

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Heritage Manor Jewish Hm For		STREET ADDRESS, CITY, STATE, ZIP CODE 517 Gypsy Lane Youngstown, OH 44504	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0570</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure the security of all personal funds of residents deposited with the facility.</p> <p>47570</p> <p>Based on review of resident funds accounts, review of surety bond, interview and review of facility policy, the facility failed to provide a surety bond large enough to cover the total amount of money in all resident personal funds accounts. This affected 20 residents (Resident #1, #2, #4, #5, #8, #9, #18, #21, #24, #25, #26, #27, #31, #36, #43, #47, #53, #55, #65, #99) of 20 residents with personal funds accounts.</p> <p>Findings include:</p> <p>A review of resident fund account for the facility dated as of 10/31/24 revealed a total amount of \$35,221.26 dollars. Resident #1, #2, #4, #5, #8, #9, #18, #21, #24, #25, #26, #27, #31, #36, #43, #47, #53, #55, #65, #99 had personal funds accounts with the facility.</p> <p>A review of resident fund accounts revealed Resident #5 had a current total of \$32,805 in their account.</p> <p>A review of the document by Selective Insurance Company of America, bond number B 400737, revealed an effective date of 07/10/24. The document revealed the surety bond was for \$25,000 dollars.</p> <p>Interview on 11/19/24 at 10:08 A.M. with Director of Operations (DO) #300 revealed Resident #5 received a large amount of money each month. DO #300 verified the surety bond did not cover resident funds and asked Resident #5's guardian to wire the money into the guardianship account.</p> <p>Review of facility policy titled Resident Personal Funds dated January 2024, revealed the facility would purchase a surety bond to assure the security of all personal funds of residents deposited with the facility.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522</p> <p>Based on record review and interview, the facility failed to ensure care plans were in place for high risk medications. This affected one resident (#31) out of five residents reviewed for unnecessary medications. Facility census was 68.</p> <p>Findings include:</p> <p>Review of Resident #31's medical record revealed an admitted [DATE] and diagnoses including type two diabetes, epilepsy, COVID-19, depression, sepsis, hypertension, other pulmonary embolism without acute cor pulmonale and hyperlipidemia.</p> <p>Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #31 had severe cognitive impairment and received antipsychotic, antidepressant, anticoagulant, antibiotic, hypoglycemic and anticonvulsant medications.</p> <p>Review of Resident #31's physicians' orders revealed an order dated 06/10/24 for rivaroxaban (Xarelto) oral tablet 20 milligrams, give one tablet by mouth in the evening related to other pulmonary embolism without acute cor pulmonale.</p> <p>Review of Resident #31's plan of care revealed no evidence she received an anticoagulant.</p> <p>Interview on 11/21/24 at 1:12 P.M. with the Director of Nursing (DON) verified Resident #31 was currently on an anticoagulant medication.</p> <p>Interview on 11/21/24 at 1:15 P.M. with MDS/Licensed Practical Nurse (LPN) #369 revealed Resident #31's previous anticoagulation care plan was resolved in July 2021 and verified Resident #31 did not have a current care plan in place for anticoagulation since her Xarelto was started on 06/10/24.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567</p> <p>Based on observation, interviews, medical records review, and review of facility policy the facility failed to provide appropriate incontinence care resulting in shearing and a new open skin alteration to Resident #36. This affected one resident (Resident #36) of two residents who were reviewed for activities of daily living. The facility census was 68.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, paroxysmal atrial fibrillation, ulcerative colitis, hypertension, peripheral vascular disease, and anemia.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 10/18/24 revealed Resident #36 had severe cognitive impairment, was always incontinent of bowel and bladder, and dependent for toileting and personal hygiene. Further review of the MDS revealed Resident #36 was at risk for developing pressure ulcers, had no unhealed pressure ulcers, had two venous or arterial ulcers, and no other ulcers, wounds, or skin problems.</p> <p>Review of the care plan dated 10/18/24 revealed Resident #36 experienced urinary incontinence and urinary accidents and required assistance with toileting hygiene to keep clean and dry and maintain skin integrity. Further review of the care plan revealed Resident #36 was at risk for Impairment of skin integrity related to impaired mobility, incontinence, refusal of ROHO cushion (a wheelchair cushion that distributes pressure to minimize shear forces and prevent skin breakdown), refusals to lay down to be changed, refusal for perineal care, and thin fragile skin. Interventions included turning and repositioning every two hours when in bed, ROHO cushion to wheelchair when out of bed, reporting any reddened areas to the charge nurse, and application of barrier cream after each incontinent episode.</p> <p>Review of the last weekly skin assessment completed on 11/18/24 revealed Resident #36 had no new skin areas. Review of the two Weekly Non-Pressure Ulcer Reports dated 11/18/24 revealed resident #36 had two ulcers, one on his right shin and one on the medial aspect of his right shin. There were no non-pressure wounds or pressure wounds noted on the buttocks, upper thighs, or ischium on the skin and wound assessments completed on 11/18/24.</p> <p>Observation on 11/19/24 from 1:02 P.M. to 1:10 P.M. of Resident #36 receiving incontinence care from Certified Nursing Assistant (CNA) #396 and CNA #397 revealed CNA #396 pulled the soiled incontinence brief out from under Resident #36 while he was lying on his right side, causing friction and shearing to the skin beneath the brief. CNA #396 was observed tugging at the brief intermittently with short pauses whenever she met resistance, then resumed pulling. Further observation revealed when Resident #36 was rolled off his right side to fasten the new brief, a speck of bright red blood was noted on the new brief. CNA #397, with the assistance of CNA #396, assisted Resident #36 to roll to his left side which revealed an open area with a scant amount of fresh blood. During this observation, CNA #397 confirmed the open area was new and she left the room to notify the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/19/24 at 1:18 P.M. with Registered Nurse (RN) #351 confirmed Resident #36 had a newly opened wound on his right ischium which measured 1.5 centimeters (cm) by 2.5 cm by 0.1 cm. During this interview, RN #351 confirmed the wound appeared to be the result of friction or shearing.</p> <p>Interview on 11/19/24 at 1:25 P.M. with CNA #396 confirmed she met some resistance when pulling the soiled brief from under Resident #36 and that she kept pulling, a little at a time, without attempting to roll Resident #36 to reposition or roll and tuck the brief for ease of removal. CNA #396 also confirmed she had not seen the open area prior to performing his incontinence care.</p> <p>Interview on 11/19/24 at 1:28 P.M. with CNA #397 confirmed the soiled brief was pulled out from under Resident #36 and that he should have been rolled back and forth to prevent any shearing during brief removal.</p> <p>During follow-up review of the Weekly Non-Pressure Ulcer Reports revealed a new assessment dated [DATE] of a new skin area to the right ischium which measured 1.5cm x 2.5 cm x 0.1 cm, noted as a new area with an onset of 11/19/24 from shearing described as pink tissue with edges rolling away from wound bed.</p> <p>Review of the progress note dated 11/19/24 at 5:06 P.M. revealed Resident #36 was evaluated for a new skin area consisting of peeling and shearing, new wound care orders were obtained, and notification to the providers and the power of attorney were notified of the new skin concern.</p> <p>At 2:20 P.M. on 11/21/24, Director of Operations #300 presented wound notes regarding a skin alteration described as a derroofed blister to the right rear thigh with an onset date of 05/22/24 which was resolved on 07/02/24. At that time, Director of Operations #300 confirmed this evidence was presented to support Resident #36 already had fragile skin on the right posterior thigh area prior to the observed shearing motion observed during incontinence care on 11/19/24.</p> <p>Review of the policy titled Check and Change dated 09/29/21 revealed incontinence checks and incontinence care were to be performed in a manner that promoted the dignity, comfort, hygiene, and skin integrity of the resident.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567</p> <p>Based on medical record review, interviews, and review of facility policy the facility, the facility failed to ensure pharmacist recommendations were acted upon timely. This affected one resident (Resident #3) of five residents who were reviewed for unnecessary medications. The facility census was 68.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including unspecified dementia with agitation, type two diabetes mellitus, anorexia, atrial fibrillation, anxiety, major depressive disorder, unspecified symptoms involving cognitive functions and awareness, stage three chronic kidney disease, oropharyngeal phase dysphagia, and adult failure to thrive.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 09/27/24 revealed Resident #3 had severe cognitive impairment with continuous display of inattention and fluctuating patterns of disorganized thinking. Further review if the MDS revealed Resident #3 required substantial assistance with bathing, was dependent for toileting hygiene and bed and tub transfers, and was receiving Hospice services.</p> <p>Review of the physician orders for Resident #3 revealed an order dated 06/16/22 for Multivitamin Gummies Adult chewable tablets (a multiple vitamin with minerals), one tablet by mouth two times a day as a supplement. Further review of the orders also revealed an order dated 10/05/22 for PreserVision age-related eye disease study two (AREDS2) (a multiple Vitamin with minerals), one capsule by mouth one time a day related to macular degeneration.</p> <p>Review of the pharmacy consultant's Note To Attending Physician/Prescriber dated 03/29/24 revealed the monthly medication regimen review found duplication of multivitamins orders, the order for Multivitamin Gummy twice a day and the PreserVision daily vitamin. Further review of this note revealed it was recommended by the pharmacist for the prescribing provider to review the need for this [AGE] year-old resident to receive both vitamins and to consider discontinuing one of them.</p> <p>Review of the Physician/Prescriber Response section at the bottom of the Note To Attending Physician/Prescriber dated 03/29/24 revealed the provider reviewed the pharmacist's recommendation on 04/30/24, agreed with the pharmacy consultant's recommendation , and provide documentation to discontinue the Multivitamin Gummy. Further review of the document revealed the providers okay to discontinue the Multivitamin Gummy signed on 04/30/24 was noted on 05/06/24 by Registered Nurse (RN) #347.</p> <p>Review of the progress note dated 05/06/24 at 4:12 P.M. revealed RN #347 noted the new order to discontinue the Multivitamin Gummy and provided notification of the medication update to Resident #3's family representative.</p> <p>Review of the Medication Administration Record (MAR) from April 2024 and May 2024 revealed Resident #3 continued to receive both ordered multivitamins (Multivitamin Gummy twice a day and the PreserVision daily) until after the morning dose of the Multivitamin Gummy on 05/06/24.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/21/24 at 12:43 P.M. with Consulting Pharmacist #446 confirmed when a pharmacy recommendation was made or an irregularity was found during monthly medication regimen reviews, the recommendation was sent to the Director of Nursing (DON) via email once the review was finished.</p> <p>Interview on 11/21/24 at 12:49 P.M. with the DON confirmed she received emails from the Consulting Pharmacist with recommendations and it was the charge nurse's responsibility to contact Physician #343, unless he rounds that week, in which case the recommendation would be handed to Physician #343 during rounds. Further interview with the DON confirmed the prescribing providers response time to pharmacist recommendations should be a day or two at the most. During the interview, the DON confirmed Resident # 3 received both ordered multivitamins through the month of April 2024 through 05/05/24 and that the Multivitamin Gummy was discontinued after the morning dose was administered on 05/06/24.</p> <p>Review of the policy titled Medication Regimen Review dated February 2023 revealed the pharmacist was to communicate any recommendations and irregularities of their monthly drug regimen review via email within 10 working days of the review and the facility was to act upon all recommendations per attending physician's orders.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47570</p> <p>Based on record review, observation and interview, the facility failed to ensure food was served at palatable temperatures. This had the potential to affect all 68 of 68 residents that resided in the facility who received meals from the kitchen.</p> <p>Findings include:</p> <p>Observation of tray line on 11/19/24 from 11:44 A.M. to 12:25 P.M. revealed food was above 165 degrees Fahrenheit (F) . A test tray was requested as the last resident's food was plated. The food cart left the kitchen at 12:25 P.M. and arrived to at the central unit at 12:29 P.M.</p> <p>When the last tray on the cart was delivered on 11/19/24 at 12:37 P.M., the test tray was removed from the cart where food temperatures were taken. The Dietary Manager (DM) #316 took the temperature of the food and stated that the temperature for the pasta was 120 degrees F and the fruit cup was 52.1 degrees F. DM #316 stated pasta should be hotter. Upon tasting the pasta, it was tepid.</p> <p>Interview on 11/19/24 at 5:36 P.M. with Resident #61 revealed the food was always cold especially after 5:00 P.M.</p> <p>Interview on 11/20/24 at 12:44 P.M. with Resident #57 revealed the food was always cold.</p> <p>Review of facility policy titled Record of Food Temperatures dated February 2023, revealed hot foods would be held at 135 degrees F or greater and hot foods would be stirred during holding to redistribute heat throughout the food. Potentially hazardous cold food temperatures would be kept at or below 41 degrees F.</p>

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522</p> <p>Based on facility assessment review and interview, the facility failed to ensure the facility assessment was complete and accurate. This finding had the potential to affect all 68 residents who reside in the facility.</p> <p>Findings include:</p> <p>Review of the facility assessment dated [DATE] revealed under 'Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies' section 3.1 Staff Type indicated necessary staff members are listed on our organizational chart (attached) to care for our resident population. The Infection Preventionist role was not marked on the organizational chart.</p> <p>Continued review of the assessment revealed under section 3.2, Staff Plan, revealed the following information: Our staffing levels will never fall below the minimum needed for each resident per day. We will never fall below the required minimum of 3.48 Nurse Hours per Resident Day (NHRD). We strive to maintain 4.0 nurse hours per resident day but adjust based on resident needs. If we are unable to meet this requirement we will enlist the support of our contracted staffing agencies partners. We will also use these contracted staffing agency partners as our contingent/emergency staff after all internal facility staff has been deployed. No specific amount of hours or number of staff needed per day were listed for any staff type including the Infection Preventionist.</p> <p>Interview on 11/21/24 at 12:11 P.M. with Director of Operations (DO) #300 confirmed the facility assessment provided did not list the Infection Preventionist role under the Staff Type or Staff Plan to determine the amount of hours required of the infection preventionist to assess, develop, implement, monitor, and manage the facility infection control program. DO #300 also confirmed the assessment lacked specific staffing information such as numbers or hours of various staff types per shift and per day.</p>