STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335313	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Memorial Hospital S N F	200 Ohio Street Medina, NY 14103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview, and record review conducted during the Standard survey completed on [DATE], the facility did not ensure the system developed for advance directives was implemented in a manner that was consistent with residents' wishes for three (Resident #6, #21, and #24) of 16 residents reviewed for advance directives. Specifically, the facility did not ensure that all advance directive identifiers were consistent with the resident's advance directives. Facility staff were utilizing a process that was not consistent with the facilities current documented processes. The findings are: The policy and procedure titled Advanced Directives RHCF (Residential Health Care Facility) dated [DATE] documented the facility is committed to honoring the wishes of their patients' regarding their treatment. The Social Worker will inform the patient and/or health care agent and/or surrogate that the patient has a full code order. The Full Code status will be communicated through the application of a Blue Star sticker on the patient's wristband as well as a Blue Star placed at the head of the patient's bed. For any patient who is unable to or chooses not to wear a wristband and has a DNR order, a licensed nurse will provide education to patients and/or patient representatives that CPR will be initiated until code status is confirmed. 1. Resident #6 had diagnoses including dementia, chronic kidney disease stage 3, and osteoarthritis. The Minimum Data Set (Resident Assessment tool) dated [DATE] documented Resident #6 had moderate cognitive impairment, and advance directives that included do not resuscitate. The Kardex (guide used by staff to provide care) dated [DATE] documented Resident #6 had the advance directive of do not resuscitate. The Medical Orders for Life-Sustaining Treatment (MOLST) dated [DATE] documented a do not resuscitate order. The Order Summary Report dated [DATE] included a physician order for do not resuscitate. During an observation on [DATE] at 12:28 PM Resident #6 was observed in the main dining room, the name band on the resident's wrist did not include a red dot. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #21 had diagnoses that included venous insufficiency (improper functioning of the vein values in the leg), heart failure and hypertension. The Minimum Data Set, dated dated dated [DATE] documented Resident #21 was cognitively intact. Review of the Comprehensive Care Plan with date initiated [DATE] documented that Resident #21 had Medical Orders for Life-Sustaining Treatment in place. Interventions include that Resident #21 was a do not resuscitate and do not intubate. Review of the Physician Orders dated [DATE] documented that Resident #21 had a medical provider order for do not resuscitate and do not intubate. Review of the Medical Orders for Life-Sustaining Treatment signed by Resident #21 documented on [DATE] documented that the resident's wishes were to have a do not attempt resuscitation-allow natural death medical providers order. During an observation and resident interview on [DATE] at 3:05 PM, Resident #21 had a red dot sticker on the spine of their medical record paper chart and a red dot sticker on their name placard outside of their door. There was no red dot sticker observed on their name tag that was attached to their wheelchair. Resident #21 stated that their advance directive wishes were to be a do not resuscitate. Resident #21 looked at their name band that was attached to their wheelchair and stated that it did not have a red dot sticker on it and added that it was an old name band. 3. Resident #24 had diagnoses that included dementia, Alzheimer's disease, and chronic obstructive pulmonary disease. The Minimum Data Set, dated dated dated [DATE] documented Resident #24 had severe cognitive impairment. Review of the Comprehensive Care Plan with date initiated [DATE] documented that Resident #24 had advance directives. Interventions include that Resident #24 was a do not resuscitate and do not intubate. Review of the Physician Orders dated [DATE] documented that Resident #24 had a medical provider order for do not resuscitate and do not intubate. Review of the Medical Orders for Life-Sustaining Treatment signed by Resident #24's health care proxy on [DATE] documented that the resident's wishes were to have a do not attempt resuscitation-allow natural death medical providers order. During on observation on [DATE] at 2:55 PM, Resident #24 had a red dot sticker located on their name band that was attached to their wheelchair and a red dot sticker on the name placard outside of their bedroom door. Resident #24 spine of their medical record paper chart did not have a red dot sticker. During an interview on [DATE] at 9:15 AM, Registered Nurse #2 stated resident code status identifiers were a red dot on the residents' name band, red dot on spine of chart, and a red dot on the door placard for residents with a do not resuscitate status/order. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:52 AM, Certified nursing assistant #1 stated residents wear bracelets with codes on them, red is do not resuscitate but was unsure what the red dot on the door placard meant. During an interview on [DATE] at 10:52 AM, Charge Nurse Registered Nurse #1 stated advance directive status can be found in the electronic medical record, the Medical Orders for Life-Sustaining Treatment. Additionally, for a resident with a do not resuscitate there were red dots on the spine of chart, name band, and door placard. During an interview on [DATE] at 12:36 PM, the Interim Director of Nursing stated they were unsure of the color codes without looking at a graph, but there would be an identifier on the resident's name band and spine of chart. If all identifiers were not accurate, there was the possibility a resident's code status wishes would not be honored. During an interview on [DATE] at 1:19 PM, the Administrator stated the advance directive policy and procedure dated [DATE] was the current advance directive policy. They stated they were aware of red dots on the resident name bands, door placards, and spines of chart signifying do not resuscitate but were unaware of where the red dot process originated. 10NYCRR 400.21

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview and record review conducted during a Standard survey completed on 5/24/24, the facility did not ensure residents were free from physical restraints imposed for purposes of discipline or convenience that were not required to treat the resident's medical symptoms, used for the least amount of time and document ongoing re-evaluation of the need for restraints for three (Resident #9,23, and 24) of three residents reviewed for physical restraints. Specifically, Residents #9, #23 and #24 had no assessments for the initiation or ongoing re-evaluation of the continued use of position change alarms. Additionally, there were no provider orders or notes to address the medical reason that warranted the use of the device. The findings are: The policy and procedure titled Alarm Use dated 11/1/2020 documented position change alarms are defined as chair and bed sensor pads, bedside alarmed mats, and alarms clipped to resident clothing. Position change alarms are never to be used as a restraint. Examples of negative potential or actual outcomes which may result from the use of position change alarms as a physical restraint include loss of dignity, bowel and bladder incontinence and sleep disturbance. The State Operational Manual issued 2/3/2023 defines position change alarms as alerting devices intended to monitor a resident's movements and emits an audible signal when a resident moved in certain ways. Additionally, a position alarm may limit a resident's movement when the resident was afraid to move to avoid setting off the alarm. 1.Resident #9 had diagnoses including depression, anxiety and atrial fibrillation (irregular heart rhythm). The Minimum Date set (resident assessment tool) dated 4/21/2024 documented the resident was understood, understands and was cognitively intact, an extensive assist of one person for ambulation and transfers and a bed/chair alarm was used daily. During an observation on 5/21/24 at 12:04 PM Resident #9 was observed in the main dining room in their wheelchair with an alarm on the seat of the wheelchair and the alarm box hanging from the wheelchair handle. During an observation on 5/22/24 at 2:05 PM Resident #9 was observed in their recliner in their room, feet were elevated with the alarm on the seat of the recliner and the alarm box was placed on the overbed table next to the recliner. During an observation on 5/23/24 8:38 AM Resident #9 was in their room in their wheelchair with the alarm box hanging from the wheelchair handle. During the observations, Resident #9 did not exhibit any unsafe movements or attempts to transfer self from the recliner or wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan dated 4/17/24 documented the resident was at risk for falls due to vision and hearing problems and adjustment to a new facility. Interventions included resident uses a pad alarm, and to ensure the device was in place at all times, initiated on 4/12/2024. Review of the interdisciplinary Progress Notes and provider notes dated 4/15/2024-5/23/2024 revealed no documented evidence that Resident #9 was assessed for, or consent was given for the use of the alarm. The current Physician Orders dated 4/15/2024 did not include documentation of an order for alarms. During an interview on 5/23/2024 at 8:43 AM, Resident #9 stated the blue box on the back of their wheelchair was an alarm, so they didn't get up and they thought it was in the seat of the wheelchair. Resident #9 stated they were getting used to the different sounds when it went off. Resident #9 stated it was on when they were in bed and if they moved around in bed too much it would go off and wake them up and they did not like that it woke them up. Resident #9 could not recall how long they have had the alarm and did not know why the alarm was being used. During an interview on 5/24/2024 at 8:49 AM, Certified Nursing Assistant #3 stated Resident #9 used the alarm because they were a fall risk. They were not sure why the resident had an alarm and did not believe the resident had fallen in the past and did not think the resident needed the alarm. During an interview on 5/24/2024 at 8:54 AM, Licensed Practical Nurse #3 stated Resident #9 used chair and bed alarms because they self-transferred a lot and was unsure if the resident had a history of falls. Licensed Practical Nurse #3 stated the resident has only been here a short time and I believe the alarm was initiated on admission. 2.Resident #23 had diagnoses including dementia, peripheral vascular disease (poor circulation of the lower extremities), and hypertension. The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment, required substantial/maximal assistance (helper does more than half the effort) with sit to stand transfer, had not experienced any falls since the prior assessment, and a bed/chair alarm was used daily. During an observation on 5/20/2024 at 12:08 PM, Resident #23 was observed sitting in a recliner at the nurse's station. A chair alarm was observed clipped to the back of the resident's shirt. During an observation on 5/22/2024 at 10:41 AM, Resident #23 was observed sitting in a recliner at the nurse's station. A chair alarm was observed clipped to the back of the resident's shirt. During an observation on 5/23/2024 at 11:51 AM Resident #23 was observed sitting in a recliner at the nurse's station. A chair alarm was observed clipped to the back of the resident's shirt. An interview was attempted at that time, and Resident #23 was unable to verbalize their name or the reason for the alarm. During the observations, Resident #23 did not exhibit any unsafe movements or attempts to transfer self from the recliner. The comprehensive care plan initiated 3/31/22, documented the resident was at risk for falls due to confusion. Interventions included alarm on at all times was initiated on 2/20/2023. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Kardex (care guide) dated 5/24/2024 included alarm on at all times. The current Physician Orders dated 5/24/24 did not include documentation of an order for alarms. Review of the interdisciplinary Progress Notes, Assessments, and Provider Notes from 1/1/24 to 5/24/24 revealed there was no documented evidence of an assessment to determine the indication or need for the use of alarms or a consent for the use of alarms. During an interview on 5/22/2024 at 9:50 AM, the Activities Director stated Resident #23 used the alarm for safety, to alert staff if they have attempted to self-transfer. During an interview on 5/23/2024 at 11:58 AM, Certified Nursing Assistant #2 stated Resident #23 utilized the alarm to notify staff if they attempted to self-transfer. During an interview on 5/23/2024 at 1:27 PM, Certified Nursing Assistant #4 stated Resident #23 utilized the alarm to alert staff if they attempted to get up from the recliner because they were unsteady with ambulation. Certified Nursing Assistant #4 stated Resident #23 had an overall decline in their activities of daily living and they don't try to get up as much as they used to. 3.Resident #24 had diagnoses that included dementia, Alzheimer's disease, and fracture of the left pelvis. The Minimum Data Set, dated dated dated [DATE] documented the resident was usually understood, usually understands, and had severe cognitive impairment. Review of the Comprehensive Care Plan dated 3/4/2023, documented that Resident #24 was at risk for falls related to an unsteady gait and fall with fractured pelvis. Interventions included that Resident #24 was to have an alarm at all times. Review of the Order Summary Report with active orders as of 5/12/2024 revealed no documented evidence of a medical provider's order for Resident #24 to have an alarm. Review of Medical Doctor #1's progress notes from 3/4/2024-5/13/2024 revealed no documentation regarding Resident #24's use of an alarm. Review of the interdisciplinary Progress Notes dated 3/4/2024-5/23/2024 revealed no documented evidence that Resident #24 was assessed for, or consent was given for the use of the alarm. During intermittent observations on 5/21/2024 at 8:37 AM, 5/22/2024 at 9:43 AM, 5/22/2024 at 12:12 PM, 5/22/2024 at 1:31 PM, 5/23/2024 at 8:32 AM, 5/23/2024 at 10:17 AM, 5/23/2024 at 11:52 AM and 5/24/2024 at 8:19 AM, Resident #24 was either sitting in their wheelchair or a recliner chair with an alarm box that was clipped to the chair that had an attached magnet on a string attached to their top. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/21/2024 at 3:39 PM, Resident #24 stood up from their wheelchair in the living space at the nursing station. The chair alarm was still attached to the resident with the alarm box still attached to the wheelchair. The alarm did not sound due to there being enough slack in the string that remained attached to the resident. Registered Nurse #1 approached Resident #24 and assisted them to sit back into the wheelchair. Registered Nurse #1 demonstrated how the alarm sounded by removing the magnetic piece from the alarm box. Registered Nurse #1 stated that Resident #24 had an alarm to alert staff when Resident #24 stood up and that there were many residents on the unit that utilized alarms. During a telephone interview on 5/24/2024 at 9:24 AM, Medical Doctor #1 stated they did not recall if they wrote an order for Resident #24's alarm. Medical Doctor #1 stated that Resident #24 had a fractured pelvis that was not completely healed and hoped the alarm would prevent Resident #24 from further hurting themselves by restricting their movement. During an interview on 5/24/2024 at 10:34 AM, the Administrator stated they could not locate documented evidence that Resident #24 had an order, was assessed for, or had a consent for the use of an alarm. The Administrator stated that Resident #24 alarm was the least restrictive safety intervention to prevent them from falling. During an interview on 5/24/2024 at 9:12 AM, Registered Charge Nurse #1 stated chair and bed alarms were used for residents #9, #23 and #24 because they were at risk for falls. Resident #24 fell and fractured their pelvis and Resident #9 and #23 self-transferred. The interdisciplinary team would discuss the resident's behaviors as a team at the residents quarterly meeting. There were no written assessments because the alarm was not a restraint as it's not restricting the residents for getting up. Families were notified by phone or when they come to visit and see the alarm on the resident. MD was made aware on rounds and there were no orders for the alarms. During an interview on 5/24/2024 at 9:44 AM, the Chief Nursing Officer stated they would expect there to be a reason for the use of the alarm, an assessment, get provider approval and family notification. During an additional interview on 5/24/2024 at 10:49 AM, the Administrator stated the interdisciplinary team would meet and would talk about the reason for the alarm other than that, the charge nurse would know more. 10 NYCRR 415.4(a)(2)(3)