20 and had known sexually inappropriate behaviors since 02/03/20, entered Resident #2's room, fondled her breast under her clothing while self-stimulating with his hand and completely saturated the front of her with yellow tinged fluid, presumed urine. The facility failed to ensure Resident 115's care plan that addressed his potential to participate in physical intimate interactions with females was implemented as written, updated when interventions were unsuccessful, and ensure adequate monitoring and supervision to ensure the behavior did not continue. As of 11/13/20, the Immediate Jeopardy remains ongoing. Findings include: Medical record review revealed Resident #2 was admitted to the facility on 03/23/19 with diagnoses including cognitive	F 0600	Resident assessments completed per nursing staff scheduled on dementia unit (area perpetrator resides). Sixteen residents and no adverse or unusual findings. Upon physical assessments by the DON/Designee on 11/9/2020, residents were found to be non-interviewable. All facility residents were assessed by the DON/designee and there were no residents with inappropriate sexual behaviors. In order to ensure residents are free from abuse the Director of Nursing was re-educated on the daily practice of reading progress notes and following up by the QA nurse by 12/04/2020. By 12/04/2020 the nursing staff received education regarding steps to take in response to a similar situation including assessment, notifications, and investigation by the QA nurse/designee. In order to ensure that residents are free from abuse, 3-5 residents will be interviewed/observed via shower sheets and chart review 3-5 times/week by Administrator/designee. In order to ensure residents are free from abuse observations will be conducted on 3-5 residents/3-5 times/week for appropriate interactions by the Administrator/designee. Staff knowledge of abuse policies will be conducted by the Administrator/designee 3-5 residents, 3-5 times per week to validate their knowledge of abuse prohibition policies and procedures. Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. *Audits will be completed at least 4 weeks or until compliance is achieved. *Audits will include staff interviews	

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F 0600	Continued From page 23 communication deficit, Alzheimer's Disease, dementia without behavioral disturbance, depression, insomnia and persistent mood affective disorder. Review of a Significant Change MDS assessment dated 10/02/20 revealed Resident #2 was severely impaired for daily decision making, had adequate hearing, clear speech, could make self-understood and used corrective lenses with adequate vision. The resident was extensive assist of two for bed mobility and transfers and two-person physical assist for moving from sitting to standing and walking. She was not able to answer questions accurately. Medical record review revealed Resident #115 was admitted to the facility on 01/20/20 with diagnoses including major depressive disorder, Alzheimer's disease, cognitive communication deficit, dementia without behavioral disturbance, and mood affective disorder. Further record review for Resident #115 revealed a 02/03/20 change of condition progress note, with the initial documentation of inappropriate sexual behaviors. Review of the 02/05/20 Self-Reported Incident (SRI) #188158 to the State Agency revealed Resident #115 was in his room with his shirt off with female Resident #67 who's pants were off. In addition the note indicated "hypersexual activity" was displayed 02/07/20, though	F 0600	to verify staff is knowledgeable of abuse policies.	

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F 0600	Continued From page 24 not descriptive of the behavior. A comprehensive plan of care was developed 02/07/20 for the potential to participate in physical intimate interactions with females. Interventions all dated 02/07/20 included medications as ordered, anticipate needs, provide opportunity for positive interaction, attention by stopping and talking with resident, intervene as necessary to protect the rights and safety of others by approaching/speaking in a calm manner, divert attention and remove from situation and take to alternate location as needed. Redirect when participating in physical intimate interactions with females. Review of the progress notes for Resident #115 revealed the following: • 04/24/20 nurses note indicated the resident was touching a female resident • 04/26/20 the resident was flirtatious and following a female resident around the unit. • 04/29/20 Resident #115 was found in a female resident's room with his clothes off. After being returned to his room and dressed, he left in less than five minutes with his shirt off heading back to the same room. • 05/04/20 he was wandering the unit pulling his pants down and his penis out. A 05/06/20 nurses note included the resident came out of his room naked. • 05/19/20, 06/14/20, and 06/19/20	F 0600		

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F 0600	Continued From page 25 wandering in and out of rooms, "flirty" behavior toward females was documented. • 06/20/20 the resident was following a female resident waving her on and telling her "come on" when she was not next to him. • 06/25/20 the resident was wandering in and out of other residents' rooms, at times he would take his pants down and urinated or defecated on chairs, beds, floors, and trashcans. • 07/13/20 he was in a room with a female resident being affectionate. • 08/01/20 he followed a female resident around the unit for several hours telling her "come on" and "let's go". • 08/07/20 urinating on other residents' beds. Review of the 08/12/20 Quarterly Minimum Data Set 3.0 (MDS) revealed Resident #115 was severely impaired for daily decision making, felt down, depressed and tired with little energy 7-11 days of the lookback period. Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 1-3 days. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) 4-6 days. Wandering	F 0600		

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F 0600	Continued From page 26 4-6 days, supervision of one for bed mobility, supervision of one for transfers, supervision set up for walking in corridor and room, locomotion on and off the unit and toilet use with limited assist of one. The resident was frequently incontinent of bowel and bladder. A nurse notes dated 08/23/20 indicated the resident was attempting to hold a female resident's hand and grabbing other residents. Review of Resident #115's comprehensive plan of care for the potential to participate in physical intimate interactions with females was not updated with new interventions since the 02/07/20 initiation. Interventions included administer medications as ordered. Monitor/document for side effects and if effective, anticipate and meet needs, caregivers to provided opportunity for positive interaction and attention, stop and talk with resident when passing by, intervene as necessary to protect the rights and safety of others. Review of the TASK section of the electronic documentation for Resident #115 revealed 19 of the last 29 days 10/11/20 through 11/08/20 the resident was sexually inappropriate. Nineteen of 29 days the resident showed physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others	F 0600		

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F 0600	Continued From page 27 sexually). Eighteen of the last 29 days the resident showed verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). Twenty four of the last 29 days the resident showed behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Review of Resident #115's nurses note late entry entered 11/09/20 at 1:41 A.M. for 11/08/20 at 08:30 P.M. included, when staff saw that resident was not in his room, they went to look for him and found him in Resident #2's room standing at the bed fondling the female resident's breast. The top part of Resident #2's gown was completely wet with a yellow tinged fluid. It was presumed Resident #115 urinated on Resident #2. The resident was upset. (Resident #2). Resident #115 was redirected back to his room. Review of Self-Reported Incident #198821 submitted to the State Survey Agency by the facility on 11/09/20 at 5:12 A.M. revealed an allegation of sexual abuse. The initial source of the allegation was listed as staff. Involved residents were listed as Resident #115 and Resident #2. The incident form stated both residents	F 0600		

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F 0600	Continued From page 28 had dementia, and neither were able to provide any meaningful information. State Tested Nurse Aide (STNA) #218 reported (Resident #115) was in bed with female (Resident #2) touching her breasts. The Summary of Incident Statement included' "STNA stated she witnessed a male dementia resident on secured dementia unit in female dementia resident's room. Female resident was laying in her bed. Male resident was standing beside female's bed. STNA stated male had his hand on female's breast. STNA stated she immediately redirected male resident out of female's room to common area away from other residents. STNA then notified nurse. STNA stated she then went to female resident's room to check on female resident. STNA stated female resident was whining as is normal behavior for resident during care. Review of the summary revealed: Substantiated - abuse, neglect or misappropriation verified by evidence. Review of Resident #2's nurses notes revealed no documentation indicating Resident #115 entered her room on 11/08/20, fondled her breast and upset her. A nurses' note dated 11/09/20 at 8:06 P.M. indicated the resident's son and Physician Assistant #404 were notified of allegations of sexual abuse regarding Resident #2 and #115. Observations on 11/09/20 at 10:00 A.M.	F 0600		

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F 0600	Continued From page 29 revealed Resident #2 sitting in the dining area of the dementia unit with her eyes closed. Observations on 11/09/20 at 10:05 A.M. revealed Resident #115 coming out of the bathroom inside his room, on the dementia unit. He walked over and sat on his bed. At that time, he did not respond appropriately to questions asked of him, such as how he was, or what day it was. Interview with Licensed Practical Nurse (LPN) #217 on 11/09/20 at 10:10 A.M. revealed she was the nurse assigned to work on the dementia unit (400 hall) beginning at 7:00 P.M. on 11/08/20 through 7:00 A.M. on 11/09/20. However, she stated she was also assigned to cover the 300 halls for that shift. She stated on 11/08/20 around 8:30 P.M. STNA #218 reported to her that, after being in a resident room providing care on the dementia unit, she was unable to find Resident #115 in his room. STNA #218 then looked for him and found him in female Resident #2's room. She reported that Resident #115 had his hands under Resident #2's gown near her breast area. She reported that Resident #2's gown was wet up the front. LPN #217 stated that STNA #218 presumed Resident #115 had urinated on Resident #2 as her disposable underwear was dry. LPN #217 stated Resident #2 was unable to verbally express what happened but STNA #218	F 0600		

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name of provider or supplier	street address, city, state, zip code
EMBASSY OF LOGAN	**300 ARLINGTON AVENUE LOGAN OH, 43138**

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F 0600	Continued From page 30 said Resident #2 seemed irritated and was moaning at the time of the incident. LPN #217 stated that STNA #218 indicated Resident #115 tended to follow the female residents around and be friendly with them. LPN #217 stated she was working on 300 halls (outside of the secured doors of the dementia unit) at the time of the incident. She stated she had never worked on the dementia unit before and did not know how to handle the incident. When asked what was done as a result of the incident, LPN #217 stated they separated Resident #115 from Resident #2 and then got Resident #2 cleaned up. She stated Resident #115 then went to bed and the STNA "kept an eye on him". Interview with STNA #220 on 11/09/20 at 10:25 A.M. revealed she was working on the dementia unit. She stated she does not normally work on the dementia unit and had not worked on that unit for approximately one month. She stated she had received report from night shift STNA #219 that morning. She stated she was not aware of any male resident having any type of sexually inappropriate behavior towards female residents, including Resident #115. She stated it was not reported to her that Resident #115 had touched any female, so she was unaware she was to do 15-minute checks. Interview with STNA #219 on 11/09/20 at 11:00 A.M. revealed she had been	F 0600		

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F 0600	Continued From page 31 assigned to work on the dementia unit (400 unit) last night, 11/08/20 from 7:00 P.M. to 7:00 A.M. on 11/09/20. However, she was pulled to work on the 300 halls. She stated STNA #218 was working on the dementia unit (400 hall) by herself at the time the incident regarding Resident #115 happened. She stated STNA #218 came off the dementia unit and reported that Resident #115 had gone into Resident #2's room and put his hand under the resident's gown in the chest area. Resident #2 was crying and STNA #218 got him out of her room. STNA #218 went back and saw that Resident #2 was wet and Resident #115 had urinated on her. Resident #2 was still upset. Resident #2's gown was wet at the top but her depend (incontinence brief) was dry. STNA #219 stated when there was only one staff on the dementia unit, you could not keep an eye on the residents, especially when you are in a room providing care. She stated the week prior; the nurse was only able to be on the dementia unit about two hours per shift because of working on another unit also. STNA #219 stated Resident #115 had a history of going into female residents' rooms, patting them on the back, following them around, pulling his pants down, and urinating and defecating in other residents' rooms. She stated he would not sit down and wandered up and down the hall going in other resident rooms. She stated there was nothing they could do when they were short staffed and only had one or two staff	F 0600		

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F 0600	Continued From page 32 on the unit. STNA #219 stated she felt Resident #115 knew when the staff were busy and that was when he went in female resident rooms. The STNA stated there were residents who required assistance from two staff so there are times when, if there are two staff, that they are both in a resident room providing care. Interview with the DON on 11/09/20 at 11:30 A.M. confirmed the facility had submitted a self-reported incident to the State Survey Agency that morning regarding Resident #115. She stated she had statements from staff but had not had time to look at them. A physician order for Resident #115 for every 15-minute checks was entered on 11/09/20 at 11:31 A.M. Interview with the DON on 11/09/20 at 1:00 P.M. revealed she was unable to find a witness statement from STNA #218 and had no other investigation information to provide at that time, except that the residents involved were unable to provide any information related to the incident. She stated she would have to look to see if Resident #115 had any previous sexually inappropriate behaviors. Interview with the DON on 11/09/20 at 4:30 P.M. revealed 15-minute checks were started on Resident #115 last night after the incident with Resident #2. She stated	F 0600		

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F 0600	Continued From page 33 evidence of this was documented on paper forms on the unit. She stated the facility did not need a physician's order to do this. Interview with Registered Nurse (RN) #221 on 11/09/20 at 4:55 P.M. revealed she was currently the nurse on duty for the day shift for the dementia unit. She stated she was notified in report this morning regarding the incident with Resident #115. She stated she was the one who wrote the order for 15-minute checks for Resident #115 that morning (11/09/20) after report from the night shift nurse at 8:30 A.M. She revealed there was no evidence that 15-minute checks had been completed on the night shift (11/08/20 into 11/09/20) or on the day shift for 11/09/20. She further confirmed there was no evidence the physician or family had been notified of the incident that occurred with Resident #115. A physician order for Resident #115 was entered 11/09/20 at 9:00 P.M. for staff one on one supervision of the resident. Interview with LPN #222 on 11/10/20 at 10:35 A.M. revealed one to one staff supervision had been started for Resident #115 at 7:00 A.M. that morning. Review of the one to one supervision form used by the staff to document revealed on 11/10/20 it was blank prior to 7:00 A.M. Interview with LPN #222 on 11/10/20 at	F 0600		

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F 0600	Continued From page 34 10:35 A.M. confirmed the form was blank prior to 7:00 A.M. She did not have any documentation available to show that one to one supervision had been provided for Resident #115 prior to 7:00 A.M. on 11/10/20. She further stated that Resident #115 was quick and went into other resident rooms a lot. Interview with Resident #2's son on 11/12/20 at 6:18 PM revealed he was not called on Sunday related to the sexual assault. He indicated he was called this week maybe two days ago. He checked his phone history and revealed he was notified of the incident on 11/09/20 at 8:04 P.M. Interview on 11/12/20 at 6:31 P.M. with Resident #115's wife revealed she was called Monday or Tuesday at around 8 P.M. related to her husband being in a female resident's room touching her breast. Review of Resident #2 and Resident #115's nurses note dated 11/12/20 revealed there was no evidence of Social Service intervention related to the incident on 11/08/20. Resident #2 did not have a progress note indicating there was a male perpetrator in her room. There was no evidence in the record of what transpired on 11/08/20 and her reaction as observed by STNA #218.	F 0600		

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F 0600	Continued From page 35 Interview 11/12/20 at 9:04 P.M. with Corporate Registered Nurse #200 via a returned email verified there was no documentation of 15-minute checks being provided to Resident #115. Corporate Registered Nurse #200 indicated staff reported they were monitoring the resident's whereabouts on the evening of 11/08/20 after the incident. Staff reported Resident #115 did not enter any other rooms nor did he come into contact with any other residents. Resident #115 later went to sleep and settled for the evening. Corporate Registered Nurse #200 further verified the families and the physician were not notified of the incident until the following evening. On 11/12/20 at 9:28 P.M. the first nursing skin assessment for Resident #2 following the 11/08/20 incident was provided indicating it was completed 11/09/20 at 9:54 P.M. Interview on 11/15/20 at 11:45 A.M. with STNA #218 revealed she was the only staff working the Dementia Unit on 11/08/20 when Resident #2 was sexually assaulted by Resident #115. Her co-worker had been pulled to another unit at 7:00 P.M., the beginning of their 12-hour shift and the nurse normally did not arrive on the Dementia Unit until approximately 11:00 P.M. due to working three units. STNA #218 indicated on 11/08/20 at 8:30 P.M. she was in the room across from Resident	F 0600		

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F 0600	Continued From page 36 #115 and his roommate. She noticed the door was open and did not see Resident #115's feet in bed. STNA #218 revealed due to his history she started to check all the rooms. Resident #2's door was closed. When she opened the door STNA #218 found Resident #115 in his pajamas standing at the side of Resident #2's bed. Resident #115 had his right hand on his crouch. His left hand was up under her night gown touching the skin of her left breast. She was whimpering telling him to stop and "no". STNA #218 indicated he didn't. STNA #218 revealed Resident #2 whimpers with care when she doesn't know what is happening and is scared. STNA #218 said she startled Resident #115 when she said his name and he jumped. She asked him what he was doing. He said he was doing "nothing". She indicated he repeated you didn't catch me doing nothing. STNA #218 told him to get out of the room and that they had discussed this before. After she got him out of the room, she talked to him about consent while walking him back to his room. STNA #218 included the resident said he didn't care. STNA #218 indicated she generally believed the resident knows what he is doing because of how he takes opportunities when no one is around and says they did not catch him. After walking him to his room and putting him in bed she opened the double door to the next unit to summons the nurse to come to the unit due to the incident. The nurse was unable	F 0600		

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F 0600	Continued From page 37 to come to the unit due to other responsibilities. STNA #218 went back to Resident #2 and noticed she had a yellow tinged liquid over the top of her clothing. The STNA got Resident #2 out of bed and put her in a wheelchair next to the nurse station. She texted the Director of Nursing (DON) and asked her what she should do. The DON responded I don't know and included an emoji with a person shrugging. STNA #218 indicated the resident had what she thought was urine saturating her clothing, so she took her into the shower and showered her leaving no one on the unit to monitor the residents. STNA #218 included the resident was a two person assist for transfer and shower, but she was the only one on the unit, had urine all over her and she needed to bathe her. STNA #218 indicated the resident's brief was dry. She did a head to toe skin assessment when she did the shower and saw no physical evidence of injury. She was the only one to see the wet clothes on her and did not think to save them for the nurse to see for evidence. STNA #218 indicated the nurse arrived on the unit approximately 11:30 P.M. The nurse used the shower sheet for her assessment. STNA #218 thought the nurse documented what she told her. STNA #218 recalled the nurse saying it's 11:30 P.M., I am not calling the doctor and family. The STNA revealed she told the DON she was going to do 15-minute checks, but she did not fill out a form for the checks because she did not	F 0600		

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F 0600	Continued From page 38 have the DON's approval. Further interview 11/15/20 at 12:22 P.M. with STNA #218 verified when she observed Resident #115 sexually assault Resident #2 by touching her bare breast while he had his other had over his own crotch. STNA #218 heard Resident #2 say no. STNA #218 had called for assistance after the sexual assault since she was the only staff on the unit. The nurse did not arrive until three hours later. She transferred and showered Resident #2, leaving no one on the unit to monitor Resident #115. STNA #218 verified the nurse did not complete an assessment of the resident after the assault. STNA #218 completed the skin assessment on a shower sheet. STNA #218 included the nurse took her word to use to document. There was no family or physician notification the evening of the incident as verbalized to her by the nurse. The STNA indicated there were 21 residents on the unit at the time of the incident. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation of Resident Property Policy revised 10/2020 revealed the facility would not tolerate Abuse. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or	F 0600		

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F 0600	Continued From page 39 physical condition, cause physical harm, pain or mental anguish. It includes sexual abuse. Sexual Abuse was defined as nonconsensual sexual contact of any type with a resident. Prevention and Identification included the deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual resident's care needs. The assessment, care planning, and monitoring of residents with needs and behavior's which might lead to conflict or neglect, such as residents with a history of aggressive behaviors and resident who have behaviors such as entering other residents' rooms. Response included staff should not have moved the resident until he/she had been assessed by a nurse supervisor for possible injuries. This deficiency substantiates Complaint Number OH00117087.	F 0600		

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F 0607	Continued From page 40	F 0607		
F 0607 SS=F	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This STANDARD is not met as evidenced by: Based on staff interview, family interview, review of medical records, facility policy and procedure for abuse, facility's Self-Reported Incident (SRI), and facility investigation, the facility failed to develop and implement an abuse policy to prevent sexual abuse of a resident. This affected one (Resident #2) of seven residents involved in eight SRIs reviewed for allegations of sexual abuse. Findings include: Medical record review revealed Resident #2 was admitted to the facility on 03/23/19 with diagnoses including cognitive communication deficit, Alzheimer's	F 0607	F 607 Resident #2 and #115 are no longer in facility. On 11/11/2020, the investigations was expanded to include statements, record review and observations by the QA Nurse. In order to ensure that resident abuse is reported to abuse coordinator and immediate interventions are taken, the QA nurse educated the Administrator and DON on facility Abuse policy/procedure, the investigative protocol (including witness statements) and interventions/care plan needs by 11/09/2020. On 11/9/20 9:00 pm Resident assessments completed per nursing staff scheduled on dementia unit (area perpetrator resides). Sixteen residents and no adverse or unusual findings. Upon physical assessments by the DON/Designee on 11/9/2020, residents were found to be non-interviewable. All facility residents were assessed by the DON/designee and there were no residents with inappropriate sexual behaviors. Staff received education regarding reporting requirements and chain of command by the Administrator/designee by 12/04/2020. In order to ensure implementation of Abuse policy and procedures and investigative protocols meeting, 3-5 residents will be audited 3-5 times/week by the Administrator/designee to ensure nursing notes were reviewed for potential incident, incidents were addressed and care planned and investigated. In order to ensure implementation of Abuse policy and procedures, investigative protocols, and care plans the QA nurse will audit incidents for a thorough investigation, implementation of interventions and care plans 3-5 residents/3-5	12/07/2020

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F 0607	Continued From page 41 Disease, dementia without behavioral disturbance, depression, insomnia and persistent mood affective disorder. Review of a Significant Change MDS assessment dated 10/02/20 revealed Resident #2 was severely impaired for daily decision making, had adequate hearing, clear speech, could make self-understood and used corrective lenses with adequate vision. The resident was extensive assist of two for bed mobility and transfers and two-person physical assist for moving from sitting to standing and walking. She was not able to answer questions accurately. Medical record review revealed Resident #115 was admitted to the facility on 01/20/20 with diagnoses including major depressive disorder, Alzheimer's disease, cognitive communication deficit, dementia without behavioral disturbance, and mood affective disorder. Further record review for Resident #115 revealed a 02/03/20 change of condition progress note, with the initial documentation of inappropriate sexual behaviors. Review of the 02/05/20 Self-Reported Incident (SRI) #188158 to the State Agency revealed Resident #115 was in his room with his shirt off with female Resident #67 who's pants were off. In addition, the note indicated "hypersexual activity" was displayed 02/07/20, though not descriptive of the behavior.	F 0607	times per week. In order to ensure residents are free from abuse observations will be conducted on 3-5 residents/3-5 times/week for appropriate interactions by the Administrator/designee. Staff knowledge of abuse policies will be conducted by the Administrator/designee 3-5 residents, 3-5 times per week to validate their knowledge of abuse prohibition policies and procedures. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. *Audits will be completed at least 4 weeks or until compliance is achieved. *Audits will include staff interviews to verify staff is knowledgeable of abuse policies.	

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F 0607	Continued From page 42 A comprehensive plan of care was developed 02/07/20 for the potential to participate in physical intimate interactions with females. Interventions all dated 02/07/20 included medications as ordered, anticipate needs, provide opportunity for positive interaction, attention by stopping and talking with resident, intervene as necessary to protect the rights and safety of others by approaching/speaking in a calm manner, divert attention and remove from situation and take to alternate location as needed. Redirect when participating in physical intimate interactions with females. Review of the progress notes for Resident #115 revealed the following: * 04/24/20 nurses note indicated the resident was touching a female resident * 04/26/20 the resident was flirtatious and following a female resident around the unit. * 04/29/20 Resident #115 was found in a female resident's room with his clothes off. After being returned to his room and dressed, he left in less than five minutes with his shirt off heading back to the same room. * 05/04/20 he was wandering the unit pulling his pants down and his penis out. A 05/06/20 nurses note included the resident came out of his room naked. * 05/19/20, 06/14/20, and 06/19/20 wandering in and out of rooms, "flirty" behavior toward females was documented.	F 0607		

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F 0607	Continued From page 43 * 06/20/20 the resident was following a female resident waving her on and telling her "come on" when she was not next to him. * 06/25/20 the resident was wandering in and out of other residents' rooms, at times he would take his pants down and urinated or defecated on chairs, beds, floors, and trash cans. * 07/13/20 he was in a room with a female resident being affectionate. * 08/01/20 he followed a female resident around the unit for several hours telling her "come on" and "let's go". * 08/07/20 urinating on other residents' beds. Review of the 08/12/20 Quarterly Minimum Data Set 3.0 (MDS) revealed Resident #115 was severely impaired for daily decision making, felt down, depressed and tired with little energy 7-11 days of the look back period. Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 1-3 days. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) 4-6 days. Wandering 4-6 days, supervision of one for bed mobility, supervision of one for transfers,	F 0607		

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F 0607	Continued From page 44 supervision set up for walking in corridor and room, locomotion on and off the unit and toilet use with limited assist of one. The resident was frequently incontinent of bowel and bladder. A nurse notes dated 08/23/20 indicated the resident was attempting to hold a female resident's hand and grabbing other residents. Review of Resident #115's comprehensive plan of care for the potential to participate in physical intimate interactions with females was not updated with new interventions since the 02/07/20 initiation. Interventions included administer medications as ordered. Monitor/document for side effects and if effective, anticipate and meet needs, caregivers to provided opportunity for positive interaction and attention, stop and talk with resident when passing by, intervene as necessary to protect the rights and safety of others. Review of the TASK section of the electronic documentation for Resident #115 revealed 19 of the last 29 days 10/11/20 through 11/08/20 the resident was sexually inappropriate. Nineteen of 29 days the resident showed physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Eighteen of the last 29 days the resident showed verbal behavioral	F 0607		

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F 0607	Continued From page 45 symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). Twenty four of the last 29 days the resident showed behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Review of Resident #115's nurses note late entry entered 11/09/20 at 1:41 A.M. for 11/08/20 at 08:30 P.M. included, when staff saw that resident was not in his room, they went to look for him and found him in Resident #2's room standing at the bed fondling the female resident's breast. The top part of Resident #2's gown was completely wet with a yellow tinged fluid. It was presumed Resident #115 urinated on Resident #2. The resident was upset. (Resident #2). Resident #115 was redirected back to his room. Review of Self-Reported Incident #198821 submitted to the State Survey Agency by the facility on 11/09/20 at 5:12 A.M. revealed an allegation of sexual abuse. The initial source of the allegation was listed as staff. Involved residents were listed as Resident #115 and Resident #2. The incident form stated both residents had dementia, and neither were able to provide any meaningful information. State	F 0607		

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F 0607	Continued From page 46 Tested Nurse Aide (STNA) #218 reported (Resident #115) was in bed with female (Resident #2) touching her breasts. The Summary of Incident Statement included' "STNA stated she witnessed a male dementia resident on secured dementia unit in female dementia resident's room. Female resident was laying in her bed. Male resident was standing beside female's bed. STNA stated male had his hand on female's breast. STNA stated she immediately redirected male resident out of female's room to common area away from other residents. STNA then notified nurse. STNA stated she then went to female resident's room to check on female resident. STNA stated female resident was whining as is normal behavior for resident during care. Review of the summary revealed: Substantiated - abuse, neglect or misappropriation verified by evidence. Review of Resident #2's nurses notes revealed no documentation indicating Resident #115 entered her room on 11/08/20, fondled her breast and upset her. A nurses' note dated 11/09/20 at 8:06 P.M. indicated the resident's son and Physician Assistant #404 were notified of allegations of sexual abuse regarding Resident #2 and #115. Observations on 11/09/20 at 10:00 A.M. revealed Resident #2 sitting in the dining area of the dementia unit with her eyes	F 0607		

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F 0607	Continued From page 47 closed. Observations on 11/09/20 at 10:05 A.M. revealed Resident #115 coming out of the bathroom inside his room, on the dementia unit. He walked over and sat on his bed. At that time, he did not respond appropriately to questions asked of him, such as how he was, or what day it was. Interview with Licensed Practical Nurse (LPN) #217 on 11/09/20 at 10:10 A.M. revealed she was the nurse assigned to work on the dementia unit (400 hall) beginning at 7:00 P.M. on 11/08/20 through 7:00 A.M. on 11/09/20. However, she stated she was also assigned to cover the 300 halls for that shift. She stated on 11/08/20 around 8:30 P.M. STNA #218 reported to her that, after being in a resident room providing care on the dementia unit, she was unable to find Resident #115 in his room. STNA #218 then looked for him and found him in female Resident #2's room. She reported that Resident #115 had his hands under Resident #2's gown near her breast area. She reported that Resident #2's gown was wet up the front. LPN #217 stated that STNA #218 presumed Resident #115 had urinated on Resident #2 as her disposable underwear was dry. LPN #217 stated Resident #2 was unable to verbally express what happened but STNA #218 said Resident #2 seemed irritated and was moaning at the time of the incident. LPN	F 0607		

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F 0607	Continued From page 48 #217 stated that STNA #218 indicated Resident #115 tended to follow the female residents around and be friendly with them. LPN #217 stated she was working on 300 halls (outside of the secured doors of the dementia unit) at the time of the incident. She stated she had never worked on the dementia unit before and did not know how to handle the incident. When asked what was done as a result of the incident, LPN #217 stated they separated Resident #115 from Resident #2 and then got Resident #2 cleaned up. She stated Resident #115 then went to bed and the STNA "kept an eye on him". Interview with STNA #220 on 11/09/20 at 10:25 A.M. revealed she was working on the dementia unit. She stated she does not normally work on the dementia unit and had not worked on that unit for approximately one month. She stated she had received report from night shift STNA #219 that morning. She stated she was not aware of any male resident having any type of sexually inappropriate behavior towards female residents, including Resident #115. She stated it was not reported to her that Resident #115 had touched any female, so she was unaware she was to do 15-minute checks. Interview with STNA #219 on 11/09/20 at 11:00 A.M. revealed she had been assigned to work on the dementia unit (400 unit) last night, 11/08/20 from 7:00	F 0607		

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F 0607	Continued From page 49 P.M. to 7:00 A.M. on 11/09/20. However, she was pulled to work on the 300 halls. She stated STNA #218 was working on the dementia unit (400 hall) by herself at the time the incident regarding Resident #115 happened. She stated STNA #218 came off the dementia unit and reported that Resident #115 had gone into Resident #2's room and put his hand under the resident's gown in the chest area. Resident #2 was crying and STNA #218 got him out of her room. STNA #218 went back and saw that Resident #2 was wet and Resident #115 had urinated on her. Resident #2 was still upset. Resident #2's gown was wet at the top but her depend (incontinence brief) was dry. STNA #219 stated when there was only one staff on the dementia unit, you could not keep an eye on the residents, especially when you are in a room providing care. She stated the week prior; the nurse was only able to be on the dementia unit about two hours per shift because of working on another unit also. STNA #219 stated Resident #115 had a history of going into female residents' rooms, patting them on the back, following them around, pulling his pants down, and urinating and defecating in other residents' rooms. She stated he would not sit down and wandered up and down the hall going in other resident rooms. She stated there was nothing they could do when they were short staffed and only had one or two staff on the unit. STNA #219 stated she felt Resident #115 knew when the staff were	F 0607		

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F 0607	Continued From page 50 busy and that was when he went in female resident rooms. The STNA stated there were residents who required assistance from two staff so there are times when, if there are two staff, that they are both in a resident room providing care. Interview with the DON on 11/09/20 at 11:30 A.M. confirmed the facility had submitted a self-reported incident to the State Survey Agency that morning regarding Resident #115. She stated she had statements from staff but had not had time to look at them. A physician order for Resident #115 for every 15-minute checks was entered on 11/09/20 at 11:31 A.M. Interview with the DON on 11/09/20 at 1:00 P.M. revealed she was unable to find a witness statement from STNA #218 and had no other investigation information to provide at that time, except that the residents involved were unable to provide any information related to the incident. She stated she would have to look to see if Resident #115 had any previous sexually inappropriate behaviors. Interview with the DON on 11/09/20 at 4:30 P.M. revealed 15-minute checks were started on Resident #115 last night after the incident with Resident #2. She stated evidence of this was documented on paper forms on the unit. She stated the facility	F 0607		

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F 0607	Continued From page 51 did not need a physician's order to do this. Interview with Registered Nurse (RN) #221 on 11/09/20 at 4:55 P.M. revealed she was currently the nurse on duty for the day shift for the dementia unit. She stated she was notified in report this morning regarding the incident with Resident #115. She stated she was the one who wrote the order for 15-minute checks for Resident #115 that morning (11/09/20) after report from the night shift nurse at 8:30 A.M. She revealed there was no evidence that 15-minute checks had been completed on the night shift (11/08/20 into 11/09/20) or on the day shift for 11/09/20. She further confirmed there was no evidence the physician or family had been notified of the incident that occurred with Resident #115. A physician order for Resident #115 was entered 11/09/20 at 9:00 P.M. for staff one on one supervision of the resident. Interview with LPN #222 on 11/10/20 at 10:35 A.M. revealed one to one staff supervision had been started for Resident #115 at 7:00 A.M. that morning. Review of the one to one supervision form used by the staff to document revealed on 11/10/20 it was blank prior to 7:00 A.M. Interview with LPN #222 on 11/10/20 at 10:35 A.M. confirmed the form was blank prior to 7:00 A.M. She did not have any	F 0607		

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F 0607	Continued From page 52 documentation available to show that one to one supervision had been provided for Resident #115 prior to 7:00 A.M. on 11/10/20. She further stated that Resident #115 was quick and went into other resident rooms a lot. Interview with Resident #2's son on 11/12/20 at 6:18 PM revealed he was not called on Sunday related to the sexual assault. He indicated he was called this week maybe two days ago. He checked his phone history and revealed he was notified of the incident on 11/09/20 at 8:04 P.M. Interview on 11/12/20 at 6:31 P.M. with Resident #115's wife revealed she was called Monday or Tuesday at around 8 P.M. related to her husband being in a female resident's room touching her breast. Review of Resident #2 and Resident #115's nurses note dated 11/12/20 revealed there was no evidence of Social Service intervention related to the incident on 11/08/20. Resident #2 did not have a progress note indicating there was a male perpetrator in her room. There was no evidence in the record of what transpired on 11/08/20 and her reaction as observed by STNA #218. Interview 11/12/20 at 9:04 P.M. with Corporate Registered Nurse #200 via a	F 0607		

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F 0607	Continued From page 53 returned email verified there was no documentation of 15-minute checks being provided to Resident #115. Corporate Registered Nurse #200 indicated staff reported they were monitoring the resident's whereabouts on the evening of 11/08/20 after the incident. Staff reported Resident #115 did not enter any other rooms nor did he come into contact with any other residents. Resident #115 later went to sleep and settled for the evening. Corporate Registered Nurse #200 further verified the families and the physician were not notified of the incident until the following evening. On 11/12/20 at 9:28 P.M. the first nursing skin assessment for Resident #2 following the 11/08/20 incident was provided indicating it was completed 11/09/20 at 9:54 P.M. Interview on 11/15/20 at 11:45 A.M. with STNA #218 revealed she was the only staff working the Dementia Unit on 11/08/20 when Resident #2 was sexually assaulted by Resident #115. Her co-worker had been pulled to another unit at 7:00 P.M., the beginning of their 12-hour shift and the nurse normally did not arrive on the Dementia Unit until approximately 11:00 P.M. due to working three units. STNA #218 indicated on 11/08/20 at 8:30 P.M. she was in the room across from Resident #115 and his roommate. She noticed the door was open and did not see Resident	F 0607		

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F 0607	Continued From page 54 #115's feet in bed. STNA #218 revealed due to his history she started to check all the rooms. Resident #2's door was closed. When she opened the door STNA #218 found Resident #115 in his pajamas standing at the side of Resident #2's bed. Resident #115 had his right hand on his crouch. His left hand was up under her night gown touching the skin of her left breast. She was whimpering telling him to stop and "no". STNA #218 indicated he didn't. STNA #218 revealed Resident #2 whimpers with care when she doesn't know what is happening and is scared. STNA #218 said she startled Resident #115 when she said his name and he jumped. She asked him what he was doing. He said he was doing "nothing". She indicated he repeated you didn't catch me doing nothing. STNA #218 told him to get out of the room and that they had discussed this before. After she got him out of the room, she talked to him about consent while walking him back to his room. STNA #218 included the resident said he didn't care. STNA #218 indicated she generally believed the resident knows what he is doing because of how he takes opportunities when no one is around and says they did not catch him. After walking him to his room and putting him in bed she opened the double door to the next unit to summons the nurse to come to the unit due to the incident. The nurse was unable to come to the unit due to other responsibilities. STNA #218 went back to	F 0607		

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F 0607	Continued From page 55 Resident #2 and noticed she had a yellow tinged liquid over the top of her clothing. The STNA got Resident #2 out of bed and put her in a wheelchair next to the nurse station. She texted the Director of Nursing (DON) and asked her what she should do. The DON responded I don't know and included an emoji with a person shrugging. STNA #218 indicated the resident had what she thought was urine saturating her clothing, so she took her into the shower and showered her leaving no one on the unit to monitor the residents. STNA #218 included the resident was a two person assist for transfer and shower, but she was the only one on the unit, had urine all over her and she needed to bathe her. STNA #218 indicated the resident's brief was dry. She did a head to toe skin assessment when she did the shower and saw no physical evidence of injury. She was the only one to see the wet clothes on her and did not think to save them for the nurse to see for evidence. STNA #218 indicated the nurse arrived on the unit approximately 11:30 P.M. The nurse used the shower sheet for her assessment. STNA #218 thought the nurse documented what she told her. STNA #218 recalled the nurse saying it's 11:30 P.M., I am not calling the doctor and family. The STNA revealed she told the DON she was going to do 15-minute checks, but she did not fill out a form for the checks because she did not have the DON's approval.	F 0607		

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F 0607	Continued From page 56 Further interview 11/15/20 at 12:22 P.M. with STNA #218 verified when she observed Resident #115 sexually assault Resident #2 by touching her bare breast while he had his other had over his own crotch. STNA #218 heard Resident #2 say no. STNA #218 had called for assistance after the sexual assault since she was the only staff on the unit. The nurse did not arrive until three hours later. She transferred and showered Resident #2, leaving no one on the unit to monitor Resident #115. STNA #218 verified the nurse did not complete an assessment of the resident after the assault. STNA #218 completed the skin assessment on a shower sheet. STNA #218 included the nurse took her word to use to document. There was no family or physician notification the evening of the incident as verbalized to her by the nurse. The STNA indicated there were 21 residents on the unit at the time of the incident. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation of Resident Property Policy revised 10/2020 revealed the facility would not tolerate Abuse. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes sexual	F 0607		

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F 0607	Continued From page 57 abuse. Sexual Abuse was defined as nonconsensual sexual contact of any type with a resident. Prevention and Identification included the deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual resident's care needs. The assessment, care planning, and monitoring of residents with needs and behavior's which might lead to conflict or neglect, such as residents with a history of aggressive behaviors and resident who have behaviors such as entering other residents' rooms. Response included staff should not have moved the resident until he/she had been assessed by a nurse supervisor for possible injuries, residents would be protected from the alleged perpetrator and responsible parties including family and physician would be notified. This deficiency substantiates Complaint Number OH00117087.	F 0607		

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F 0677	Continued From page 58	F 0677		
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This STANDARD is not met as evidenced by: Based on resident interview, staff interview and record review, the facility failed to ensure a dependent resident received showers as requested. This affected one (Resident #83) of three residents reviewed for showers. Findings include: Review of Resident #83's medical record revealed a 10/19/19 admission with diagnoses including cerebrovascular disease, need for assistance with personal care, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. A 10/21/19 preference plan of care included the resident prefers to shower if able in the morning. A 10/21/19 Self Care Deficit plan of care included the resident had a cerebral vascular accident affecting his dominant right side. Interventions included to assist with activities of daily living and the use of a Sit to Stand with two Person Assist.	F 0677	Resident #83 was enrolled in physical therapy to determine safe transfers effective on 11/9/2020 to current. Resident #83 received daily bathing services and was satisfied with this until resident transfer status/appropriate equipment was in place. Resident sit to stand lift was ordered on 11/9/2020. Residents potentially affected by inoperable equipment had their equipment audited on 11/30/2020 by the Maintenance Director/ Designee. Residents potentially affected by the inoperable equipment will be screened by Therapy by 12/4/2020 to ensure safe transfers. Any Equipment found inoperable was removed from patient care, a safe replacement/transfer was implemented as needed by the DON/designee and will be repaired/or replaced by 12/4/2020. Residents were interviewed/observed to ensure that their care planned ADLS are carried out per the resident preferences by the DON/Designee on 12/1/20. In order to ensure that residents have operable equipment and ADLs carried out according to their preferences, 3-5 residents will be interviewed/observed 3 times/week by the Administrator/designee. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation.	12/07/2020

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F 0677	Continued From page 59 Review of the 01/06/20 Baseline Care Plan meeting included the resident prefers showers two times a week. The plan was signed by the resident. Review of the 07/29/20 quarterly minimum data set (MDS) revealed the resident was independent for daily decision making, extensive assist of two for bed mobility, transfers, and physical help in part by two for bathing, with lower and upper extremity impairment on one side. Interview 11/04/20 at 10:37 A.M. with Corporate Registered Nurse #200 revealed the facility was not 100 percent on their electronic documentation system and there are paper shower sheets also for showers. Corporate Registered Nurse #200 included they would pull them and send the surveyor September, October and November, 2020. Interview on 11/04/20 at 3:00 P.M. with Resident #83 revealed he had not had a shower that week and only had one shower last week. Resident #83 claimed he preferred to have two showers a week on night shift. The resident included he had not gotten a shower like he prefers due to the Hoyer lift being broken. Review of the STNA electronic documentation under TASK included the resident had no scheduled showers to alert	F 0677		

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F 0677	Continued From page 60 the staff to shower the resident. Review of the TASK documentation 10/06/20 until 11/04/20 revealed there was no baths documented 10 of the 30 days. There were no showers documented as being provided in last 30 days. Interview on 11/05/20 at 12:00 P.M. with STNA #406 revealed the sit to stand has been broken for a few weeks and it has been reported. The area on the machine where residents place their knees to keep them from sliding is broken off. STNA #406 confirmed the facility only has one in the building. STNA #406 claimed that they have not been able to give Resident #83 a shower due to this being broken. STNA #406 claimed Resident #83 has an order to use the sit to stand with all transfers, but they have been using two staff assist for his transfers. Interview 11/13/20 at 11:29 A.M. with Corporate Registered Nurse #200 included they were still pulling together the shower sheets. The shower sheets were not provided to the surveyor. This deficiency substantiates Master Complaint Number OH00117118.	F 0677		

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F 0684	Continued From page 61	F 0684		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to complete ordered monitoring for a resident with a diagnosis of congestive heart failure. This affected one (Resident #78) of three residents reviewed for weight loss. Findings include: Review of Resident #78's medical record revealed a 06/30/20 admission and a readmission 08/19/20. Diagnoses included fluid overload, localized edema, acute respiratory failure with hypoxia, shortness of breath and end stage renal disease. The 09/01/20 Quarterly Minimum Data Set (MDS) revealed the resident was independent for daily decision making, required extensive assist of two for bed mobility, transfers, did not walk in room or corridor and had no weight loss or gain.	F 0684	F 684 Resident # 78 had her weight recorded on 11/21/2020 and the POC was updated.On 12/4/2020 physicians orders were reviewed for implementation by the QA nurse on 11/29/2020. Physician reviewed resident weights and gave new orders. Resident orders for daily or weekly weights were clarified with Physician by QA nurse on 11/29/2020. Residents potentially affected by the not having weights obtained had their weights reviewed/obtained by the Dietician on 11/21/2020. In order to ensure that weights are obtained timely, nursing staff and managers will receive education on the weight system and care plan updates by the DON/designee by 12/4/2020. Weight procurement and care plans for 3-5 residents, 3-5 times/week will be audited by the DON/designee. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. *All orders will be audited for completion on 12/7/2020. 3-5 residents 3-5 times per week will be audited to verify orders were carried out by DON/Designee.	12/07/2020

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F 0684	Continued From page 62 Review of a nurse's note dated 8/12/20 at 5:00 A.M. revealed the staff was informed the resident was transferred to the hospital with a diagnosis of Congestive Heart Failure (CHF). Physician Orders included an order dated 08/21/20 for weights every other day. Review of the treatment record and weights revealed between 08/21/20 and 11/04/20 seven weights were obtained. August, 2020 treatment record revealed one refusal and five "others" from 08/21/20 through the end of August, 2020. September, 2020 treatment sheet included three weights, four days were blank, two non applicable, five coded "other" and one refusal. The October, 2020 treatment sheet included one refusal, four weights, five blank areas, two non applicable, one coded nausea and vomiting, and two coded "other". The November, 2020 treatment sheet between 11/01/20 and 11/04/20 included no weights. There was one refusal and one "other". There was no evidence of a plan of care that addressed if the resident refused to be weighed. Interview 11/03/20 at 2:04 P.M. with Corporate Registered Nurse #200 revealed the resident was sent to the hospital with signs and symptoms of CHF but the	F 0684		

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F 0684	Continued From page 63 diagnosis was not added. Review of the record revealed the resident has a history of refusals. At the time of the interview, Corporate Registered Nurse #200 was informed there were blanks in the treatment record and weights were not completed every other day. Corporate Registered Nurse #200 verified if the resident refused to be weighed it should have been marked refused. This deficiency is cited as an incidental finding to Master Complaint Number OH00117118. This deficiency is evidence of continued non-compliance from the survey dated 10/06/20.	F 0684		

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F 0689	Continued From page 64	F 0689		
F 0689 SS=E	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This STANDARD is not met as evidenced by: Based on observations, staff interview, resident interview, medical record review, and review of the Resident Smoking Policy, the facility failed to ensure the resident environment remained as free of accident hazards as is possible in the area of smoking. This affected 19 of 126 residents who identified as smokers in the facility (Residents #69, #125, #102, #8, #116, #10, #124, #27, #24, #55, #82, #71, #128, #92, #57, #23, #44, #4, and #129) and had the potential to affect all residents. The facility also failed to ensure each resident received adequate supervision and assistance devices to prevent accidents in the areas of falls and transfers. This affected four of 36 sampled residents (Residents #2, #42, #83, and #118). The facility census was 126. Findings include: 1. Observations on 11/03/20 at 10:00	F 0689	F 689 Residents #2, 115, 102, 118, 128, and 129 are no longer in the facility. Resident 69,125, 42, and 83, had no negative outcomes from the environment and potential accident hazards. Resident # 69 and 125 were assessed by the DON/designee on 11/16/2020 and experienced no adverse effect of improper cigarette disposal and not wearing aprons. Resident # 42 was assessed by the DON/designee on 11/16/2020, and did not experience any negative outcome from hitting the bed with his knee, or having safety interventions in place. Care planned interventions were put in place to prevent accidents and injuries. Resident #83 was enrolled in physical therapy to determine safe transfers on 11/9/2020 to present. Resident sit to stand lift was ordered on 11/9/2020. Resident #83 was assessed by the DON/designee on 11/16/2020 and has no negative effects from two person transfers. Resident #2 and #15 are no longer in the facility. Residents potentially affected by the availability of smoking devises, had their smoking areas assessed for the availability of safety devises by the Administrator/designee on 11/3/2020. The smoking area had appropriate ash trays, receptacles placed in the area on 11/3/2020 by the Administrator/designee. Facility hallways were assessed to validate that they were clear of beds and other safety hazards by the Administrator/designee on 11/3/2020. Resident fall and other safety care plans were reviewed/observed for implementation by the DON/designee on 11/30/2020. Residents	12/07/2020

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F 0689	Continued From page 65 A.M. revealed there were three residents outside smoking cigarettes on the patio (Residents #69, #102, and #125). The smoking area was located outside of a door across from the first dining room after leaving the 100/200 unit and heading toward the 300/400 unit. State Tested Nursing Assistant (STNA) #202 was outside with the residents who were smoking. Observations did not reveal any ash trays or cigarette butt receptacles in the smoking area. The residents were observed to be flipping their cigarette ashes on the ground. Resident #69 was seated approximately one foot from a pile of leaves that had collected near the exterior wall of the facility. Resident #69 was observed to flip his cigarette ashes on the ground near the leaves. Resident #125 stated the residents had been smoking on this outside patio area for about three days with no ash trays or cigarette butt receptacles. STNA #202 was observed to be holding a plastic, disposable cup. When the residents were done smoking their cigarettes, they were observed to hand the cigarette to STNA #202. STNA #202 put Resident #102's cigarette on the ground and used her foot to extinguish the cigarette. She then placed the cigarettes in the plastic, disposable cup she was holding. STNA #202 confirmed there were no ash trays or cigarette butt receptacles to put cigarette butts in. She stated that was why she was using the plastic, disposable cup. She also stated that since	F 0689	potentially affected by inoperable equipment had their equipment audited on 11/30/2020 by the Maintenance Director/ Designee. Any Equipment found inoperable was removed from patient care and will be repaired/or replaced by 12/4/2020. Residents were interviewed/observed by the DON/designee on 11/9/2020 for potential for abuse and there were no adverse findings. In order to ensure safe smoking, clear environments and care plan implementation, staff will be educated on the policy and procedure for resident smoking/safe environment and proper disposal of smoking materials, keeping environment clear of hazards, the importance of carrying out plan of care interventions, the maintenance repair request process and abuse reporting policy by the Administrator/designee by 12/4/2020. Audits will be completed on the implementation of smoking per policy, keeping environment free of hazards, care plan interventions and the maintenance request process 3-5 times/week by the Administrator/designee. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation.	

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F 0689	Continued From page 66 the location of the smoking area had changed, there were no smoking aprons for residents to wear to protect their clothing from burns. She stated all residents were to wear a smoking apron. None of the residents were observed to be wearing a smoking apron. STNA #202 confirmed there were leaves on the ground near the smoking area that could catch fire from the cigarette ashes which were being put on the ground. STNA #202 was then observed to take the cup of smoked cigarettes inside the facility. Interview with Corporate Registered Nurse (RN) #200 on 11/03/20 at 10:15 A.M. confirmed there should be ash trays and cigarette butt receptacles in the outside smoking area and there were not. She stated the residents should not be putting ashes on the ground. She stated the staff person should not have brought the cigarette butts back inside the facility after they were smoked. Interview with STNA #202 on 11/03/20 at 10:20 A.M. revealed she threw the cup of cigarette butts away in the trash can behind the 100/200 unit nurses station. On 11/03/20 at 10:50 A.M. STNA #202 confirmed she did not alter the cigarette butts prior to throwing them away in the trash can. Observations and interview with Corporate RN #200 on 11/03/20 at 10:22 A.M.	F 0689		

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F 0689	Continued From page 67 confirmed the cup of cigarette butts were in the trash can, containing paper products, behind the 100/200 unit nurses station. The cigarette butts were still in the plastic cup and no liquid was observed in the cup. Interview with the Administrator on 11/03/20 at 11:00 A.M. revealed this was a new smoking area as of Saturday morning (10/31/20). She stated the old smoking area was located in an area where residents would have to pass through the COVID positive unit to get to the smoking area, so it was moved for residents who are not positive. Interview with Corporate RN #200 on 11/03/20 at 11:00 A.M. revealed the facility did not think about needing ash trays or receptacles in the new smoking area as it was a fast decision after multiple residents tested positive for COVID-19 on 10/30/20. Smoking times listed four daily smoke times for this location. Review of the facility policy titled Resident Smoking Policy and dated 06/18 revealed the facility shall make every best effort to establish and maintain safe resident smoking practices. Appropriate containers and receptacles are available in smoking areas and must be used. 5. Record review revealed Resident #2 was admitted to the facility on 03/23/19	F 0689		

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F 0689	Continued From page 68 with diagnoses of cognitive communication deficit, Alzheimer's Disease, dementia without behavioral disturbance, depression, insomnia and persistent mood affective disorder. Review of a Significant Change MDS assessment dated 10/02/20 revealed Resident #2 was severely impaired for daily decision making, had adequate hearing, clear speech, could make self-understood and used corrective lenses with adequate vision. The resident required extensive assist of two for bed mobility and transfers and two-person physical assist for moving from sitting to standing and walking. She was not able to answer questions accurately. Review of Self-Reported Incident #198821 submitted to the State Survey Agency by the facility on 11/09/20 at 5:12 A.M. revealed an allegation of sexual abuse. Involved residents were listed as Resident #115 and Resident #2. The Summary of Incident Statement indicated STNA #218 witnessed resident #115 in Resident #2's room. Resident #2 was laying in bed and Resident #115 was standing beside the bed and had his hand on her breast. STNA #218 immediately redirected Resident #115 out of the room and away from other residents and notified the nurse. Interview 11/15/20 at 11:45 A.M. with STNA #218 revealed she was the only staff	F 0689		

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F 0689	Continued From page 69 working the Dementia Unit on 11/08/20 when Resident #2 was sexually assaulted by Resident #115. After walking him to his room and putting him in bed she opened the double door to the next hall to summons the nurse to come to the unit due to the incident. The nurse was unable to come to the unit due to other responsibilities. STNA #218 went back to Resident #2 and noticed she her gown was wet with a yellow tinged liquid that she believed to be urine. STNA #218 got Resident #2 out of bed and put her in a wheelchair next to the nurses station then proceeded to take her into the shower and showered her. STNA #218 indicated she knew the resident required two persons for transfers and shower, but she was the only one on the unit, Resident #2 was soaked with urine, and needed to be showered so she did it by herself. STNA #218 indicated the nurse arrived on the hall approximately 11:30 P.M. which was three hours after she called her to come to the floor. This deficiency substantiates Complaint Number OH00117045, and OH00116553. 2. Review of Resident #42's medical record revealed an admission date of 04/16/19 with diagnoses including unspecified dementia without behavioral disturbance, unspecified intracranial injury without loss of consciousness, and unsteadiness of feet.	F 0689		

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F 0689	Continued From page 70 Review of Resident #42's quarterly Minimum Data Set (MDS) 3.0 assessment dated for 10/09/20, revealed resident was severely impaired for daily decision making with limited assist of two for bed mobility, with limited assist of one for transfers, walking in room and corridor, and required extensive assistance from two staff members for toilet use and was frequently incontinent of bowel and bladder. Review of the resident's fall assessment dated 10/27/20 revealed an score of 21 indicating Resident #42 was a high fall risk due to having three or more falls in the past three months, taking 3-4 qualifying medications, and not taking rest periods when encouraged. Review of Resident #42's physician orders for the month of November 2020 revealed: • 07/18/20- Geri-sleeves to bilateral upper extremities every shift for placement. • 10/08/20- Encourage rest periods with gospel music, day and night shift. • 10/13/20- Hipsters (pads worn to protect the hip area) to be worn when out of bed. Review of Resident #42's plan of care dated 04/18/29 revealed a potential risk for falls related to a history of falls, confusion, wandering, and intracranial injury. Interventions included, reduce clutter in residents environment if possible,	F 0689		

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F 0689	Continued From page 71 encourage to lay down after lunch and play gospel music, hipsters to be worn at all times when out of bed, rearrange furniture in lobby to maintain open space. Review of Resident #42 plan of care revealed resident requires placement on a secured memory care unit for therapeutic environment due to dementia and wandering. Interventions include for resident to reside on secure memory care unit, and supervised ambulation. Review of the nurses progress note dated 11/02/20 revealed Resident #42 was transferred from the memory care unit to the COVID unit. Observation on 11/04/20 at 12:30 P.M. revealed Resident #42 ambulating up and down the facility's COVID unit. Noted in the hallway of the COVID unit was an empty patient bed, trash and linen barrels, and empty wheelchairs. Resident #42 was observed ambulating on the 700 hall of the COVID unit when he walked into an empty patient bed located in the hallway. Resident #42 was noted to have hit his right knee on the head board of the bed. Resident #42 was then observed continuing to ambulate and rub his right knee at the same time. Interview on 11/04/20 at 12:40 P.M. with Licensed Practical Nurse (LPN) #216 confirmed there was an empty patient bed	F 0689		

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F 0689	Continued From page 72 placed in the hallway of the 700 Hall and that Resident #42 had walked into the headboard of the bed, bumping his right knee. LPN #216 also confirmed that Resident #42 did not have the ordered geri-sleeves in place to his bilateral upper extremities, nor did he have on hipsters to protect his hips in case of a fall. Review of the facility's policy titled "Fall Management," dated 01/29/20, revealed, The facility will identify each resident who is at risk for falls and will develop a Plan of Care and will implement interventions to manage falls. 3. Review of Resident #118's medical record revealed an admission date of 08/12/20 and diagnoses of dementia, malignant neoplasm of the pharynx and chronic obstructive pulmonary disease (COPD). Review of Resident #118's quarterly MDS 3.0 assessment dated 08/19/20 revealed resident with a Brief Interview for Mental Status (BIMS) score of 05 indicating severely impaired cognition for daily decision making abilities. Resident #118 required limited assistance from one staff member for hygiene, toileting, bed mobility, transfers, walking, locomotion and dressing and supervision for eating. Review of Resident #118's physician	F 0689		

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F 0689	Continued From page 73 orders for November 2020 revealed: • 08/12/20- wanderguard to right lower extremity every shift. • 08/18/20- encourage resident to use assistive devices for transfers/ambulation. • 10/20/20- place non-skid strips next to residents bed. • 10/23/20- place a perimeter mattress (has raised edges to define parameters) to residents bed. Review of Resident #118's plan of care dated 08/12/20 revealed a potential risk for falls related to a history of falls and dementia. Interventions included to encourage use of assistive devices for transfers and ambulation, to wear non-skid foot wear when out of bed, to have non-skid strips placed on the floor next to bed, and place a perimeter mattress to the bed. Observation on 11/05/20 at 4:44 P.M. revealed Resident #118 laying supine in bed with the right side of her bed placed up against the wall. Ordered fall interventions including, non-skid strips on the floor beside residents bed, and perimeter mattress were not in place to keep resident safe. Interview on 11/05/20 at 4:50 P.M. with STNA #506 confirmed Resident #118's bed was a regular mattress and not a perimeter mattress and confirmed there were no non-skid strips on the floor next to the	F 0689		

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F 0689	Continued From page 74 residents bed. Review of the facility's policy titled "Fall Management," dated 01/29/20, revealed, The facility will identify each resident who is at risk for falls and will develop a Plan of Care and will implement interventions to manage falls. 4. Review of the medical record for Resident #83 revealed an admission date of 10/19/19 with diagnoses of need for assistance with personal care, muscle weakness, difficulty walking, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and dependence on wheelchair. Review of Resident #83's quarterly MDS 3.0 assessment dated for 07/29/20 revealed the resident was independent for daily decision making. Resident #83 required extensive assistance from two staff members for bed mobility, transfers, and physical help in part by two staff members for bathing due to upper and lower extremity impairment to one side. Review of Resident #83's plan of care dated 10/21/19 revealed a self care deficit related to status post cerebral vascular accident affecting right dominant side. Interventions included the resident's needs will be met, encourage the resident to get up into wheelchair 4-5 days a week for 6-8 hours a day, and transfers with the use of	F 0689		

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F 0689	Continued From page 75 two staff members and the use of a sit to stand (a patient lift or or electrical/hydraulic power transfer device that allows safer and easier transfers for dependent residents). Observation on 11/04/20 at 2:50 P.M. revealed STNA #212 and #511 exiting Resident #83's room. Resident #83 was sitting in his electric wheelchair which was placed by the window. Continued observation revealed a sit-to-stand placed next to the wall between A and B bed. Multiple items including bed linen and Resident #83's clothing were noted to be placed on the sit-to-stand. Interview on 11/04/20 at 3:00 P.M. with Resident #83 revealed he had just gotten up for the day after asking staff to get him up since 6:30 A.M. that day. Resident #83 pointed to the sit-to-stand and said it was broken and that was what they used to get him out of bed. Resident #83 confirmed STNA #212, and #511 just got him out of bed without the use of the sit-to-stand. Interview on 11/04/20 at 3:23 P.M. with STNA #212 confirmed the sit-to-stand was broken and it took two staff members to get Resident #83 out of bed. STNA #212 confirmed the resident had an order for all transfers to be done with the use of the sit-to-stand. STNA #212 claimed the sit-to-stand had been broken for weeks and no one had done anything about it	F 0689		

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F 0689	Continued From page 76 even after it was reported to management. Interview on 11/05/20 at 12:00 P.M. with STNA #406 confirmed the sit-to-stand had been broken for a few weeks and that staff could not safely use it to transfer residents. STNA #406 revealed the area on the machine where residents are to place their knees to keep them form sliding, was broken off. STNA #406 revealed the facility only had one sit-to-stand for the whole facility. STNA #406 claimed staff have not been able to provide Resident #83 with his preferred showered due to the sit-to-stand being broken and any transfers for this resident requiring two staff. STNA #406 continued to reveal even with two staff members, transfers with Resident #83 were very difficult and not safe due to the resident not being able to assist or bear weight. Interview on 11/09/20 at 10:12 A.M. with the Maintenance Director #528 confirmed there was only one sit to stand for the whole facility. Maintenance Director #528 revealed that he was not aware the sit to stand was broken until 10/29/20 and this was completed verbally and no through an work order. Maintenance Director #528 claimed he was not aware of when the sit to stand became broken. Review of the facility's maintenance log revealed no indication that the sit-to-stand had been reported to the maintenance	F 0689		

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F 0689	Continued From page 77 director for repair. Review of the invoice provided by the Maintenance Director #528 revealed a new sit to stand had been ordered on 11/09/20 at 10:12 A.M.	F 0689		

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F 0725	Continued From page 78	F 0725		
F 0725 SS=L	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This STANDARD is not met as evidenced by: Based on observation, record review, interviews, review of staffing policies, and	F 0725	F 725 Staffing corrective action plan • The schedule was reviewed by RDO on 11/9/2020 to assure adequate staffing levels to meet the residents' needs. • On 11/09/20 at 9:00 P.M. QA Nurse re-educated all administrative staff on staffing and meeting the needs of the residents timely. • On 11/09/20 at approximately 9:00 P.M. the Regional QA Nurse provided immediate Re-education to the Interdisciplinary Team (IDT) on Staffing and Scheduling. • On 11/10/20 at approximately 6:00 P.M. the Regional QA Nurse initiated a Root Cause analysis to identify the cause of staffing challenges that was completed on 11/10/20 at approx. 4:00 P.M. The analysis identified the root cause was due to many staff members being out for COVID leave / quarantine, along with call offs. o The identified cause will be addressed by: ¿ Tracking of each staff member out – with onset of s/s or test date – along with return to work date ¿ Supplementing with agency staff and sister facility support as needed and able. • On 11/11/20 at approx. 3:00 P.M. facility initiated random interviews, with interviewable residents with supplemental clinical assistance to determine if needs were being met timely. A total of 71 residents were interviewed. The results of the interviews showed: Questions asked 1. Do you feel staff are caring 2. Do you feel like the staff are responding to your needs timely 3. If you have concerns – do you know who to voice them to? 4. If you have concerns – do you feel like they are addressed appropriately? Results were positive – one person said "not entirely" for addressed	12/07/2020

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F 0725	Continued From page 79 facility's assessment, the facility failed to ensure adequate staffing to meet the needs of residents related to medication administration, falls, abuse, smoking, prompt response to call lights, and assistance for other activities of daily living for dependent residents. This resulted in Immediate Jeopardy on 11/02/20 when one nursing assistant was not able to timely deliver meal trays to residents on the 300-quarantine unit where approximately 23 residents resided, resulting in cold food. In addition, the lack of adequate staffing resulted in delayed medication administration, including insulin and antihypertensive medication, affecting 25 residents, (Residents #1, #5, #6, #8, #23, #27, #30, #31, #37, #53, #54, #62, #66, #70, #73, #74, #84, #85, #88, #101, #106, #110, #114, #126, and #127), delayed assistance in getting requested ice water, affecting Resident #101, delayed assistance getting out of bed for a dependent resident affecting Resident #83, delayed assistance with smoke breaks affecting Residents #4, #92, and #125, lack of proper supervision resulting in falls, affecting Resident #42, lack of supervision resulting in sexual abuse, affecting Residents #2, and #115, and delayed call light response, affecting Resident #66. The lack of adequate staffing placed all residents at risk for the likelihood for serious harm, serious injury, or death. The facility census was 126.	F 0725	appropriately. Referring to Social Service Director. • On 11/11/20, call light audits were initiated by the IDT to monitor for timely response to resident needs. The audits were being completed on all units to include random residents and times throughout the shift. ¿ The results of the audits showed - Longest response time – 6 minutes on current observations – ongoing and will continue daily on 5 random residents daily until compliance is achieved and then three times weekly x 2 weeks and then weekly x 2 weeks. To Reduce Staff Burdon: This is to reduce staff burden – staff are using same the PPE throughout the unit (only on COVID positive unit?) Yes this is on COVID units – this allows better time management with COVID patients and conserves PPE. o Facility combined halls – Initiated 11/11/20 approximately 10:30am residents were separated into designated Covid units (initially 300/600 and 700). o Halls were further segregated again on 11/11/20 and the 400 hall was also converted to a designated Covid unit as well. o All Covid positive and negative residents are separated • On 11/11/20 at approx. 9:00am The Regional QA Nurse created an audit tool to monitor staffing that will be conducted every 8 hours for first 48 hours and then three times weekly x 2 weeks, then weekly x 2 weeks This was requested per ODH. Additional Support with Sister Facility 11/17: RN 7-3 RN 7-3 LPN 3-11 RN 3-11 HR 9a,-5pm RN 7am-5pm Support staff 7am-3pm LNHA – 8am – 5pm support 8am-5pm 11/18: RN 7-3 RN 7-3 RN 7-5pm LPN 3-11pm RN – 11p-7a RN 9-5pm RN 9-5pm LPN 9-5pm	

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F 0725	Continued From page 80 On 11/09/20 at 5:25 P.M. the Regional Executive Director of Operations #501 and the Director of Nursing (DON) were notified that a situation of Immediate Jeopardy was present starting 11/02/20 when the facility failed to ensure enough staff was available to meet the care needs of its residents. This included adequate number of nurses and state tested nursing assistants (STNAs) to provide assistance with activities of daily living, medication administration, prompt response to call lights, and supervision to prevent falls and sexual abuse. As of 11/13/20 the Immediate Jeopardy remained ongoing. Findings include: 1. During an interview with the Administrator on 11/02/20 at 11:17 A.M. she stated the normal staffing pattern for the 300 unit was one STNA and one nurse. The Administrator reported when two STNAs were assigned to the 300 unit she would normally find one sitting at the nurses' station. The Administrator stated she felt one STNA and one nurse would be sufficient at this time when the 300 unit was also being utilized for the COVID-19 quarantine unit. At the time, there were approximately 23 residents on the 300 unit. On 11/02/20 at 11:20 A.M. noon meal	F 0725	Support staff – 9-5pm 11/19: RN 7-3 RN 7-3p LPN 3-11 RN 11p-7a RN 9-5pm RN9-5pm LPN 9-5pm Support staff 9-5pm RN 7-5pm RN 3-11pm RN 11-7am 11/20: RN 7-3 RN 7-3pm LPN 3-11pm RN 11p-7a RN 9-5pm RN 9-5pm LPN 8-4pm 11/21: RN 7-3 LPN 7-3 RN 9-5pm 11/22: LNHA Support 7-3 LPN 3-11pm LPN 7-3pm 11/23: RN 7-3 RN 7-3 LPN 11a-7p RN 3-11pm RN 11p-7a DIETICIAN 7a-3pm 11/24: RN 7-3 RN 7-3pm LPN 4p-12a RN 3-11pm Dietician 7-3 RN 11a-7pm 11/25: RN 7-3p RN 7-3pm LPN 4pm-12am Dietician 9-5p RN 9-5pm 11/26: RN 7-3 RN 7-3p LPN 4p-12am 11/27: RN 7-3pm RN 3-11pm LPN 11a-7pm 11/28: LPN 7-3pm LPN 7-3pm RN 7-3pm 11/29: LPN 7-3pm RN 11a-7pm LPN – 3-11pm 11/30: RN 7-3pm RN 7-3pm LPN 3-11pm RN 8-5pm RN 11am-7pm Support 11a-7p 12/1: RN 7-3 RN 7-3 RN 8-5pm LPN 11a-7p support 11a-7pm This was requested per ODH The audit will include: 1. Are staff needs met? 2. Interview if able to meet needs of residents 3. If not did they notify someone of concern 4. Review of schedule daily to ensure staffing present as scheduled – adjust with call offs. The results have been positive – only action needed was on first day of huddle meeting – nurse reported running low on med cups, drinking cups on cart at time of interview. Able to get to central supply and provide supplies needed. • The facility has made the following attempts to secure supplemental staffing to include the following: Agreements with four separate agencies as of 11/10/20. Unfortunately, the agencies have not been able to secure supplemental staffing and we will	

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F 0725	Continued From page 81 trays for Residents #8 and #23 were observed left on a cart near the 300 unit nurses' station. STNA #303 was observed on 11/02/20 at 12:21 P.M. taking the noon tray to Resident #8 (a full hour after it had been delivered to the floor). STNA #303 was observed setting the meal tray up. Resident #8 did not respond when the tray was set up. STNA #303 reported he did not know if Resident #8 would eat anything or not, she appeared to be tired today. STNA #303 confirmed he did not attempt to assist Resident #8 with the meal at this time because he was the only one answering lights and giving resident care. Occupational Therapy Assistant (OTA) #307 reported on 11/02/20 at 11:45 A.M. Resident #8 and #23's meal trays were delivered before the cart trays because they needed assistance with their meal. On 11/02/20 at 11:30 A.M. the call light for Room #312 was on. The call light was answered by STNA #303 on 11/02/20 at 11:47 A.M. (17 minutes later). The call light for Room 311 was observed to be triggered on 11/02/20 at 11:32 A.M. STNA #303 was observed to enter the room on 11/02/20 at 11:46 A.M. and assist Resident #106 with a bedpan. (12 minutes later).	F 0725	continue to reach out daily to assist in securing with additional staff. - Offered the facility staff incentives to pick up shifts. o Bonuses offered starting 10/30/20 including 10.00/hr in addition to hazard pay of 5.00/hr - Hazard pay offered to employees 5.00/hr - Sister facility staff scheduled to offer assistance for next 2 weeks. - Please see attached calendar for corporate clinical support staff - (attachment) with disciplines projected to be above 2.5 PPD staffing. - Facility assessment has been updated to determine resident acuity and care needs and estimated number of staff needed to ensure resident care is met - please see attached updated facility assessment. o Target STNA 1.9 PPD o Target licensed Nurses 1.0 PPD - PPD is the daily number of hours of care per resident per day • Effective 11/19 all audit results will be reviewed by Regional Quality Assurance Nurse weekly with re-education or audit changes made as needed. • Effective with the November QAPI meeting and ongoing, all audit results will be reviewed by the Facility QAPI Committee to determine if the audit should be discontinued, modified, or continued with no changes. In addition: • Facility will be initiating staggered schedules for clinical managers to assist with staffing needs, resident needs, etc. To be initiated beginning 11/22/20 – ongoing until staffing is stable. • DON will work Wednesday through Sunday • ADON 1 will work Tuesday through Saturday • ADON 2 will work Sunday through Thursday • Corporate Regional Nurse will be here Monday through Friday • Additional clinical support via sister facilities, agency	

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F 0725	Continued From page 82 The call light for Room #313 was observed to be triggered on 11/02/20 at 11:35 A.M. On 11/02/20 at 11:54 A.M. (19 minutes later), STNA #303 entered the room and upon exit reported Resident #127 needed a riser for the toilet and left the floor to find a toilet riser for the resident. STNA #303 stated on 11/02/20 at 11:38 A.M. that he was working as an STNA today, however he was the Housekeeping Supervisor. STNA #303 stated he and Registered Nurse (RN) #203 were the only staff assigned to the 300 unit. STNA #303 stated if two STNAs were working on the floor, resident care, answering call lights and passing trays would be timelier. On 11/02/20 at 12:05 P.M. Resident #106's call light was observed to trigger. RN #203 was observed to answer the call light on 11/02/20 at 12:21 P.M. (16 minutes later) and assisted the resident off the bedpan. Resident #106 stated she did not think it would take that long to get the bedpan and it was uncomfortable. On 11/02/20 at 12:10 P.M. the 300 unit cart with noon meal trays was brought to the unit. STNA #303 and RN #203 were working on the 300 unit. STNA #320, whose normal job was in the business office had been pulled to work on the 300 unit, was observed donning personal protective equipment (PPE) on 11/08/20 at 12:30 P.M. and delivered the first tray from	F 0725	clinical managers, mobile DON will be scheduled through November and ongoing as needed. Beginning 11/10/20 • Staff out with COVID will be coming back beginning 11/18/20 post COVID isolation. • Job postings reviewed and updated for current job postings via Indeed, Local radio station 98.3 and continue to reviewed and updated as needed per Corporate HR director with on the spot interview process • Offering the temporary 8 hour STNA course approved by CMS and ODH. • 2 more additional Agency contracts secured and will be contacted daily with staffing needs to assist in providing sufficient staffing. • All agencies will continue to be contacted and utilized ongoing until permanent staff are obtained and vacancies are filled • COVID-19 staff will be returning beginning 11/18/20 – 2 staff members and then additional staff will continue to be able to return to work starting 11/18/20. Residents #6, 70, 88, 92, 2, 57,102, 1, 73 is no longer in the facility Resident #5, 8, 15, 23,27,30,31,37,53,54,62,66,74,84, 85's physicians were notified of late medications on 11/2/2020, by the DON/designee, no adverse effects noted. Resident #101 was assessed by the DON/Designee on 11/27/2020 and had no adverse effects from waiting for water pass. Resident #83 was assessed by the DON/designee on 11/27/2020 and had no adverse effects of waiting to get out of bed. Resident #4 and 125 were assessed by the DON/designee on 11/27/2020 and had no adverse effects from waiting for their smoke break. Resident #42 and 125 was assessed by the DON/designee and care plan was updated	

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F 0725	Continued From page 83 the meal cart to Resident #41 on 11/08/20 at 12:36 P.M. (26 minutes after the cart was delivered to the floor). The second tray from the meal cart was removed on 11/08/20 at 12:43 P.M. and delivered to Resident #12. STNA #320 reported on 11/08/20 at 12:47 P.M. she was waiting for someone to bring the size gloves she wore to the floor before she could deliver anymore trays. On 11/02/20 at 12:52 P.M., STNA #320 delivered Resident #57 her dinner tray. STNA #303 had been providing resident care while STNA #320 was delivering meal trays and on 11/02/20 at 12:53 P.M. STNA #303 started delivering meal trays to resident rooms. On 11/02/20 at 1:04 P.M. the surveyor requested Dietary Manager (DM) #309 to take temperatures of food which had been on the cart since arrival to the floor at 12:10 P.M. Pork cutlet was 99 degrees (*) Fahrenheit (F), Brussel Sprouts were 99.3*F and potatoes were 88.5*F. The oranges, which were to be served cold, were 72.8*F. DM #309 reported temperatures ranged from 190*F to 204*F for hot food and the oranges were 38*F when leaving the kitchen. On 11/02/20 at 1:08 P.M. STNA #320 confirmed the trays were being delivered to residents after sitting on the meal cart for an extended time. STNA #320 stated no staff was available to hand the tray into a resident room after she had donned the	F 0725	on 12/1/2020. Resident #66 was assessed by the DON/designee on 11/27/2020, and had no adverse effects from waiting for call light to be answered. Resident #8 and #23 were assessed by the DON/designee on 11/27/2020 and had no adverse effects from waiting for delayed tray delivery. In order to ensure adequate staffing the DON and Administrator were re-educated on the facility staffing policy and procedure (including reviewing staffing at beginning of shift and taking action to replace call offs with on-call, sister facility and agency staff, by the QA nurse on 11/9/2020. The local Emergency Medical Association (EMA) was contacted for staffing assistance on 10/30/2020 by the QA nurse in response to twenty-three staff out sick with COVID. Agency contractors were notified and have been providing supplemental staff effective 11/10/2020 . By 12/4/2020 nursing staff/charge nurses were educated by the DON/designee on the importance of reporting to supervisor if medication pass was running late or if there is not sufficient staff reported for duty. Schedules will be reviewed at morning meeting and as needed to ensure that staff working as scheduled by the Administrator/Designee. The daily staffing worksheet will be audited by the Administrator/designee 3-5 times/week to verify that staffing is sufficient to meet the needs of the residents. 3-5 residents and 3-5 staff members will be interviewed 3 times/week to verify staffing is sufficient to meet their needs. Residents will be interviewed/observed to ensure that their care planned ADLS, call lights, medication observations are carried out	

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F 0725	Continued From page 84 PPE and this was also taking more time, however, felt even without the PPE, it would be difficult for one STNA to pass trays, provide care and answer call lights on the 300 unit. Corporate RN #200 confirmed on 11/02/20 at 1:12 P.M. during observation of meal delivery that staffing had been an issue with timely delivery of the noon meal. The Administrator stated she had just informed staff that if a resident would like another tray from the kitchen to let them know and they would get the resident warm food. RN #200 and the Administrator confirmed that they had not offered to assist STNA #303 and #320 with delivery of the noon meal. On 11/02/20 at 1:13 P.M. RN #203, who was working on the 300 unit, stated she had just finished the medication administration and observation of the noon meal delivery did not appear efficient and with the number of staff, they were not able to pass trays in a timely manner. On 11/02/20 at 1:15 P.M. upon entering the Covid-19 unit, five call lights were observed on. LPN #312 and #201 were observed talking at the nurses' station. LPN #201 stated it was almost time to take residents outside to smoke and she needed to see which residents wanted to go out to smoke. LPN #312 remained at the nurses' station.	F 0725	per the resident preferences by the DON/Designee on 12/1/20. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. **3-5 residents 3-5 times per week will interviewed-observed to ensure their careplanned ADLS, call lights, medication observations are carried out per the resident preference for at least 4 weeks or until compliance is achieved by DON/Designee	

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F 0725	Continued From page 85 On 11/02/20 at 1:24 P.M. STNA #316 was observed performing housekeeping duties. STNA #316 reported nursing staff on the Covid-19 unit were currently responsible for housekeeping and activities. STNA #316 stated two other STNAs were working the unit today, however, did not know where they were at this time and did not think they were inside the building. STNA #316 was observed to answer the first call light that had been on since 1:15 P.M. at 1:47 P.M. LPN #201 stated on 11/02/20 at 1:50 P.M. call lights should be answered with 10 minutes. 2 (a). Interview with LPN #216 on 11/03/20 at 1:45 P.M. revealed she was the only nurse on duty for the 600 and 700 units with 37 residents who were all COVID positive. On 11/03/20 at 2:00 P.M. she stated there were nine residents (Residents #27, #37, #53, #66, #70, #73, #110, #114, and #126) who had not received their morning medications due between the time window of 7:00 A.M. and 11:00 A.M. which included insulin for Resident #110 and blood pressure medication for Resident #66. In addition, she stated Resident #31 was due to receive pain medication (oxycodone) at 12:00 P.M. which had not been given as of 2:00 P.M. She stated it was impossible for one nurse to administer medications for	F 0725		

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F 0725	Continued From page 86 both the 600 and 700 units. Review of the Medication Administration Records (MAR) on 11/03/20 at 2:00 P.M. confirmed the medications were past due for Residents #27, #31, #37, #53, #66, #70, #73, #110, #114, and #126. The MARs for November 2020 for Residents #27, #31, #37, #53, #66, #70, #73, #110, #114, and #126 were requested from the facility. However, the facility failed to provide the records. Interview with Residents #27, #31, #37, #73, #114, and #126 confirmed medications were late. (b). Observation on 11/04/20 at 11:10 A.M. revealed the Minimum Data Set 3.0 (MDS) Nurse #221 was still administering "Rise" medication to the 300 unit. MDS Nurse #221 confirmed she still had the back half of the 300 unit to administer medication to which included 15 Residents (#1, #5, #6, #8, #23, #30, #54, #62, #74, #84, #85, #88, #101, #106, and #127), Medication not yet administered included blood pressure medication for Resident #54. Interview on 11/04/20 at 11:15 A.M. with MDS Nurse #221 revealed that due to the originally scheduled nurse calling off she was pulled from her normal position as MDS nurse to work as a floor nurse, and this was something she did not normally do and was falling behind. MDS Nurse #221 also confirmed that when a medication was assigned to be administered at "Rise" in the resident's	F 0725		

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F 0725	Continued From page 87 electronic medication administration record (MAR), that indicted morning time or every morning time. The MAR for November 2020 for Residents #1, #5, #6, #8, #23, #30, #54, #62, #74, #84, #88, #101, #106, and #127 were requested from the facility. The facility failed to provide the records. Review of the facility's medication administration times revealed medication that was noted to be administered every morning, every day, every other day, twice a day, three times a day, and four times a day, the first dose for the day would be administered between 7:00 A.M. and 11:00 A.M. Review of the facility's policy titled "Medication Administration and Documentation-Education," revised on 07/2018, revealed under Documentation of Medication Administration number 4. Medications may be given up to 60 minutes before or after the designated administration time unless ordered at specific time. Under number 6. If medications are given outside of the scheduled administration times, the physician will be notified, and every effort made to return to the established schedule. Under number 7. Any omission or delay in medication administration requires a brief explanation.	F 0725		

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F 0725	Continued From page 88 Review of the facility's assessment, revised on 03/12/20, revealed under Part 2: Services and Care We Offer Based on Our Residents' Needs, under General Care Medication, "Awareness of any limitations of administering medications, administration of medication that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous, intramuscular, inhaled, vaginal, ophthalmic, etc. 3. Observation on 11/04/20 at 11:20 A.M. revealed Resident #101 asking staff for some ice water because her water pitcher was empty. STNA #524 and STNA #220 were both observed telling Resident #101 that they would get her some fresh water in a few minutes. STNA #524 proceeded to enter another resident's room to obtain vital signs and STNA #220 entered another resident's room while holding a meal tray to assist with feeding. Continued observation revealed Resident #101 did not receive fresh ice water until 12:30 P.M. Interview with STNA #220 confirmed they were not able to get Resident #101's ice water in a timely manner due to not having enough time to meet everyone needs nor having enough staff to help out. 4. Observation on 11/04/20 at 2:30 P.M. revealed staff exiting Resident #83's room after assisting him out of bed into his wheelchair.	F 0725		

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F 0725	Continued From page 89 Interview on 11/04/20 at 2:31 P.M. with Resident #83 revealed he had asked the staff if he could get up out of bed around 6:30 A.M. Resident #83 revealed the staff told him they were too busy to get him up at that time and it would have to be later on. Resident #83 confirmed that 2:30 P.M. was the first time he had been out of bed for that day. Interview on 11/04/20 at 2:40 P.M. with STNA #212 confirmed Resident #83 requested to get out of bed earlier that morning but due to there only being one nursing assistant providing care on that unit for 18 residents , they were not able to get Resident #83 out of bed till later on that day. 5 (a). Observation on 11/04/20 at 1:26 P.M. revealed Residents #4, #92, and #125 sitting by the 100 and 200 unit nurses station, waiting for a staff member to come and take them outside for their scheduled smoke time, which was at 1:30 P.M. Continued observation revealed these residents did not go outside to smoke until 1:50 P.M. Interview on 11/04/20 at 1:45 P.M. with STNA #212 revealed it was the responsibility of the 100 unit or 200 unit staff members to take the residents out for their scheduled smoke breaks. STNA #212 revealed she had asked Licensed Practical	F 0725		

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F 0725	Continued From page 90 Nurse (LPN) Infection Preventionist (IP) #201 to ask for someone else to do this task because aides did not have time to do it and LPN IP#201 was the only nurse for both the 100 unit and 200 unit until 2:00 P.M. Observation on 11/09/20 at 9:30 A.M. revealed Residents #4, #92, and #125 sitting by the 100 and 200 unit nurses station, waiting for a staff member to take them outside for their scheduled smoke time which was at 9:30 A.M. Continued observation at 10:32 A.M. revealed the same mentioned residents still sitting by the nurses station waiting to go outside to smoke. At 10:38 A.M. Residents #4, #92, and #125 were assisted outside to smoke. Interview on 11/09/20 between 9:36 A.M. and 9:45 A.M. with Residents #4, #92, and #125 confirmed having to wait for staff to find time to take them outside to smoke happened all the time. It was rare for smoke breaks to occur at the scheduled times. Interview on 11/09/20 at 9:50 A.M. with LPN #207, revealed she was still currently administering morning medication and the STNAs were busy providing resident care. Observation on 11/09/20 at 9:52 A.M. revealed Scheduler #525 approached LPN #207 and informed her that it was time for the residents to go out for their scheduled	F 0725		

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F 0725	Continued From page 91 9:30 A.M. smoke break. LPN #207 informed Scheduler #525 that the floor staff was too busy and did not have enough help to do this right now. (b). Observations on 11/03/20 at 9:38 A.M. revealed Resident #102 sitting in the hallway on the 100 unit asking for staff to come and supervise outside smoking. STNA #212 was observed providing care to a resident. Interview with STNA #212 on 11/03/20 at 9:38 A.M. revealed staff on the 100 unit were assigned to supervise outside smoking. She stated she was the only nursing assistant scheduled to work on the 100 unit, making it difficult to supervise outside smoking and provide care to the residents. 6. Review of Resident #42's medical record revealed a progress note dated 11/07/20 at 6:57 P.M. by RN #225 revealed "Writer called to the 600 (unit) for resident lying on floor with puncture wound/ laceration to posterior head. Moderate amount bright red active bleeding observed. Upon assessment writer noted resident's skull visible through gaping head wound. Resident also noted to have skin tear to right elbow. Nurse Practitioner #502 made aware of resident's fall with injuries, writer given instruction to send to the emergency room for eval of head wound and possible need for sutures." Interview on 11/09/20 at 11:52 A.M. with	F 0725		

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F 0725	Continued From page 92 STNA #526 revealed she was working the COVID unit on 11/07/20 when Resident #42 had his fall. STNA #526 claimed she was in another resident's room when she heard the code falling star being called. When she came out of the resident's room, she saw two nurses holding the back of Resident #42's head and trying to keep him calm. STNA #526 said she approached the resident in attempts to calm him down as well and keep him from getting up. STNA #526 also revealed that on that day there was only one nurse and one STNA on the 600 unit and one nurse and one STNA on the 700 unit for 38 residents which both were COVID units, and felt they were not adequately staffed to provide care and supervision for residents. STNA #526 also revealed that she felt Resident #42's fall may have been prevented if there were more staff on the units and there would have been more staff available to keep a closer eye on this resident. Review of the facility's policy titled "Fall Management," dated 01/29/20, revealed the facility will identify each resident who is at risk for falls and will develop a Plan of Care and implement interventions to manage falls. The facility will provide an environment that is free from potential hazards. The licensed nurse will perform a Fall Risk Assessment immediately if the resident is deemed to be at risk.	F 0725		

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F 0725	Continued From page 93 Review of the facility's assessment, revised on 03/12/20, revealed under Part 2: Services and Care We Offer Based on our Residents' Needs revealed a general care area of "Mobility and fall/fall injury prevention," Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself. 7. Review of a self-reported incident form submitted to the State Survey Agency by the facility on 11/09/20 revealed it was dated 11/09/20 and date of discovery listed as 11/09/20. The allegation was sexual abuse. The alleged perpetrator was listed as another resident. The initial source of allegation was listed as staff. Involved residents were listed as Resident #115 and Resident #2. The incident form stated both residents had dementia, and neither were able to provide any meaningful information. The date, time, and location of the occurrence were blank on the form. The narrative summary of the incident and witness statements were blank. Interview with STNA #219 on 11/09/20 at 11:00 A.M. revealed she had been assigned to work on the dementia unit (400 unit) last night, 11/08/20 from 7:00 P.M. to 7:00 A.M. on 11/09/20. However, she was pulled to work on the 300 unit. She stated STNA #218 was working on the dementia unit by herself at the time an	F 0725		

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F 0725	Continued From page 94 incident regarding Resident #115 happened. She stated STNA #218 came off the dementia unit and reported that Resident #115 had gone in Resident #2's room and put his hand under her gown in the chest area. Resident #2 was crying and STNA #218 got him out of her room. STNA #218 went back and saw that Resident #2 was wet and Resident #115 had urinated on her. Resident #2 was still upset. Resident #2's gown was wet at the top but her incontinence brief was dry. STNA #219 stated when there was only one staff on the dementia unit, you couldn't keep an eye on 21 residents, especially when in a room providing care. She stated the week prior; the nurse was only able to be on the dementia unit about two hours per shift because of working on another unit also. STNA #219 stated Resident #115 had a history of going into female resident's rooms, patting them on the back, following them around, pulling his pants down, urinating and defecating in other residents' rooms. She stated he won't sit down and wandered up and down the unit going in other resident rooms. She stated there was nothing they could do when they were short staffed and only had one or two staff on the unit. She stated she felt Resident #115 knew when the staff were busy and that was when he went in female resident rooms. She stated there were residents who required assistance from two staff so even when there were two staff, they could both be in a resident room	F 0725		

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F 0725	Continued From page 95 providing care. Interview with LPN #217 on 11/09/20 at 10:10 A.M. revealed she was the nurse assigned to work on the dementia unit (400 unit) beginning at 7:00 P.M. on 11/08/20 through 7:00 A.M. on 11/09/20 with 21 residents. However, she stated she was also assigned to cover the 300 unit, for that shift with 19 residents. She stated that around 8:30 P.M. on 11/08/20 STNA #218 reported to her that, after being in a resident room providing care on the dementia unit, she was unable to find Resident #115 in his room. STNA #218 then looked for him and found him in female Resident #2's room. She reported that Resident #115 had his hands under Resident #2's gown near her breast area. She reported that Resident #2's gown was wet up the front. LPN #217 stated that STNA #218 presumed Resident #115 had urinated on Resident #2 as her disposable underwear was dry. LPN #217 stated Resident #2 was unable to verbally express what happened but STNA #218 said Resident #2 seemed irritated and was moaning at the time of the incident. LPN #217 stated that STNA #218 indicated Resident #115 tended to follow the female residents around and be friendly with them. LPN #217 stated she was working on the 300 unit (outside of the secured doors of the dementia unit) at the time of the incident. She stated she had never worked on the dementia unit before and did not	F 0725		

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F 0725	Continued From page 96 know how to handle the incident. When asked what was done as a result of the incident, LPN #217 stated they separated Resident #115 from Resident #2 and then got Resident #2 cleaned up. She stated Resident #115 then went to bed and the STNA "kept an eye on him". Interview 11/15/20 at 11:45 A.M. with STNA #218 revealed the Dementia Unit had one staff working the unit on 11/08/20 when Resident #2 was sexually assaulted by Resident #115. The Dementia Unit had 21 residents at the time. STNA #218 revealed her co-worker was pulled to another unit at 7:00 P.M., the beginning of their 12-hour shift. The nurse was responsible for two other units beside the Dementia Unit and normally did not arrive on the Dementia Unit until approximately 11:00 P.M. On 11/08/20 at 8:30 P.M. Resident #115 was observed sexually assaulting Resident #2. STNA #218 was on the unit herself. STNA #218 opened the double door leading to the adjoining unit and told the staff why she needed the nurse. No one came to the unit until approximately 11:30 P.M. Resident #2 had what appeared to be urine from the perpetrator over the top part of her gown. STNA #218 transferred the resident into a wheelchair and showered her. STNA #218 included the resident was a two person assist but she was the only one on the unit, and there was urine all over her and she needed to bathe her. STNA #218	F 0725		

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F 0725	Continued From page 97 verified the unit was unsupervised when she was in the shower with Resident #2. STNA #218 indicated the unit holds 23 residents. Review of the 10/02/20 Significant Change MDS revealed Resident #2 was a two assist for bed mobility and transfers. Resident #2 was a two-person physical assist for bathing. Review of the facility's Abuse, Neglect, Exploitation & Misappropriation of Resident Property Policy revised 10/2020 revealed under Prevention and Identification the deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual residents care needs. 8. Observations on 11/09/20 at 12:20 P.M. revealed Resident #66's call light on. There were two nursing assistants working on the unit (STNAs #205 and #223) at the time who were passing the lunch meal trays. At 12:43 P.M. Resident #66's call light remained on (23 minutes later). The surveyor asked the resident if there was something she needed. She stated she had been moved to this room today without any of her personal belongings (including purse, wheelchair, pictures) and she wanted these items in her room. On 11/09/20 at 1:00 P.M. STNA #223 verified she answered and turned off Resident	F 0725		

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F 0725	Continued From page 98 #66's call light at this time. (40 minutes after the call light was activated). 9 (a). Interview with Resident #90 on 11/05/20 at 3:30 P.M. revealed sometimes there was only one STNA working on her unit, (which can house 26 residents). She stated because of this, staff were not able to answer her call light timely. She stated because of the lack of staff, she did not always get fresh ice water each day. She stated she did not get fresh ice water on 11/05/20 as of 3:30 P.M. (b). Interview with Resident #125 on 11/05/20 at 4:00 P.M. revealed there was only one STNA working on his unit at night. He stated he sometimes must wait over two hours to be changed after an incontinent episode. (c). Interview on 11/04/20 at 12:30 P.M. with Resident #66 revealed she was concerned that staff were working too hard. They were working 12 hour shifts and were exhausted. Resident #66 claimed there was a day, but she was not able to provide an exact date, when she turned on her call light around 6:30 A.M. and told staff she needed incontinence care completed. Resident #66 claimed that staff came in and told her they would be back and turned off her call light. She then revealed she did not get changed until 2:30 P.M. that day.	F 0725		

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F 0725	Continued From page 99 10. Interview on 11/04/20 at 11:00 A.M. with LPN #527 revealed she had started her scheduled shift on 11/03/20 at 7:00 P.M. and was still currently working the floor. LPN #527 revealed she was getting ready to give report to LPN IP #201 who was going to relieve her. LPN #527 confirmed the originally scheduled nurse for the 100 unit had called off and she had to work over into day shift until someone could relieve her. LPN #527 revealed this is something that has happened more than once within the last few months. LPN #527 also revealed she does not feel there is enough staff to provide the proper care to all the residents. LPN #527 confirmed staff can ensure residents care is completed, but staff run themselves ragged trying ensure all care is provided and they are getting burnt out. LPN #527 also confirmed that due to not having enough STNAs, there are many times she has to assist the one STNA who is scheduled with resident care and this prevents her from completing required charting of assessments and care provided. Interview on 11/04/20 at 11:03 A.M. with STNA #212 revealed she was the only STNA working the 100 unit and providing care for 18 residents. STNA #212 revealed she was responsible for providing incontinence care, checking and changing resident, feeding them meals if needed, providing them with their meals, providing baths and showers and other activities of	F 0725		

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F 0725	Continued From page 100 daily living (ADLs). STNA #212 revealed there was not enough help to get all the needed care provided and they needed more help and she cannot continue to work short staffed. Interview on 11/04/20 at 11:06 A.M. with STNA #511 revealed she was the only STNA working the 200 unit and providing care for 18 residents. STNA #511 revealed she had 5 scheduled showers for that day and in order for her to get them all done she would have to rush and may need to stay over into the next shift to ensure the showers were completed because if she was to leave at her scheduled time, some of the residents showers would not get done. STNA #511 confirmed the facility needs to have more staff to provide the proper care for each resident and to keep staff safe. Interview on 11/04/20 at 11:30 A.M. with LPN #513 revealed herself and one STNA were responsible for providing care for 21 residents who resided on the facility's memory care unit or the 400 unit. LPN #513 expressed concerns that there was not enough staff to properly supervise all the residents residing on the 400 unit. There were residents who required two staff assistance and there were times when the STNA needed assistance with providing care which then left all the residents remaining in the lobby area unsupervised. LPN #513 also revealed in	F 0725		

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F 0725	Continued From page 101 the lobby area there were two exit doors that lead to the outside. These doors were locked and alarmed but when someone pressed on the door handle for 15 seconds, the door will open, and an alarm will sound. If both staff members were in a resident's room providing care, by the time they heard the alarm and responded the resident could already be outside the facility. LPN #513 confirmed residents have attempted to go out these doors before and were able to hold down the door handle long enough to release the lock. LPN #513 revealed the way the memory care unit had been staffed was not safe and they were not able to provide proper care or supervision. Corporate RN #200 claimed during an interview on 11/13/20 at 1:30 P.M. the facility had reached out to multiple sister facilities and staffing agencies for staffing assistance and have been told that review of the facility's daily staffing schedules made it appear like there was adequate direct care staff and they would not be able to provide assistance with staffing at this time. Corporate RN #200 added that she felt like the sister facilities and staffing agencies were just looking at the numbers and not taking into account the acuity level of the residents or the fact that most of the facility was COVID positive. Review of the facility's assessment, revised on 03/12/20 revealed under Part 3:	F 0725		

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F 0725	Continued From page 102 Staffing Plan 3.1, the facility needed a total number or average or range daily, "Licensed nurses providing direct care, minimum of eight hours of Registered Nurse (RN) coverage a day and 3-6 Licensed Practical nurses/ Registered Nurses each shift. "Nurse aides will be staffed based on facility census. Average staffing is 1.85 per patient day (PPD). No additional information was provided. Review of the facility's 672 which indicated the acuity level of the residents revealed the following: Transfers - 114 residents required 1-2 staff assistance for transfers and 12 were dependent for transfers. Bathing - 62 residents required 1-2 staff assistance and 58 were dependent Dressing - 121 residents required 1-2 staff assistance and 5 were dependent Toilet use - 120 residents required 1-2 staff assistance and 6 were dependent Eating - 119 residents required 1-2 staff assistance and 7 were dependent. This deficiency substantiates Complaint Number OH00116914, OH00116553, and OH00116434.	F 0725		

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F 0760	Continued From page 103	F 0760		
F 0760 SS=E	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This STANDARD is not met as evidenced by: Based on observations, staff interview, resident interview, and review of facility policy the facility failed to ensure residents were free from significant medication errors. This affected 24 of 126 residents in the facility (Residents #1, #5, #6, #8, #23, #27, #30, #37, #53, #54, #62, #66, #70, #73, #74, #84, #85, #88, #101, #106, #110, #114, #126, and #127). Findings include: 1. Interview with Licensed Practical Nurse (LPN) #216 on 11/03/20 at 1:45 P.M. revealed she was the only nurse on duty for the 600 and 700 units with 37 residents who were all COVID positive. On 11/03/20 at 2:00 P.M. she stated there were nine residents (Residents #27, #37, #53, #66, #70, #73, #110, #114, and #126) who had not received their morning medications due between the time window of 7:00 A.M. and 11:00 A.M. which included insulin for Resident #110 and blood pressure medication for Resident #66. In addition, she stated Resident #31 was due to receive pain medication (oxycodone) at 12:00 P.M. which had not been given as of 2:00 P.M. She stated it was impossible	F 0760	F 760 Resident # 70, 73 is no longer in facility. Residents #27, 53, 37, 66, 110, 114, 126's physician(s) were notified of late medication administration, on 11/2/2020 by DON/ Designee, no new orders were received. In addition, resident #66 and #54 were assessed with no adverse outcome related to late blood pressure medication by the DON/designee on 11/3/2020. Resident #31 was assessed with no adverse outcome related to not receiving pain medication as ordered by the DON/designee 11/3/2020. Resident #1 got prescribed medications at 12;21PM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #5 got prescribed medications at 10:27AM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #6 got prescribed medications at 2:22PM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #8 got prescribed medications at 9:59AM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #8 got prescribed medications at 9:59AM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #8 got prescribed medications at 9:59AM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #88 got prescribed medications at 12:06PM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #101 got prescribed medications at 11:58AM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #104 got prescribed medications at 12:54PM on 11/4/2020. Physician notified, assessed no adverse effect. adverse effect.	12/07/2020

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F 0760	Continued From page 104 for one nurse to administer medications for both the 600 and 700 units. Review of the Medication Administration Records (MAR) on 11/03/20 at 2:00 P.M. confirmed the medications were past due for Residents #27, #31, #37, #53, #66, #70, #73, #110, #114, and #126. The MARs for November 2020 for Residents #27, #31, #37, #53, #66, #70, #73, #110, #114, and #126 were requested from the facility. However, the facility failed to provide the records. Interview with Residents #27, #31, #37, #73, #114, and #126 confirmed medications were late. 2. Observation on 11/04/20 at 11:10 A.M. revealed the Minimum Data Set 3.0 (MDS) Nurse #221 was still administering "Rise" medication to the 300 unit. MDS Nurse #221 confirmed she still had the back half of the 300 Hall to administer medication to which included 15 Residents (#1, #5, #6, #8, #23, #30, #54, #62, #74, #84, #85, #88, #101, #106, and #127). Medication not yet administered included blood pressure medication for Resident #54. Interview on 11/04/20 at 11:15 A.M. with MDS Nurse #221 revealed that due to the originally scheduled nurse calling off she was pulled from her normal position as MDS nurse to work as a floor nurse, and this was something she did not normally do and was falling behind. MDS Nurse #221 also confirmed that when a medication was assigned to be	F 0760	Resident #106 got prescribed medications at 12:45PM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #127 got prescribed medications at 1:32PM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #23 got prescribed medications at 2:22PM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #30 got prescribed medications at 12:42 PMon 11/4/2020. Physician notified, assessed no adverse effect. Resident #37 got prescribed medications at 2:44PM on 11/3/2020.Physician notified, assessed no adverse effect. Resident #74 got prescribed medications at 12:02PM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #84 got prescribed medications at 11:33AM on 11/4/2020. Physician notified, assessed no adverse effect. Resident #85 got prescribed medications at 1:30PM on 11/4/2020. Physician notified, assessed no adverse effect. In order to ensure that residents are free from significant medication errors, nurses will be educated by the DON/designee by 12/4/2020 on the importance of reporting to supervisor if medication pass is running late in order to ensure that medications/treatments are completed per order. Medication administration timeliness will be audited by the DON/designee 3-5 times/week via the electronic medical records medication administration audit tool. Medication medication audits will be completed by the DON/designee observing medication timeliness 3-5 residents, 3-5 times per week. 3-5 Residents will be interviewed 3-5 times/week to	

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F 0760	Continued From page 105 administered at "Rise" in the resident's electronic medication administration record, that indicted morning time or every morning time. The MARS for November 2020 for Residents #1, #5, #6, #8, #23, #30, #54, #62, #74, #84, #88, #101, #106, and #127 were requested from the facility. The facility failed to provide the records. Review of the facility's medication administration times revealed medication that was noted to be administered every morning, every day, every other day, twice a day, three times a day, and four times a day, the first dose for the day would be administered between 7:00 A.M. and 11:00 A.M. Review of the facility's policy titled "Medication Administration and Documentation-Education," revised on 07/2018, revealed under Documentation of Medication Administration number 4. Medications may be given up to 60 minutes before or after the designated administration time unless ordered at specific time. Under number 6. If medications are given outside of the scheduled administration times, the physician will be notified, and every effort made to return to the established schedule. Under number 7. Any omission or delay in medication administration requires a brief explanation.	F 0760	ensure their are receiving medications timely by the Administrator/DON. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. *Audits will continue for at least 4 weeks or until compliance is achieved.	

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F 0760	Continued From page 106 Review of the facility's assessment, revised on 03/12/20, revealed under Part 2: Services and Care We Offer Based on Our Residents' Needs, under General Care Medication, "Awareness of any limitations of administering medications, administration of medication that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous, intramuscular, inhaled, vaginal, ophthalmic, etc. This deficiency is an incidental finding, found during investigation for Master Complaint Number OH00117118 which includes Complaints Number OH00116434, OH00116553, OH00116914, OH00117045, OH00117075, OH00117087, and OH00117115.	F 0760		

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F 0804	Continued From page 107	F 0804		
F 0804 SS=E	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This STANDARD is not met as evidenced by: Based on observation, staff interview, and resident interview, the facility failed to ensure 21 residents (Resident #1, #5, #6, #12, #13, #14, #30, #41, #48, #54, #57, #62, #74, #84, #88, #98, #103, #106, #109, #124 and #127) out of 23 residents residing on the 300 Hall were served food that was warm and palatable. The facility census was 126. Findings include: On 11/02/20 at 12:10 P.M. the meal cart for 23 of 24 residents on the 300 Hall was delivered to the hall. The first tray was observed to be served from the cart on 11/02/20 at 12:36 P.M. (26 minutes after the meal cart was delivered to the hall). On 11/02/20 at 1:04 P.M., sixteen trays remained on the cart to be served (54 minutes after the meal cart was delivered	F 0804	F 804 Resident #6,48, 88, 57, 98, 109, and 127 are no longer in facility. Resident # 1,5,12,13,14,30,41,54,62,74, 84,103,106,and 124 were interviewed by the Food Service Manager/designee were interviewed for their preferences, temperature and food palatability on 11/25/2020 and and had no adverse effects. All residents were interviewed for their preferences, temperature and food palatability by the Food Service Manager/designee on 11/30/2020. In order to ensure that food and drink served is palatable, attractive and at proper temperature, the food service department will received education and on the job training from the corporate dietician by 12/4/2020. 3-5 Residents will be interviewed/audited regarding food palatability, attractiveness and temperature by the Food Service Manager/designee 3-5 times/week. The Administrator/designee will receive a test tray to evaluate palatability and temperature 3-5 times/week. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. *Kitchen will be audited by the Administrator/designee who will receive a test tray to evaluate palatability and temperature 3-5 times/week for at least 4 weeks or until compliance is achieved.	12/07/2020

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F 0804	Continued From page 108 to the hall). Temperatures on a test tray taken from the meal cart were obtained by Dietary Manager (DM) #309 on 11/02/20 at 1:04 P.M. with results as follows: Pork cutlet 99 degrees Fahrenheit (F) Brussell sprouts 99.3 degrees F Potatoes 88.5 degrees F Oranges 72.8 degrees F DM #309 confirmed on 11/02/20 at 1:04 P.M. the pork cutlet was tough and the food would be cool to taste. The oranges were to be served cold, however were warm. Interviews with Residents #41 and #57 on 11/02/20 between 12:40 P.M. to 1:00 P.M. revealed their food was not warm and the pork was cold. Resident #41 stated her food was cold most of the time, however, she did not ask for anything else. Interview with Resident #90 on 11/05/20 at 3:30 P.M. revealed the food was sometimes cold, sometimes overcooked, and sometimes undercooked. She stated she filled out a menu of what she wanted but they lose it and just send her anything. Interview with Resident #125 on 11/05/20 at 4:00 P.M. revealed he did not like the food. He stated the food had no taste, was cold, and was sometimes overcooked and sometimes undercooked.	F 0804		

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F 0804	Continued From page 109 This deficiency substantiates Master Complaint Number OH00117118 and Complaints Numbers OH00116434, OH00116553, OH00116914, OH00117045, OH00117075, OH00117087, and OH00117115.	F 0804		

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F 0842	Continued From page 110	F 0842		
F 0842 SS=E	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of	F 0842	F842 Residents # 6, 46, 70, 88, 118, and 127 are no longer in facility. Residents 42, 56, 61, and 83 had had no adverse effects for records being un-accessible. Residents 74, 84, 85, 101, 106, 110, 114, and 126 had their COVID testing results reviewed and documented by the DON/designee on 11/19/2020. Requested records were determined to be available in facility by the VPO on 11/22/2020. Root cause analysis of not providing to surveyor was determined to be relative to a lack of administrative staff available to obtain and provide records to surveyors. The Administrator, DON and Corporate Nurse were educated regarding the importance of making records and COVID testing results for resident , medication administration records for resident #1,5,6,8,23,27,30,37,53,54,62,66,70,73,74,84, 85,88,101,106,110,114,126,127., self reported investigations, shower sheets, fall investigations accessible to an agency legally authorized to request such records by the DON/designee on 11/30/2020. Resident 61 had contradictory bathing information clarified on 12/2/2020 by the QA nurse. Resident 42 orders for geri-sleeves, band-aide, hipsters, and dressing changes were clarified and put in place by the DON/designee on 12/2/2020. Nursing staff will be educated on signing off medications/treatments prior to administration is against nursing standards by the DON/designed on 12/4/2020. 3-5 resident medication passes will be audited for appropriate medication documentation 3-5 times/week by the DON/designee. Self-reported incident files will be reviewed for	12/07/2020

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F 0842	Continued From page 111 abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 0842	completeness and availability by the QA nurse weekly. 3-5 resident shower sheets will be audited 3-5 times/week for completion/accuracy by the DON/designee. 3-5 fall investigations will be audited 3-5/times/week for completion by the Administrator/designee. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation.	

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F 0842	Continued From page 112 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure accurate and accessible medical records. This affected six residents (Residents #42, #46, #56, #61, #83 and #118) of 36 residents whose records were reviewed, 24 residents (Residents #1, #5, #6, #8, #23, #27, #30, #37, #53, #54, #62, #66, #70, #73, #74, #84, #85, #88, #101, #106, #110, #114, #126, and #127) with significant medication errors, and facility staff and residents related to COVID test results. Findings include: 1. The facility failed to provide the following: a. The Medication Administration Records for Residents #1, #5, #6, #8, #23, #27, #30, #37, #53, #54, #62, #66, #70, #73, #74,#84, #85, #88, #101, #106, #110, #114, #126, and #127 who had significant medication errors were requested prior to 11/12/20 at 11:35 A.M. and were not received. b. Self Reported Investigations for SRI's 188158, 190592, and 197692 were	F 0842		

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F 0842	Continued From page 113 requested 11/09/20 at 1:38 P.M. and not received. c. Shower sheets were requested for Residents #61 and #83 on 11/04/20 at 10:05 A.M., 11/12/20 at 8:51 P.M. and 11/13/20 at 11:29 A.M.. The shower sheets were not received. d. Staff and resident COVID results were requested on 11/03/20 at 2:50 P.M., 11/04/20 at 7:28 A.M., 11/04/20 at 7:44 A.M., 11/04/20 at 12:47 P.M., 11/05/20 at 7:44 A.M., and 11/05/20 at 2:46 P.M.. The results were not provided. e. Fall investigations were requested for Residents #42, #46, #56 and #118 dating back to 03/01/20. The fall investigations were requested starting on 11/05/20 at 3:24 P.M. through 11/12/20 at 9:40 P.M.. The facility did not provide the investigations. During interview on 11/12/20 at 4:40 P.M. Corporate Registered Nurse (RN) #200 was asked if there was anyone she could delegate some of the record requests to. Corporate RN #200 indicated due to COVID and numerous staff out of the facility there were not many people to delegate to. 2. Review of Resident #61's record revealed it contained contradictory bathing information. The 09/11/19 Activity of Daily	F 0842		

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F 0842	Continued From page 114 Living (ADL) preference sheet indicated no preference for bathing. Handwritten on the bottom it read wants a day turn shower. The 12/20/19 ADL preference sheet included a shower two times a week as needed. The 01/20/20 Resident Preference plan of care stated bed baths only. The State Tested nurse Aide (STNA) TASK documentation (where the aides documented resident care) included no scheduled shower days. On 11/04/20 at 10:05 A.M. Corporate RN #200 was asked for an explanation for the discrepancy. No rationale was provided for the contradictory plans of care. 3. Review of Resident #42 revealed an admission date of 04/16/19 with diagnoses including intracranial injury and dementia. Physician orders included 07/18/20 geri sleeves to bilateral upper extremities, 09/28/20 cleanse laceration to right side of head behind right ear. Cover with Band-Aid until healed day and night shift, 10/05/20 cleanse skin tear to left elbow area with normal saline (NSS), apply steri strips, cover with non adherent pad, wrap with kling, cleanse skin tear to right wrist with NSS, cover with dry dressing, and cleanse skin tear right hand with NSS, apply dry dressing. Observation on 11/04/20 at 11:20 A.M. revealed the resident did not have hipsters on as ordered. There were no dressings to	F 0842		

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F 0842	Continued From page 115 the right wrist or hand or Band-Aid behind the right ear. Review of the November treatment record revealed geri sleeves to bilateral upper extremities, cleanse laceration to right side of head behind right ear. Cover with Band-Aid until healed day and night shift, and cleanse skin tear to right wrist with normal saline (NSS), cover with dry dressing, and cleanse skin tear right hand with NSS, apply dry dressing were all signed off for 7:00 A.M. as competed.. Interview 11/04/20 at 12:20 P.M. with Licensed Practical Nurse (LPN) #216 verified she did not do the treatments and signed them off as completed. This deficiency is an incidental finding, found during investigation for Master Complaint Number OH00117118 which includes Complaints Number OH00116434, OH00116553, OH00116914, OH00117045, OH00117075, OH00117087, and OH00117115.	F 0842		

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F 0880	Continued From page 116	F 0880		
F 0880 SS=L	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents	F 0880	F880 POC Facility Position: The reviewer of this citation should note the following: The facility had policies and procedures in place to ensure it had an effective infection control program as well as policies and procedures designed to prevent and control the spread of COVID-19. Plan of Correction: Although we do not necessarily agree with the allegations made in this citation, we are required by law to provide a plan of correction. Our plan of correction is as follows: • On 10/29/20 at approximately 3:00 P.M. Immediate PPE education for staff was started by the Assistant Directors of Nursing (ADON). • On 10/29/20 at 4:45 P.M., an IDT meeting was held to review identified concerns with team, current policies, and action items were developed as listed below. IDT members included DON/Admin and Medical Director. The IDT reviewed the policies including Isolation Unit, Triage and Quarantine Management and Isolation Precautions. The team determined that our policies were appropriate as written. The IDT conducted a count of PPE and based on PPE count and no established history of burn rate (facility with no resident COVID cases from Pandemic start in March 2020 to October 24, 2020) it was determined that facility would utilize policies for Contingency use of PPE per CDC guidelines of anticipated crisis. • On 10/29/20 at 5:30 P.M., initiated education for staff currently working with return demonstration on PPE use (provided education packet) that included Hand Hygiene, PPE use in Quarantine/Isolation and patient care, eye wear and N95 at all times, face shield cleaning, use of surgical mask over	12/07/2020

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F 0880	Continued From page 117 of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as	F 0880	N95 was completed by DON/Admin and IDT. Education continued with all staff prior to working their shift and was fully completed by telephone for education by 5:00 P.M. on 10/30/20. Staff on LOA will receive telephone education regarding the policies and upon return to work will complete a return demonstration. • On 10/29/20 at 6:00 P.M., a review was initiated to identify cause of not using PPE properly and was completed by the QA nurse by 8:00 P.M. • On 10/29/20 at 6:15 P.M., the ADON began an audit of all quarantine patients to ensure clear identification/signage on door. This was completed by 6:45 P.M. • On 10/29/20 at 6:30 P.M., residents currently on quarantine and isolation precautions had their order/care plans updated by DON/Designee. • On 10/29/20 at 8:00 P.M. the Administrator created an audit tool to observe proper PPE utilization that will be conducted every 4 hours for the first 48 hours and then two times per shift x 2 weeks. Then once a shift x 2 weeks. Then three times weekly x 2 weeks. Then weekly x 2 weeks. And as needed based on observable behavior/audit results. • On 10/29/20 at 8:00 P.M. audit tools were created related to quarantine order and care plan, COVID log, discharge notification, residents in private room or co-horted with like residents in room or on units. • On 10/29/20 at 9:00 P.M., audits began and will continue per above schedule with verification that all staff have observations completed. • On 10/29/20 at 9:00 P.M., the DON and Administrator were educated by the QA Nurse and VPO on PPE supervision	

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F 0880	Continued From page 118 necessary. This STANDARD is not met as evidenced by: Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, Department of Health and Human Services, Center for Medicare and Medicaid (CMS) Memos, Nursing Home Guidance from the Centers for Disease Control (CDC) , observations, record reviews, review of the facility's undated isolation unit policy, review of isolation precautions policy revised February 2019, review of Triage and Quarantine Management policy revised 07/20/20, review of facility COVID-19 tracking forms, and interviews with staff and the local health department, the facility failed to implement effective and recommended infection control practices, including the implementation of appropriate isolation and quarantine procedures and the appropriate use of personal protective equipment (PPE) to prevent the spread of COVID-19 throughout the facility. This resulted in Immediate Jeopardy when four residents (Residents #32, #48, #57, and #73) who tested negative for COVID 19 remained or were placed on a COVID positive unit with six residents who tested positive for COVID-19 resulting in Resident #73 testing positive for COVID-19 six days later. Two residents (Residents #1 and #118) remained on the COVID positive unit	F 0880	requirements, Quarantine policies and procedure for symptomatic, COVID + and persons under investigation (PUI). They were also educated on requirements for orders, care plan in place, and hand hygiene following care. • On 10/29/20 at 9:00 P.M., a COVID-19 assessment was initiated on all residents in facility. This was completed by DON, ADON 1 and ADON 2 on 10/29/20 at 11:40 P.M. Results revealed no new residents with signs and symptoms of COVID-19. • On 10/29/20 at 11:00 P.M., hooks were placed on all quarantine and COVID rooms for face shields by Administration. • On 10/30/20, a plan for implementation of designated units was implemented. Mass testing initiated 10/30/20 and the results revealed which residents tested positive. As a result 600 and 700 hall were converted to COVID+ units. • On 11/10/20 designated units were updated as followed based on new positive cases: 1. 300 hall unit converted to COVID unit. • Effective 10/30/20, all negative residents will have COVID-19 assessments completed by nursing daily until there are no new COVID + cases for 14 days. • Initially on 11/01/20 at 10:30 A.M., residents were separated by status and isolation COVID units were developed. Negative residents were not with positive residents on the same hall. As of 11/8/20 and 11/9/20, all residents were separated and placed on designated COVID units per test results. • On 11/09/20, re-education was completed for staff currently working with education on PPE use that included Hand Hygiene, PPE use in Quarantine/Isolation and patient care, eye wear	

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F 0880	Continued From page 119 after the negative PCR test resulting in Resident #118 testing positive for COVID-19 three days later. Two residents (Residents #78 and #100) were not moved to the designated COVID-19 unit for three days after a positive COVID-19 test result was received. Observations on 10/27/20 and 11/03/20 revealed staff not utilizing PPE appropriately and/or not completing proper hand sanitizing. The lack of current effective infection control practices during a COVID-19 outbreak in the facility placed all 126 residents at risk for the likelihood of harm, complications and/or death and specifically affected Residents #1, #22, #27, #95, #114, #73, #32, #48, #57, #118, #1, #78, #9, #100, #111, #56, #125, #50, #92, #117, #102, #66, #47, #76, #113, #63, #42, #67, #29, #96, #107, #55, #93, #81, and #71. The facility census was 126. On 10/29/20 at 3:00 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 10/24/20 when four residents (Residents #32, #48, #57, and #73) who tested negative for COVID-19 remained or were placed on a COVID positive unit with six residents (Residents #1, #22, #27, #95, #114, and #118) who tested positive for COVID-19. Resident #73 then tested positive for COVID-19 six days later. Additionally, two residents (Residents #1 and #118) tested positive initially with a rapid test, then tested negative with a PCR test three days later. Residents #1 and	F 0880	and N95 at all times, face shield cleaning, use of surgical mask over N 95 was completed by DON/Admin and IDT. • As of 11/09/20, audits continue for infection control practices and will continue per the above schedule with verification that all staff have observations completed. All audit results will be reviewed by Regional Quality Assurance Nurse weekly with re-education or audit changes as needed. All audit results will be reviewed by the Facility QAPI for prompt resolution as needed. • On 11/10/20 at 9:00 P.M., all rooms were audited by administration for hooks being present to hang PPE and all hooks confirmed to be in place. • On 11/11/20, STNAs assigned on 200 hall on dayshift on 11/9/20 were re-educated on proper PPE use and storage on 11/11/20 by QA Nurse 4:00pm. • On 11/11/20, the Plan for implementation of designated units updated due to additional COVID positives. The last 6 rooms of the 100 hall were segregated with barrier for placement of additional COVID positive residents. • On 11/11/20 3:00pm, staff education was completed on unit processes for 300/100/600/700 units by Regional QA nurse to include DON/DOFF of PPE, appropriate utilization of PPE, COVID unit process, how to enter and exit units. • On 11/11/20, 3:00pm dietary staff were educated on dietary process for meal delivery per Regional Dietary Manager related to COVID unit meal distribution. • On 11/16/20 at 10:00am, the facility support staff-initiated room audit for all resident rooms (107 residents) to determine appropriate distribution of personal belongings. All items are being secured. Each resident is individually	

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F 0880	Continued From page 120 #118 remained on the COVID positive unit after the negative PCR test. Resident #118 then tested positive for COVID-19 three days later. Furthermore, two residents (Residents #78 and #100) were not moved to the designated COVID-19 unit for three days after a positive COVID-19 test result was received. Observations on 10/27/20 and 11/03/20 revealed staff not utilizing PPE appropriately and/or not completing proper hand sanitizing. The facility's failure to effectively implement infection control practices likely contributed to the COVID-19 outbreak that spread throughout the facility infecting 44 residents with COVID-19 resulting in two deaths. As of 11/13/20 the Immediate Jeopardy remains ongoing. Findings include: Review of the Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) memo QSO 20-20-ALL dated 03/20/20 revealed the Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). As part of the CMS guidance, the Focused Infection Control Survey was made available to every provider in the country to make them aware of the Infection Control priorities	F 0880	being asked what items they would like in their new room, and any other items will be safely stored and appropriately distributed once residents return to permanent room at resolution of COVID 19 outbreak. • The Directed Plan of Correction imposed by ODH will be completed by 12/7/2020.(Attachment 1) • The consultant, Infection Preventionist, DON and other nursing leadership will conduct rounds daily and on each shift throughout the facility to ensure all residents are isolated/quarantined as appropriate, testing procedures are being implemented, staff is utilizing the proper PPE correctly, implemented methods of extending and disinfecting PPE and ensure staff are knowledgeable in following all infection control policies and procedures. Ad hoc education will be provided to persons who are not correctly quarantining/isolating residents. Such monitoring will continue for at least eight weeks. • Results of all audits completed by the facility will be reported to and reviewed by QAPI and the consultant weekly to determine if current interventions are adequate or additional action will need to be completed to ensure infection prevention and control procedures are implemented appropriately. Trash and linen barrels were equipped with lids by the maintenance director on 12/3/2020. Meal tray delivery and smoking breaks will monitored for the infection control procedures by the Administrator/designee 3-5 days/week. Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation. *All audits will be	

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F 0880	Continued From page 121 during this time of crisis, and providers and suppliers may perform a voluntary self-assessment of their ability to meet these priorities. The QSO Memo included additional instructions to Nursing Homes. "We are disseminating the Infection Control survey developed by CMS and CDC so facilities can educate themselves on the latest practices and expectations We expect facilities to use this new process, in conjunction with the latest guidance from CDC to perform a voluntary self-assessment of their ability to prevent the transmission of COVID-19 ... We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program". "Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and whom possible incidents of communicable disease or infections should be reported [42 CFR 483.80 (a)(2)(i) and (ii)]". 1. Review of the facility COVID-19 tracking form revealed Residents #1, #22, #27, #95, #114, and #118 all tested positive for COVID-19 on10/23/20 and 10/24/20. These six residents already resided on the 600	F 0880	completed for at least 4 weeks or until compliance is achieved.	

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F 0880	Continued From page 122 unit or were moved to the 600 unit on 10/24/20 when it was made the COVID positive unit. Between 10/30/20 and 11/02/20 the facility had 34 additional residents test positive for COVID-19. Two residents (Residents #22 and #111) who were positive for COVID-19 expired. The facility had 19 staff test positive for COVID-19 between 10/26/20 and 11/02/20. Interview with Corporate RN #200 on 11/12/20 at 11:00 A.M. revealed that all but seven (7) residents had tested positive for COVID (the original census was 126). She stated she did not know how many staff had tested positive or how many deaths there were. 2 (a). Review of Resident #73's medical record revealed she was admitted to the facility on 10/16/20 and resided in a room on the 600 unit. The resident had a negative COVID-19 test on 10/24/20. The facility made the 600 unit the COVID positive unit on 10/24/20. Resident #73 remained on the COVID positive unit (after testing negative on 10/24/20) with six residents who were positive for COVID-19. Review of facility COVID-19 tracking forms revealed Resident #73 then tested positive for COVID-19 on 10/30/20. Observations on 10/27/20 between 3:10 P.M. and 3:50 P.M. revealed Resident #73	F 0880		

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F 0880	Continued From page 123 did reside on the COVID-19 unit. Interview with the Administrator on 11/03/20 at 12:25 P.M. confirmed Resident #73 had been negative for COVID-19 but had resided on the COVID positive unit. Six days later on 10/30/20 Resident #73 tested positive for COVID-19. The Administrator stated the positive results had been confirmed with a PCR test. 2 (b). Review of the medical records for Residents #32 and #48 revealed they tested negative for COVID-19 on 10/24/20. Resident #32 resided on the COVID positive unit and Resident #48 was moved to the COVID positive unit on 10/24/20. Resident #32 and Resident #48 remained on the COVID positive unit with six residents who were positive for COVID-19 until 10/30/20. Residents #32 and #48 tested negative for COVID-19 on 10/30/20. Observations on 10/27/20 between 3:10 P.M. and 3:50 P.M. revealed Residents #32 and #48 did reside on the COVID positive unit. Interview with the Director of Nursing on 10/27/20 at 2:40 P.M. revealed she did not think the facility had a policy regarding where COVID positive residents and residents who require quarantine but are negative are to be placed in the facility. She confirmed residents who were negative for COVID-19 were on the same	F 0880		

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F 0880	Continued From page 124 unit with residents who were positive for COVID-19. 2 (c). Review of the medical record for Resident #57 revealed she was re-admitted to the facility on 10/25/20 from the hospital. Resident #57 was tested for COVID-19 at the hospital prior to readmission and was negative. Resident #57 was readmitted to the facility and placed in a room on the COVID positive unit that housed six residents who were positive for COVID-19. Resident #57 remained on the COVID positive unit until she was moved on 10/30/20. The resident had a negative COVID-19 test on 10/30/20. Observations on 10/27/20 between 3:10 P.M. and 3:50 P.M. revealed Resident #57 did reside on the COVID positive unit. Interview with Corporate Registered Nurse (RN) #200 on 10/29/20 at 4:35 P.M. revealed Resident #57 was placed on the COVID positive unit after readmission because that had been her room previously. 3 (a). Review of Resident #118's medical record revealed the resident was admitted to the facility on 08/12/20. Resident #118 was tested for COVID-19 with a rapid test on 10/24/20. The rapid test results were positive. Resident #118 was moved to the COVID positive unit on 10/24/20. A PCR COVID test was conducted on 10/24/20. The results were obtained on 10/27/20 and	F 0880		

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F 0880	Continued From page 125 were negative. However, Resident #118 continued to reside on the COVID positive unit. Observations on 10/27/20 between 3:10 P.M. and 3:50 P.M. revealed Resident #118 did reside on the COVID positive unit. Review of the facility COVID-19 tracking form revealed Resident #118 was tested for COVID-19 on 10/30/20 and tested positive. Interview with the Administrator on 11/03/20 at 12:25 P.M. confirmed Resident #118 continued to reside on the COVID positive unit after negative PCR test results on 10/27/20 and then tested positive for COVID-19 with a rapid test on 10/30/20 and a follow up PCR test done after the rapid test on 10/30/20 also resulted in positive results. 3 (b). Review of Resident #1's medical record revealed the resident was admitted to the facility 06/12/20. The resident was tested for COVID-19 with a rapid test on 10/24/20. The rapid test results were positive. The resident was moved to the COVID unit on 10/24/20. A PCR COVID-19 test was conducted on 10/24/20. The results were obtained on 10/27/20 and were negative. Observations on 10/27/20 between 3:10 P.M. and 3:50 P.M. revealed Resident #1 did reside on the COVID positive unit. Resident #1 continued to reside on the COVID positive unit until 10/30/20 when she was moved to	F 0880		

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F 0880	Continued From page 126 the quarantine unit due to the 10/27/20 negative PCR results. Interview with Licensed Practical Nurse (LPN) #201, who was also the facility Infection Prevention Nurse, on 10/28/20 at 7:30 A.M. confirmed Resident #1 had negative COVID test results on 10/27/20 but remained on the COVID positive unit. 4 (a). Review of the medical record for Resident #78 revealed an admission date of 08/19/20. Record review revealed the resident had a negative rapid COVID test on 10/24/20. However, an order was obtained to do a PCR COVID test. Review of the treatment administration record revealed during monitoring for symptoms of COVID, the resident was found to have a cough on 10/24/20. Record review revealed Resident #9 was moved into the room with Resident #78 on 10/25/20. Resident #9 had tested negative for COVID-19 on 10/24/20. These residents were not on the COVID positive unit. Interview with the DON on 10/30/20 at 2:15 P.M. revealed the PCR COVID test for Resident #78 was ordered due to the resident's cough, to rule out COVID. Record review revealed before the PCR results were received for Resident #78, another rapid COVID test was completed on 10/27/20 and was positive. The positive	F 0880		

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F 0880	Continued From page 127 results were documented in the nurses notes on 10/27/20 at 12:18 P.M. Resident #78 was moved to another room on a unit with negative residents (not the COVID positive unit) on 10/27/20 and was placed in a room with Resident #100 (who had tested positive on 10/27/20). Review of a room change list revealed Resident #78 was moved to the COVID positive unit on 10/30/20. Interview with RN #203 on 10/27/20 at 1:45 P.M. revealed Resident #78 was positive for COVID and Resident #9 was not. She stated both residents were on quarantine guidelines which included wearing gown, gloves, mask over N95 mask, shoe covers, and eye protection when entering room. Interview with LPN, Infection Prevention Nurse #201 on 10/27/20 at 2:20 P.M. revealed Resident #78 was positive for COVID and was on isolation precautions. However, Resident #9, her roommate, was not on any type of isolation or quarantine precautions. Observations on 10/27/20 at 2:50 P.M. revealed Resident #78 (who was COVID-19 positive) still residing in the room with Resident #9, (not on COVID positive unit). Observations at that time revealed State Tested Nursing Assistant (STNA) #202 entered Resident #78's room. STNA #202	F 0880		

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F 0880	Continued From page 128 was wearing an N95 mask and eye protection goggles with gown, gloves, and shoe covers. She provided care for Resident #78. When she came out of the room, STNA #202 stated she assisted the resident with her oxygen tubing. STNA #202 removed the gown, gloves, and shoe covers prior to exiting the room. She then removed the eye protection goggles and placed them down, lens side down, on the PPE cart outside the room. She was not observed to clean the goggles and left them laying on the PPE cart. She used hand sanitizer. She did not change the N95 mask and proceeded to Resident #3's room (this resident was COVID-19 negative) and asked that resident if she was ready to go to bed. Observations on 10/28/20 at 6:30 A.M. and interview with LPN #214 revealed Resident #9 was not on quarantine/isolation precautions at this time, even though this resident was exposed to Resident #78, her roommate, who tested positive for COVID-19 on 10/27/20. Observations on 10/28/20 at 6:40 A.M. revealed Resident #78 (who was COVID-19 positive) and Resident #100 in a room together on the 300 unit (not the COVID unit). This was a unit where all the other residents were negative for COVID-19. 4 (b). Review of the medical record for Resident #100 revealed the resident was	F 0880		

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F 0880	Continued From page 129 admitted to the facility on 11/03/19. Review of nurse's notes dated 10/16/20 at 2:30 P.M. revealed the resident was complaining of nausea, myalgia, and decreased taste. An order was obtained for a COVID-19 test. The rapid test on 10/16/20 was negative. There was no evidence the resident was placed on quarantine/isolation precautions due to symptoms. On 10/26/20 at 12:44 A.M. the resident had a temperature of 101.8. On 10/27/20 at 3:32 P.M. a rapid COVID test was positive. The resident remained on a unit with negative residents. Resident #100 was placed on quarantine on 10/27/20 and another positive resident (Resident #78) was moved into her room on 10/27/20. Resident #100 did not have a roommate prior to 10/27/20. On 10/30/20 the facility received a positive PCR COVID test result and the Resident #100 was moved to the COVID positive unit. Observations on 10/28/20 at 6:40 A.M. revealed Resident #100 was in a room on the 300 unit (not the COVID unit). This was a unit where all the other residents were negative for COVID-19. Interview with LPN, Infection Prevention Nurse #201 on 10/28/20 at 7:30 A.M. revealed Resident #100 had a cough and fever on 10/27/20 so a rapid COVID test was done. LPN #201 confirmed the test was positive. She confirmed Resident #100 was not on the COVID positive unit.	F 0880		

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F 0880	Continued From page 130 The LPN confirmed there were four residents on the COVID unit who were negative for COVID-19. She stated she did not know what the facility policy was regarding having a COVID unit or a quarantine unit. LPN #201 confirmed the facility did not have a quarantine unit and residents who were on quarantine were spread throughout the facility. The LPN confirmed Resident #100 was not on isolation precautions during the time she was having symptoms of COVID-19. 5 (a). Observations on 10/27/20 at 12:45 P.M. on the 100 unit revealed a sign on the door of Resident #56 and Resident #125's room to see the nurse before entering. Interview with LPN #206 on 10/27/20 at 12:45 P.M. revealed Resident #125 was on contact/droplet precautions due to having been out of the facility for a physician appointment and possibly being exposed to COVID-19. However, she confirmed the resident did not have a physician's order for isolation precautions. She stated she was not sure if Resident #56 was on isolation precautions or not. She confirmed Resident #56 did not have an order either for isolation precautions. She stated she thought he was on precautions or he would not be in a room with Resident #125. Observations on 10/27/20 at 12:46 P.M. revealed STNAs #204 and #205 went into Residents #125 and Resident #56's room.	F 0880		

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F 0880	Continued From page 131 Neither STNA applied any eye protection prior to entering the room. They wore N95 masks but did not change the masks when leaving the room. STNA #204 proceeded to the kitchen to obtain something for a resident and STNA #205 proceeded to the 200 unit to pick up meal trays wearing the same N95 masks that was worn in Residents #125 and #56's room. 5 (b). Observations on 10/27/20 at 12:55 P.M. revealed a sign on the door of Residents #50 and #92's room to see the nurse before entering. LPN #207 and RN #208 were observed in the room. LPN #207 was observed standing next to Resident 50's bed and a syringe was observed in her hand. LPN #207 was not observed wearing a gown, gloves, or eye protection. She only had on a N95 mask. RN #208 was standing next to her and later indicated she was in orientation. RN #208 also did not have on a gown, gloves, or eye protection. She only had on a N95 mask. On 10/27/20 at 1:00 P.M. during interview, LPN #207 stated she was administering a bolus tube feeding to Resident #50. She confirmed she was not wearing gloves. She stated Resident #50 was not on isolation precautions. She stated only the roommate was on isolation precautions (Resident #92). LPN #207 stated Resident #92 was on isolation precautions as he	F 0880		

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F 0880	Continued From page 132 had been out of the facility for chemotherapy. Record review revealed neither Resident #50 nor Resident #92 had physician orders for isolation precautions. Interview with LPN, Infection Prevention Nurse #201 on 10/28/20 at 7:30 A.M. revealed both Residents #50 and #92 were on isolation precautions due to being new admissions to the facility. She stated the facility did not have a producible tracking system for residents on isolation precautions to determine why they were on it or when it started or when it ended. Interview with the DON on 10/29/20 at 2:45 P.M. confirmed Residents #114, #95, #27, #22, #78, #100, and #111 did not have physician orders for isolation precautions related to COVID-19. On 10/30/20 at 9:30 A.M. during interview the DON stated the facility had put up signage the night before to instruct staff on how to apply and remove PPE. She stated this had not been up prior for residents on isolation precautions. 5 (c). Observations on 10/27/20 at 3:30 P.M. on the COVID positive unit revealed STNA #210 came out of Resident #22's room (positive for COVID-19). STNA #210 took off her gown and gloves. She was not observed to sanitize her hands. She then put on a gown and gloves and entered	F 0880		

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F 0880	Continued From page 133 Resident #95's room (positive for COVID-19). On 10/27/20 at 3:52 P.M. STNA #210 was observed coming out of a resident room on the COVID positive unit. She removed her gown and gloves and, without sanitizing her hands, got a packet of new isolation shoe covers, opened it, and placed the shoe covers in the PPE containers at resident doors. She then pushed the clean linen cart down the hall and placed linens in the linen closet. Interview with STNA #210 on 10/27/20 at 3:40 P.M. confirmed staff on the COVID positive unit wear the same N95 mask all shift for COVID positive residents and COVID negative residents. Interview with RN #209 on 10/27/20 at 3:50 P.M. revealed the staff on the COVID positive unit wear the same N95 mask the whole shift. She stated they wear the same N95 mask into the rooms of residents who are positive and the rooms of residents who are negative. She stated she only cleans her face shield at the end of her shift, not after each resident contact. Interview with LPN, Infection Prevention Nurse #201, on 10/29/20 at 10:00 A.M. confirmed all staff wear the same N95 masks all shift and do not change between residents. She stated staff should use bleach wipes to clean eye protection after each resident contact.	F 0880		

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F 0880	Continued From page 134 5 (d). Observations on 11/03/20 at 9:40 A.M. revealed STNA #212 came out of Resident #117's room. RN #213 identified the resident as being on isolation precautions due to his previous roommate being positive for COVID-19. STNA #212 removed her gloves and gown; used hand sanitizer; removed her face shield and laid it on the bedside table inside the room with the outside of the shield facing down. She removed her surgical mask which was over her N95 mask. She then put on gloves and cleaned the face shield. She then hung the clean face shield on the doorknob of the room door. She stated there are supposed to be hooks inside the room and on the outside of the door. The hook inside the room is to hang the dirty face shield on until you can clean it. The hook on the outside of the door is to hang the clean face shield on after you clean it. She confirmed she had to lay the dirty face shield on the bed side table as there were no hooks in the room. She was not observed to clean the bedside table prior to leaving the room. Interview with Corporate RN #200 on 11/03/20 at 9:55 A.M. confirmed there were no hooks inside or on the door for Resident #117's room and there should have been. 5 (e). Observations on 11/03/20 at 10:00 A.M. revealed five residents in the outside smoking area. STNA #212 was with the	F 0880		

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F 0880	Continued From page 135 residents while they were smoking. When Resident #102 was done smoking her cigarette, she handed it to STNA #212. (Resident #102 was COVID negative at that time). STNA #212 took the cigarette in her ungloved hand and touched the part that went in the resident's mouth with her fingers. She then put the cigarette on the ground, stomped it out, picked it up again, and put it in a plastic cup she was holding. She then, without sanitizing her hands, went over to the keypad on the outside of the door entering the facility, and punched in the code to allow a resident to go inside the building. Interview with STNA #212, at that time, confirmed she did not sanitize her hands after handling the part of the cigarette that had went in Resident #102's mouth with her bare hands. She confirmed she touched the keypad, that any staff or resident could touch, without sanitizing her hands. 5 (f). Observations on 11/03/20 at 10:45 A.M. revealed RN #213 leaving a room on the 100 unit, this room had been identified housing a resident on quarantine due to potential COVID-19. She removed her PPE and was observed cleaning the face shield she had removed without wearing any gloves. She then hung the clean face shield on the room door. The facility provided documentation that	F 0880		

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F 0880	Continued From page 136 stated staff were educated beginning 10/29/20 to remove PPE when exiting a quarantine/isolation room in the following order: remove gloves, wash hands, put on new gloves, remove face shield, gown, and surgical mask, clean face shield and place on clean hook, remove gloves, and clean hands. Interview with RN #213 on 11/03/20 at 11:50 A.M. confirmed she was not wearing gloves when she cleaned her soiled face shield and should have. She stated this was an error on her part. She stated that the signage in the room gave instructions on how to remove PPE but did not include instructions on how to clean the face shield. 6. Interview with the Administrator and Director of Nursing on 10/29/20 at 11:15 A.M. revealed they had been in contact with the local health department regarding the positive cases of COVID-19 for residents and staff. They stated the local health department was aware they had residents negative for COVID-19 on the COVID positive unit. The Administrator stated the local health department contact told them not to move the COVID negative residents off the COVID positive unit. She further stated the local health department was aware they had COVID positive residents on a unit with negative residents. She stated the local health department did not have a problem with this.	F 0880		

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F 0880	Continued From page 137 Interview with Local Health Department Nurse #211 on 10/29/20 at 2:10 P.M. revealed she was not aware the facility had COVID-19 negative residents on the COVID positive unit and that this should not happen. She also stated she was not aware the facility had COVID-19 positive residents on a unit with negative residents. She stated this had not been discussed with her by the facility. 7. On 11/02/20 at 11:26 A.M. five resident meal trays were observed on a cart outside the COVID-19 unit. A staff from the COVID-19 unit was observed to open the door and pull the cart in the unit. A concealed metal tray cart was left outside the COVID-19 unit on 11/02/20 at 11:43 A.M. and staff from the COVID-19 unit were observed to open the door to the unit and pull the tray delivery cart inside. On 11/02/20 at 1:20 P.M., a large metal tray cart was observed sitting in the hallway adjacent to the nurse's station on the COVID-19 unit. On 11/02/20 at 11:17 A.M. during interview the Administrator reported that dietary staff take the tray carts to the door of the COVID-19 unit and notify staff the carts are there. Staff from the COVID unit then come to the door and pull the carts inside the unit and pass the trays. The Administrator stated when the carts are to be returned to the kitchen, staff notify the	F 0880		

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F 0880	Continued From page 138 kitchen and push the tray carts outside the unit and the dietary staff take the trays to the kitchen where they are cleaned. On 11/02/20 at 1:15 P.M. during interview LPN #201 stated the meal cart was brought outside of the COVID unit and dietary called to let them know it was there. LPN #201 stated staff would go to the double door and wheel the carts on the unit. When they were finished with the carts, staff would push the empty cart outside the unit doors and kitchen staff would take the cart to the kitchen and clean the cart. LPN #201 confirmed the cart was not cleaned on the unit and was taken down a common hallway before entering the kitchen service area to be cleaned. On 11/09/20 at 3:32 P.M. during an interview with Dietary Manager (DM) #309 she reported kitchen staff obtained the meal carts from the hallway outside the COVID unit and the carts are taken to the dining room where kitchen staff wash each cart with soap and water, rinse and then spray with a sanitizing solution. DM #309 reported when the carts are taken into the kitchen for the next meal, they are sanitized again, just to ensure no transmission. DM #309 reported she was not aware of any type of cleaning or sanitizing nursing staff performed before they removed the carts from the COVID unit.	F 0880		

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F 0880	Continued From page 139 8. Observations on 11/09/20 at 12:20 P.M. revealed STNA #205 put on PPE to enter the room of a resident on quarantine (Room 210). STNA #205 had on an N95 mask and goggles. She put on a gown, surgical mask over the N95 mask, gloves and face shield prior to entering the room. She delivered the meal tray to the resident. When she was done, she removed the gloves and face shield. She hung the dirty face shield on the doorknob of the room door without cleaning it after use. She removed her gown and surgical mask and washed her hands. STNA #205 then put on a different face shield to deliver a tray to Resident #92 who was on quarantine. When she exited the room, she took off the face shield and laid it down on top of a box of gloves on the PPE caddy in the hallway without cleaning it. Interview with STNA #205 on 11/09/20 at 12:40 P.M. revealed there were no hooks in the rooms to hang the face shield on after use. She stated there was supposed to be a hook inside the room to hang the dirty face shield on until it was cleaned. Also, there was supposed to be a hook on the door to hang the face shield on after it was cleaned. She confirmed she did not clean the face shields prior to hanging the first one on the doorknob or prior to laying the second one on the PPE cart. Observations on 11/09/20 at 12:40 P.M.	F 0880		

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F 0880	Continued From page 140 revealed STNA #223 put on the face shield that had been worn by STNA #205 but had not been cleaned. 9. Interview with Resident #66 on 11/09/20 at 12:43 P.M. revealed she had just been moved to the room she was in (on the 200 unit) from the COVID unit. She stated that none of her personal belongings had been brought to the room and she wanted them. She stated her purse, wheelchair, and pictures had not been moved to her new room. However, observations on 11/09/20 at 12:43 P.M. revealed that there were items in the room with Resident #66 including a water pitcher with straw, snack items (bags of chips), flowers, and pictures on the wall. Additional interview with Resident #66 on 11/09/20 at 12:43 P.M. revealed that these items belonged to the resident who resided in the room prior to her. Interview with STNA #205 on 11/09/20 at 12:50 P.M. confirmed the personal items in the room with Resident #66 belonged to Resident #47, who had resided in the room prior to Resident #66. Interview with STNA #223 on 11/09/20 at 12:50 P.M. revealed that residents were being moved to new rooms without taking their personal belongings with them.	F 0880		

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F 0880	Continued From page 141 Therefore, residents were being placed in rooms with personal items that did not belong to them. She confirmed Resident #66 was placed in a room with Resident #47's personal belongings. She stated the STNAs have to try to clean the room before a new resident moves in. However, she stated staff could not clean the room when another resident's personal belongings were still in the room. She confirmed the food and water pitcher on Resident #66's side of the room belonged to Resident #47. Interview with LPN #207 on 11/09/20 at 1:05 P.M. confirmed Resident #66 was moved into a room with Resident #47's personal belongings still on the that side of the room. Review of the medical record for Resident #47 revealed the resident was moved from that room on 11/04/20. Record review also revealed she tested negative for COVID 19 on 11/02/20. Review of the medical record for Resident #66 revealed the resident was moved from the COVID unit to the 200-unit room on 11/09/20. Record review also revealed she tested positive for COVID 19 on 10/31/20. 10. Observation on 11/05/20 at 12:05 P.M. of the memory care unit/400-hall revealed Room 401 had a quarantine cart	F 0880		

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F 0880	Continued From page 142 outside the door and a note posted on the door that read "Please see nurse before entering". It was noted that Resident #76 who currently resided in the room was placed in quarantine on 10/29/20 due to her former roommate testing positive for COVID-19. Continued observation revealed Resident #113 who was COVID negative, laying in the roommate bed in Room 401.. Resident #63 was observed entering room 401 and proceeding to 401 B and touching Resident #76's feet and bed side table. Resident #63 then proceeded to exit room 401 and enter room 403 and lay in bed. Resident #113 was then observed getting out of the bed in 401 and exiting the room and entering room 400, going into the bathroom in room 400, opening the closet door and touching clothing in the closet and then laying down on the bed in Room 400 . Interview on 11/05/20 at 12:25 P.M. with STNA #520 confirmed Room 401 was a quarantine room and Resident #113 and Resident #63 were noted entering Room 400 and touching multiple items in that room along with lying in bed, then proceeding to enter additional rooms that were not their own rooms thereby potentially spreading the COVID-19 virus. 11. Interview on 11/05/20 at 3:30 P.M. with STNA #506 revealed Resident #42, who had tested positive for COVID-19 on 11/02/20, was transferred to the COVID	F 0880		

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F 0880	Continued From page 143 unit on 11/03/20. Prior to being transferred to the COVID unit, there was another resident who had resided in that room. STNA #506 revealed the room was not cleaned prior to the facility transferring Resident #42. 12. Observation on 11/09/20 at 9:30 A.M. of the memory care unit/400-unit revealed there were COVID-19 positive residents residing in the same rooms with COVID negative residents. Resident #67 who had tested COVID-19 positive on 11/08/20 and was residing in a room with Resident #29 who had tested COVID negative. Resident #96 who tested COVID-19 positive on 11/08/20 was residing in a room with Resident #107 who was COVID negative. Interview on 11/09/20 at 10:00 A.M. with the DON confirmed there was COVID-19 positive residents residing with COVID negative residents on the 400- hall. 13. Observation on 11/09/20 at 10:30 A.M. of the 200 unit (COVID-negative unit) revealed there was COVID-19 positive residents residing in the same room with COVID negative residents. Resident #55 who tested positive for COVID-19 on 11/07/20 was in a room with Resident #93 who was COVID negative. Interview on 11/09/20 at 10:35 A.M. with the DON confirmed Resident #55 who was COVID-19 positive was residing in the	F 0880		

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F 0880	Continued From page 144 room with Resident #93 who was COVID negative. 14. Interview on 11/09/20 at 12:10 P.M. with Resident #81 who tested COVID-19 positive on 10/31/20 revealed when she was moved from her original room on 10/31/20 to the COVID unit, all her personal belongings were left in her original room on the 200-unit. On 10/31/20, Resident #81 was then moved to a room on the 700-unit. When asked about the belonging that were in her current room, Resident #81 claimed she did not know and did not recognize any of it. Resident #81 also revealed she has been eating the food and drinks in the room and confirmed the food and drinks were not hers. Resident #81 claims that all her personal belongings were left in her room on the 200-unit. Interview on 11/10/20 at 11:22 P.M. with Resident #81's daughter revealed there was a day (she could not remember the exact date) but it was the week of 11/06/20 when her husband went to the facility to fill up the bird feeders located outside of her mom's old room. The daughter received a phone call from her husband informing her that he saw another resident in her mom's old room, laying in the bed with all her mom's personal belongings still in the old room. 15. Interview on 11/09/20 at 3:00 P.M. with	F 0880		

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F 0880	Continued From page 145 STNA #507 confirmed the belongings noted in a room on the 200-unit did not belong to the current resident residing in that room. The items noted in the room belonged to Resident #47 and Resident #66 was currently in there. The items in this same room on the other side belonged to Resident #102 who was transferred to a sister facility, and Resident #71 was currently in there. STNA #507 claimed that she was aware Resident#71 was going to be moved into the room sometime that day, but not sure when. STNA #507 claimed that she noticed a resident laying in in the B bed and then was informed that it was Resident #71. STNA #507 confirmed that she had not had a chance to strip the dirty linen off the bed or properly clean the room from when Resident #102 had resided in that room prior. STNA #507 confirmed Resident #71 was lying in a bed with dirty and used linen from another resident who had tested COVID-19 positive and all the items noted in the room belonged to other residents and not the residents who currently resided in the room. 16. Observation on 11/11/20 at 3:45 P.M. revealed the back section of the 100 unit was converted into a COVID unit, and the front section of the 100 unit was a quarantine unit. There was a plastic barrier noted with a zipper to allow entrance. Noted was another plastic barrier designed the same way. In-between the two plastic	F 0880		

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F 0880	Continued From page 146 barriers was a 3 drawered cart that housed PPE. Continued observation revealed Dietary Aide #508 exiting the COVID unit and passing through both plastic barrier doors without removing his contaminated PPE. 17. On 11/13/20 from 2:00 P.M to 2:15 P.M. observation of the 300- unit (COVID unit) revealed the trash barrel located in the hallway did not have a lid on it and trash was observed overflowing out of the top of the barrel. A red isolation bag was noted sitting on the floor at the end of the 300- hall by the emergency exit. Observation revealed in this red isolation bag were dirty items from mealtime such as the disposable meal trays, Styrofoam containers, and food. At the time of this observation on the 300-unit STNA #521 was observed without goggles or a face shield on. The STNA was carrying smoking items and was getting ready to take residents out for smoke break. Interview with STNA #521 revealed she had been looking for a certain kind of googles to wear and did not like the goggles she had because they suctioned to her face. STNA #521 revealed she had not worn goggles or a face shield all day. Continued observation of STNA #521 revealed she removed her PPE (except for her mouth cover) and placed the PPE in a small trash can located outside the door of a resident room. The small trash can	F 0880		

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F 0880	Continued From page 147 where STNA #521 placed her soiled PPE was noted to be overflowing with used PPE and the dirty items were noted on the floor. Review of CDC guidelines including core practices for nursing homes revealed the facility should identify space in the facility that could be dedicated to the care of residents with COVID-19. This would be used to cohort residents with COVID-19. Review of CDC guidelines indicated for residents with new-onset suspected or confirmed COVID-19 test results the facility should: • Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of SARS-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission. • If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.	F 0880		

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F 0880	Continued From page 148 • Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. Review of the undated facility policy titled Isolation Unit revealed the purpose of the policy was to establish protocol within a pandemic or outbreak situation whereas a cluster-isolation concept may be required for multiple residents at different variances in infection cycle. The plan included: establish unit/hall that will allow separation from general population in facility as possible; maintain doors to unit closed at all times; assign dedicated staff to unit as possible per staffing availability. Admission criteria for the isolation unit included COVID positive status. Review of the facility policy dated February 2019 and titled Isolation Precautions revealed Standard Precautions should be practiced by all staff and should be used for all resident's care at all times. Standard precautions apply to blood, all body fluids,	F 0880		

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F 0880	Continued From page 149 secretions, and excretions. Standard precautions include hand hygiene, use of gloves, gown, mask and eye protection or face shield depending on the anticipated exposure. The policy stated Isolation Precautions may be indicated for specific disorders. Isolation Precautions may include airborne, contact, or droplet isolation. The physician determines when isolation precautions are needed and the duration. The policy stated cohorting is the practice of grouping residents infected with the same infectious agent together to confine their care to one area and prevent contact with susceptible individuals. Review of the facility policy revised 07/20/20 and titled Triage and Quarantine Management revealed all residents admitted will be screened for fever or signs/symptoms of COVID-19. All residents will be placed in quarantine upon admission for 14 days to monitor for signs and symptoms of COVID-19. Full PPE will be worn by staff when delivering care to the residents who are in quarantine to include a face mask, a face shield, gown, and gloves. If rooms are not available on designated quarantine or isolation unit related to bed availability, facility may quarantine resident in current location while following same standard precautions as outlined including private room as possible with private bathroom. This deficiency substantiates Master	F 0880		

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F 0880	Continued From page 150 Complaint Number OH00117118 which includes Complaints Number OH00116434, OH00116553, OH00116914, OH00117045, OH00117075, OH00117087, and OH00117115. This deficiency is an example of continued noncompliance from the survey dated 10/06/20.	F 0880		
F 0908 SS=D	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This STANDARD is not met as evidenced by: Based on medical record review, interview, observation, and review of maintenance log and invoices the facility failed to ensure a sit-to-stand, transfer assist device was in proper working condition for dependent residents. This affected one, Resident #83, of three residents reviewed for the use of a sit-to-stand for transfers. Not affected included Resident #11, and #44. The facility census was 126. Findings include: Review of the medical record for Resident #83 revealed an admission date of 10/19/19 with diagnoses of need for assistance with personal care, muscle	F 0908	F908 Resident #83's sit to stand was ordered on 11/9/2020. Residents potentially affected by inoperable equipment had their equipment audited on 11/30/2020 by the Maintenance Director/ Designee. Any Equipment found inoperable was removed from patient care and will be repaired/or replaced by 12/4/2020. In order to ensure that resident equipment be maintained in safe operating conditions, the Maintenance Director was educated on equipment audit procedure and work order process by the Administrator/designee by 12/4/2020. Residents with lift transfers will be assessed by the therapy department to verify safe transfers are care planned on 12/4/2020. All staff will be educated on the work order process by the Administrator/designee by 12/4/2020. 3-5 residents will be audit 3-5 times/week by the Administrator/designee in order to verify that equipment is operating condition. All Audit Results will be forwarded to the QAPI committee for evaluation of continuing need for audit or discontinuation.	12/07/2020

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F 0908	Continued From page 151 weakness, difficulty walking, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and dependence on wheelchair. Review of Resident #83's quarterly Minimum Data Set (MDS) 3.0 assessment dated for 07/29/20 revealed the resident was independent for daily decision making. Resident #83 required extensive assistance from two staff members for bed mobility, transfers, and physical help in part by two staff members for bathing due to upper and lower extremity impairment to one side. Review of Resident #83's plan of care dated 10/21/19 revealed the resident had a self care deficit related to status post cerebral vascular accident affecting right dominant side. Interventions included resident's needs will be met, encourage resident to get up into wheelchair 4-5 days a week for 6-8 hours a day, and resident transfers with the use of two staff members and the use of a sit-to-stand (a patient lift or or electrical/hydraulic power transfer device that allowed safer and easier transfers for dependent residents). Observation on 11/04/20 at 2:50 P.M. revealed State Tested Nurse Aide (STNA) #212 and #511 exiting Resident #83's room. Resident #83 was sitting in his electric wheelchair which was placed by the window. Continued observation	F 0908		

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F 0908	Continued From page 152 revealed a sit-to-stand placed next to the wall in his room between A and B bed. Multiple items including bed linen and Resident #83's clothing were noted to be placed on the sit-to-stand. Interview on 11/04/20 at 3:00 P.M. with Resident #83 revealed he had just gotten up for the day after asking staff to get him up since 6:30 A.M. that day. Resident #83 pointed to the sit-to-stand and said it was broken and that was what they used to get him out of bed. Resident #83 confirmed STNA #212, and #511 just got him out of bed without the use of the sit-to-stand. Interview on 11/04/20 at 3:23 P.M. with STNA #212 confirmed the sit-to-stand was broken and it took two staff members to get Resident #83 out of bed. STNA #212 confirmed the resident had an order for all transfers to be done with the use of the sit-to-stand. STNA #212 claimed the sit-to-stand had been broken for weeks and no one had done anything about it even after it was reported to management. Interview on 11/05/20 at 12:00 P.M. with STNA #406 confirmed the sit-to-stand had been broken for a few weeks and that staff could not safely use it to transfer residents. STNA #406 revealed the area on the machine where residents are to place their knees to keep them form sliding, was broken off. STNA #406 revealed the facility only had one sit-to-stand for the whole	F 0908		

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F 0908	Continued From page 153 facility. STNA #406 claimed staff have not been able to provide Resident #83 with his preferred showered due to the sit-to-stand being broken and any transfers for this resident requiring two staff members and most of the time there was not enough staff to complete this task. STNA #406 added even with two staff members, transfers with Resident #83 were very difficult and not safe due to the resident not being able to assist or bear weight. Interview on 11/09/20 at 10:12 A.M. with the Maintenance Director #528 confirmed there was only one sit-to-stand for the whole facility. Maintenance Director #528 revealed that he was not aware the sit to stand was broken until 10/29/20 and this was completed verbally, not through an work order. Maintenance Director #528 claimed he was not aware of when the sit-to-stand became broken. Review of the facility's maintenance log revealed no indication that the sit-to-stand had been reported to the maintenance director for repair. Review of the invoice provided by the Maintenance Director #528 revealed a new sit-to-stand had been ordered on 11/09/20 at 10:12 A.M. This deficiency is an incidental finding, found during investigation for Master	F 0908		

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F 0908	Continued From page 154 Complaint Number OH00117118 which includes Complaints Number OH00116434, OH00116553, OH00116914, OH00117045, OH00117075, OH00117087, and OH00117115.	F 0908		