

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Geriatric Center of Mansfield		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Blymyer Avenue Mansfield, OH 44903	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>34297</p> <p>Based on record review and interview, the facility failed to provide residents with quarterly statements of their resident trust fund account. This affected eighteen residents (#15, #17, #20, #28, #30, #31, #33, #35, #36, #39, #41, #43, #44, #46, #47, #51, #53, and #55) of eighteen residents with resident fund accounts.</p> <p>Findings include:</p> <p>Review of the Trust-Current Account Balance form (resident trust funds) dated 04/01/24 revealed eighteen residents including Resident #15, #17, #20, #28, #30, #31, #33, #35, #36, #39, #41, #43, #44, #46, #47, #51, #53, and #55 were not provided quarterly balance statements from their resident trust fund account.</p> <p>Interview on 04/0124 at 10:01 A.M. with the Administrator confirmed quarterly statements identifying the balance on resident trust fund accounts were not provided to the residents. When questioned, she could not state when the last quarterly statements were issued to the resident/resident representatives.</p> <p>On 04/11/24 from 9:02 A.M. to 9:05 A.M. interviews with Residents #31 and #48 denied receiving quarterly resident fund statements.</p> <p>Review of the Resident Rights policy dated 03/21/24 revealed residents may maintain a resident fund account at the facility to cover day-to-day expense such as personal items, beauty/barber services and some activities.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00151839.</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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure monies in a resident fund account were finalized and dispersed within 30 days as required. This affected seven residents (#92, #93, #94, #95, #96, #97 and #98) of 12 discharged residents who the facility managed a resident fund account.</p> <p>Findings include:</p> <p>1. Review of Resident #92's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Alzheimer's disease, need for assistance with personal care and muscle weakness.</p> <p>Review of Resident #92's progress note dated 12/14/23 at 10:07 P.M. indicated the nurse called the hospital and the resident was admitted for sepsis. The resident did not return to the facility.</p> <p>Review of the Trust-Current Account Balance form (resident fund accounts) dated 04/01/24 revealed Resident #92 had a resident fund balance of \$40.00.</p> <p>Interview on 04/01/24 at 12:05 P.M. with Business Office Manager (BOM) #831 confirmed Resident #92's trust fund monies were not returned to the resident/resident representative within thirty days as required.</p> <p>2. Review of Resident #93's medical record revealed the resident was initially admitted on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses including major depressive disorder, difficulty in walking and muscle weakness.</p> <p>Review of Resident #93's progress note dated 11/01/23 revealed the resident was discharged with the family.</p> <p>Review of the Trust-Current Account Balance form (resident fund accounts) dated 04/01/24 revealed Resident #93 had a resident fund balance of \$45.90.</p> <p>Interview on 04/01/24 at 12:05 P.M. with BOM #831 confirmed Resident #93's trust fund monies were not returned to the resident/resident representative within thirty days as required.</p> <p>3. Review of Resident #94's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including abnormal posture, overactive bladder and dementia.</p> <p>Review of Resident #94's progress note dated 12/06/23 at 7:40 P.M. revealed the resident's body was released to the funeral home.</p> <p>Review of the Trust-Current Account Balance form (resident fund accounts) dated 04/01/24 revealed Resident #94 had a resident fund balance of \$2,146.88.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 04/01/24 at 12:05 P.M. with BOM #831 confirmed Resident #94's trust fund monies were not returned to the resident representative/estate within thirty days as required.</p> <p>4. Review of Resident #95's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including chronic obstructive pulmonary disease, encounter for palliative care and diabetes.</p> <p>Review of Resident #95's progress note dated dated 11/03/23 at 2:29 P.M. revealed the resident was discharged with the family and all medications sent with the family.</p> <p>Review of the Trust-Current Account Balance form (resident fund accounts) dated 04/01/24 revealed Resident #95 had a resident fund balance of \$40.00.</p> <p>Interview on 04/01/24 at 12:05 P.M. with BOM #831 confirmed Resident #95's trust fund monies were not returned to the resident/resident representative within thirty days as required.</p> <p>5. Review of Resident #96's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including sarcopenia, dementia and essential hypertension.</p> <p>Review of Resident #96's progress note dated 02/14/24 at 8:03 A.M. revealed the resident would be discharging on 02/29/24 to another facility.</p> <p>Review of the Trust-Current Account Balance form (resident fund accounts) dated 04/01/24 revealed Resident #96 had a resident fund balance of \$3,788.40.</p> <p>Interview on 04/01/24 at 12:05 P.M. with BOM #831 confirmed Resident #96's trust fund monies were not returned to the resident/resident representative within thirty days as required.</p> <p>6. Review of Resident #97's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Alzheimer's disease with late onset, hypertension and major depressive disorder.</p> <p>Review of Resident #97's progress note dated 01/21/24 at 2:21 P.M. revealed the resident was discharged to the wife.</p> <p>Review of the Trust-Current Account Balance form (resident fund accounts) dated 04/01/24 revealed Resident #97 had a resident fund balance of \$10.00.</p> <p>Interview on 04/01/24 at 12:05 P.M. with BOM #831 confirmed Resident #97's trust fund monies were not returned to the resident/resident representative within thirty days as required.</p> <p>7. Review of Resident #98's medical record revealed the resident was readmitted on [DATE] and discharged on [DATE] with diagnoses including Alzheimer's disease with early onset, encounter for palliative care and anxiety disorder.</p> <p>Review of Resident #98's progress note dated 11/27/23 at 5:34 P.M. revealed the resident was admitted to the hospital with a diagnosis of pneumothorax and did not return to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Trust-Current Account Balance form (resident fund accounts) dated 04/01/24 revealed Resident #98 had a resident fund balance of \$60.00</p> <p>Interview on 04/01/24 at 12:05 P.M. with BOM #831 confirmed Resident #98's trust fund monies were not returned to the resident/resident representative within thirty days as required.</p> <p>Review of the facility Resident Rights policy dated 03/21/24 revealed residents may maintain a resident fund account at the facility to cover day-today expense such as personal items, beauty/barber services and some activities.</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure residents admitted to the facility were provided a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources as well as information concerning Medicare and Medicaid eligibility and coverage. This finding affected 41 residents (#2, #3, #5, #6, #7, #9, #10, #11, #14, #21, #27, #34, #35, #45, #48, #104, #109, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #120, #121, #122, #123, #124, #125, #126, #127, #128, #129, #130, #131, #132 and #133) of 100 residents whose records were reviewed for admission documentation.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident #2's medical record revealed the resident was admitted on [DATE] with diagnoses including hypertension, heart failure and chronic kidney disease. <p>Review of Resident #2's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <ol style="list-style-type: none"> 2. Review of Resident #3's medical record revealed the resident was admitted on [DATE] with a diagnosis of hyperglycemia, diabetes and hypertension. <p>Review of Resident #3's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <ol style="list-style-type: none"> 3. Review of Resident #5's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy, chronic obstructive pulmonary disease and hypertension. <p>Review of Resident #5's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <ol style="list-style-type: none"> 4. Review of Resident #6's medical record revealed the resident was readmitted on [DATE] with diagnoses including chronic pain syndrome, edema and heart failure. <p>(continued on next page)</p>

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #6's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>5. Review of Resident #7's medical record revealed the resident was admitted on [DATE] with diagnoses including unsteadiness of her feet, sleep disorder and hypertension.</p> <p>Review of Resident #7's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>6. Review of Resident #9's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including kidney transplant status, depression and emphysema.</p> <p>Review of Resident #9's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>7. Review of Resident #10's medical record revealed the resident was initially admitted on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses including metabolic encephalopathy, diabetes and hypertension.</p> <p>Review of Resident #10's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>8. Review of Resident #11's medical record revealed the resident was admitted on [DATE] with diagnoses including hypertension, end stage renal disease and dialysis services.</p> <p>Review of Resident #11's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Review of Resident #14's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including obesity, essential hypertension and hyperlipidemia.</p> <p>Review of Resident #14's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>10. Review of Resident #21's medical record revealed the resident was admitted on [DATE] with diagnoses including diabetes, major depressive disorder and insomnia.</p> <p>Review of Resident #21's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>11. Review of Resident #27's medical record revealed the resident was admitted on [DATE] with diagnoses including opioid dependence, other chronic pain and anxiety.</p> <p>Review of Resident #27's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>12. Review of Resident #34's medical record revealed the resident was admitted on [DATE] with diagnoses including other lack of coordination, hypothyroidism and depression.</p> <p>Review of Resident #34's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>13. Review of Resident #35's medical record revealed the resident was admitted on [DATE] with diagnoses including other lack of coordination, anxiety and chronic pain syndrome.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #35's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>14. Review of Resident #45's medical record revealed the resident was admitted on [DATE] with diagnoses including diabetes, other lack of coordination and depression.</p> <p>Review of Resident #45's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>15. Review of Resident #48's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including diabetes, hypertension and heart failure.</p> <p>Review of Resident #48's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>16. Review of Resident #104's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Alzheimer's disease, anxiety disorders and rheumatoid arthritis.</p> <p>Review of Resident #104's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>17. Review of Resident #109's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including other lack of coordination, disorder of the thyroid and hyperlipidemia.</p> <p>Review of Resident #109's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>18. Review of Resident #110's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Parkinson's disease, portal hypertension and insomnia.</p> <p>Review of Resident #110's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>19. Review of Resident #111's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including muscle weakness, chronic respiratory failure and hyperlipidemia.</p> <p>Review of Resident #111's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>20. Review of Resident #112's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including anemia, hypertension and need for assistance with personal care.</p> <p>Review of Resident #112's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>21. Review of Resident #113's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including diabetes, leukemia and neutropenia.</p> <p>Review of Resident #113's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>22. Review of Resident #114's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including muscle weakness, hyperlipidemia, and glaucoma.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #114's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>23. Review of Resident #115's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease and infection and inflammatory reaction due to indwelling urethral catheter.</p> <p>Review of Resident #115's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>24. Review of Resident #116's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including anxiety disorder, heart disease and other lack of coordination.</p> <p>Review of Resident #116's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>25. Review of Resident #117's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including diabetes, repeated falls and difficulty in walking.</p> <p>Review of Resident #117's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>26. Review of Resident #118's medical record revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>Review of Resident #118's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Geriatric Center of Mansfield		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Blymyer Avenue Mansfield, OH 44903	
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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>27. Review of Resident #119's medical record revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>Review of Resident #119's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>28. Review of Resident #120's medical record revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>Review of Resident #120's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>29. Review of Resident #121's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including pain in the right hip, anxiety and hypertension.</p> <p>Review of Resident #121's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>30. Review of Resident #122's medical record revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>Review of Resident #122's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>31. Review of Resident #123's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] including a diagnosis of Parkinson's disease.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #123's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>32. Review of Resident #124's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including diabetes and hypertension heart disease.</p> <p>Review of Resident #124's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>33. Review of Resident #125's medical record revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>Review of Resident #125's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>34. Review of Resident #126's medical record revealed the resident was initially admitted on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses including end stage renal disease, hyperlipidemia and dependence on renal dialysis.</p> <p>Review of Resident #126's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>35. Review of Resident #127's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including anemia, hypertension and heart failure.</p> <p>Review of Resident #127's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>36. Review of Resident #128's medical record revealed the resident was initially admitted on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses including Alzheimer's disease and dementia.</p> <p>Review of Resident #128's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>37. Review of Resident #129's medical record revealed the resident was initially admitted on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses including Alzheimer's disease with late onset and dementia.</p> <p>Review of Resident #129's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>38. Review of Resident #130's medical record revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>Review of Resident #130's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>39. Review of Resident #131's medical record revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>Review of Resident #131's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>40. Review of Resident #132's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including major depressive disorder, hypertension and low back pain.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #132's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>41. Review of Resident #133's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including bipolar disorder, mood disorder and dysphagia.</p> <p>Review of Resident #133's admission documentation revealed the resident and/or representative did not sign the Consent to Treatment and Other Acknowledgements form nor was the form signed by a witness as indicated. The admission documentation revealed the Nursing Home Admission Agreement describing the daily room rate, the right to an assessment of resources and the authorization to bill Medicaid or Medicaid for services rendered was not signed by the resident/resident representative nor was the form witnessed by a facility representative.</p> <p>Interview on 04/04/23 at 2:13 P.M. with Social Service Designee (SSD) #828 on 04/04/24 confirmed the facility did not ensure the above 41 residents had a signed admission agreement providing a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources, as well as information concerning Medicare and Medicaid eligibility and coverage. SSD #828 indicated the lack of signed admission agreement with the above 41 residents resulted in the facility not having consent to bill Medicare/Medicaid for services rendered or a consent to treat while the resident was admitted to the facility.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00151839.</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>34297</p> <p>Based on observation, facility policy review and interview, the facility failed to ensure resident mail was delivered to residents unopened and failed to ensure residents had access to a private working telephone. This affected 11 residents (#14, #15, #23, #24, #18, #30, #35, #39, #41, #52 and #55) and had the potential to affect all 56 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Observation on 04/01/24 at 8:10 A.M. of Business Office Manager (BOM) #831's desk revealed a stack of opened resident mail addressed and belonging to Resident #15, #18, #30, #35, #39, #41 and #55 who currently reside in the facility.</p> <p>Interview on 04/01/24 at 8:35 A.M. with BOM #831 revealed Chief Executive Officer (CEO) #805 had opened the resident mail.</p> <p>Interview on 04/01/24 at 4:50 P.M. with CEO #805 revealed he opened resident mail, but only Medicaid and Medicare mail because he thought that was allowed. He stated he would open the envelopes and place them on BOM #831's desk. He denied reading the mail addressed to residents and stated he only opened the mail.</p> <p>Review of the undated facility Resident Mail Services policy indicated residents had the right to private and unrestricted communications and to receive and send sealed, unopened correspondence, access to a telephone and private visits.</p> <p>2. On 04/01/24 at 9:30 A.M. an attempt to contact the facility by telephone was unsuccessful. The call could not be completed as dialed. Interviews with staff during the investigation verified the facility phone system was not currently working and they could not receive incoming calls or make outgoing calls using the facility phone system. The staff interviewed revealed they had to use their own personal cell phones to make calls, including calls to physicians.</p> <p>On 04/01/24 at 2:18 P.M. telephone interview with Phone Representative #848 revealed telephone service in the building had been initiated in May 2022 and was not working on this date due to a technical issue. Phone Representative #848 revealed the facility had an outstanding current balance owed of \$3,170.00 for the rental of telephone equipment and this balance would have to be paid before the company would come out to service the phones. Phone Representative #848 revealed the facility broke their 5-year contract (end date 04/01/27) due to non-payment and now the full amount due must be paid in the amount of \$31,700.00 to resume services.</p> <p>On 04/01/24 from 2:43 P.M. to 3:00 P.M. interviews with Resident #14, #15, #23, #24, and #52 revealed they used the facility phone to contact their family members.</p> <p>Interview on 04/01/24 at 2:45 P.M. with Resident #23 revealed she used the facility phone to call her family and she did not have a personal cellular phone for use.</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 04/01/24 at 2:47 P.M. with Resident #52 revealed she did not have a personal cell phone for use and her family usually called on the facility phone.</p> <p>Interview on 04/01/24 at 2:52 P.M. with Resident #14 indicated the daughter called to check on her on the facility phone.</p> <p>Review of the Telephone Rental bill dated 04/02/24 revealed the facility owed \$3,170.00 due on 03/01/24 and total amount owed as of 04/01/24 was \$31,700.00.</p> <p>On 04/02/24 at 12:20 P.M., an interview with the Administrator indicated she was unaware the phone system was not in good working order as of this time.</p> <p>On 04/02/24 at 11:03 A.M., 04/03/24 at 11:21 A.M., 04/04/24 at 10:21 A.M., 04/06/24 at 8:58 A.M., 04/09/24 at 8:59 A.M. and 04/10/24 at 8:10 A.M. attempts were made to contact the facility via phone. The calls could not be completed as dialed as the phone system was still interrupted on these dates/times.</p> <p>On 04/03/24 at 11:38 A.M. interview with the Administrator and DON revealed Receptionist #849 voiced concerns out of state families were not going to be able to reach residents by phone so the Administrator advised her to email the families to let them know the residents were okay.</p> <p>On 04/04/24 at 11:01 A.M. interview with Receptionist #849 revealed she had sent emails on 04/03/24 to some of the family members of residents to inform them the phone system was not working including Resident #15, #18, #23, #28, #30, #41, #47, #51 and #55. She revealed she did not have emails for other residents to let families know the phone system was not working.</p> <p>On 04/09/24 and 04/10/24 attempts to call the facility were unsuccessful as the phones were not working on these dates. On 04/10/24 at 9:24 A.M. an interview with the Administrator revealed she was aware the telephone system was still not working but could not state why the phones were not working as of this time. No additional information was provided on 04/10/24 related to the status of facility phones or what measures were in place to secure functioning phones as of this time.</p> <p>On 04/11/24 at 10:07 A.M. interview with the Administrator revealed the facility phones were currently still not working. The Administrator stated she was told CEO #805 was working on the phone system, but refused to give her additional information. The Administrator indicated CEO #805 had since gone out of state, didn't tell her when he would be returning but stated she heard he told someone else he would be back on 04/16/24.</p> <p>On 04/12/24 at 10:22 A.M. attempts to call the facility were unsuccessful as the phones were not working on this date/time.</p> <p>On 04/15/24 at 8:58 A.M. attempts to call the facility were unsuccessful as the phones were not working on this date/time.</p> <p>On 04/15/24 at 11:11 A.M. an interview with the Administrator revealed CEO #805 was working to obtain a new phone company. The Administrator indicated CEO #805 did not provide details, but stated the plan was to get a new company which would result in the loss of all previous phone numbers. The Administrator revealed she was not aware of a timeline when the new service would be secured.</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the undated facility Resident Mail Services policy indicated residents had the right to private and unrestricted communications and to receive and send sealed, unopened correspondence, access to a telephone and private visits.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00151839.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>34297</p> <p>Based on review of facility billing records, emails, invoices and past due notices, review of bank statements, review of the facility assessment, Nursing Home Admission Agreement, facility policy and procedures, and interviews with residents/family, staff, vendors, and company personnel, the facility neglected to meet financial obligations for the delivery of care and maintenance and to operate in a manner to ensure all bills were being paid in a timely manner to prevent the actual and potential interruption in services and to meet the total care needs of all residents admitted to and/or retained in the facility. This resulted in Immediate Jeopardy on 04/01/24 when the identified lack of financial solvency placed all facility residents at risk for serious harm, injury, hospitalization, displacement due to the actual and potential interruption in utility and/or outside service providers. Financial concerns were identified and included, but were not limited to delinquent balances owed to the water company resulting in a shut off notice issued 04/01/24 with water services to end 04/12/24, delinquent balances owed to the phone leasing company resulting in phone service interruption on 04/01/24, delinquent balances owed to the facility current food vendor which resulted in food delivery being placed on hold on 04/02/24, and delinquent balances owed to the contracted therapy provider resulting in therapy services terminating on 04/05/24. This had the potential to affect all 56 residents residing in the facility.</p> <p>On 04/02/24 at 2:47 P.M., the Administrator, Director of Nursing (DON) and Chief Executive Officer (CEO) #805 were notified Immediate Jeopardy began on 04/01/24 when an onsite investigation determined the facility neglected to meet all financial obligations for the delivery of care and maintenance of the facility by not paying vendors in a timely manner to prevent actual and potential interruption in services and to meet the total care needs of residents.</p> <p>The Immediate Jeopardy remains ongoing as of 04/15/24 as the facility failed to provide evidence of an effective abatement plan.</p> <p>Findings include:</p> <p>On 03/22/24 at 2:50 P.M. confidential information provided to the State agency revealed ongoing financial solvency concerns in the facility and that the facility was not paying their vendors. The concerns included therapy services being on hold for residents due to non-payment, the facility running out of food for residents, having little to no resident care supplies (including incontinence briefs) and that the facility phones were set to be turned off due to non-payment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Additional confidential concerns provided to the State agency included concerns the facility had been in financial trouble for almost a year due to the inability to pay vendors. The source of the concern indicated the facility would change vendors, with a specific example given of the facility food vendor, who after owing upwards of \$60,000-\$70,000 to the previous company and not being able to pay them, the facility simply switched to a new vendor. The source indicated there were some utilities/vendors who required cash payment as they would no longer take a check or electronic payment from the facility. The source also shared he/she had witnessed vendors come into the facility and sit until they received payment, because the facility was so far behind on payments. Lastly the source indicated the facility was utilizing agency staffing to fill 99% of their shifts and had not had a Director of Nursing or Minimum Data Set (MDS) nurse for some time.</p> <p>On 03/26/24 at 7:38 A.M. an interview with the Administrator revealed she began her employment with the facility on 03/20/23. During the interview she indicated she did not handle any financial aspects of the facility. The Administrator indicated the facility was a non-profit facility with a Board of Directors and Chief Executive Officer (CEO) #805 was responsible for the financial aspect of the facility including paying vendors.</p> <p>On 03/27/24 at 12:38 P.M. interview with CEO #805 revealed the facility had payment issues due to a low census and low funds and were now just catching up on their payments.</p> <p>On 03/27/24 at 1:44 P.M. a telephone interview with Business Office Manager (BOM) #831 revealed during routine audits she noted the facility was unable to process payments for resident care and the facility bills were not paid timely (date(s) not provided). BOM #831 indicating she reported these concerns to CEO #805 (date(s) not provided).</p> <p>On 04/01/24 at 1:41 P.M. an interview with the Medical Director revealed he was not aware of the facility being behind on payments. The Medical Director revealed he was unaware of residents not having enough supplies, food, medications, or not receiving resident care. The Medical Director revealed he attended a quarterly Quality Assurance/Performance Improvement (QAPI) meeting the week prior and the facility did not bring up any issues with the inability to pay vendors. The Medical Director then stated he was not involved in the financial side of the facility.</p> <p>On 04/01/24 at 4:06 P.M. an interview with CEO #805 revealed the facility had a cash flow issue due to changes in management. CEO #805 indicated their Minimum Data Set (MDS) employee, MDS #826 quit recently on 02/25/24 and the previous BOM, BOM #870 quit 12/29/23, and the facility had a difficult time finding replacements. CEO #805 stated resident MDS 3.0 comprehensive assessments were not being completed on time and the facility was not generating payments for resident care due to late MDS assessments. He denied the facility initiated or developed any type of QAPI plan to resolve the identified financial issues, to ensure vendors were paid in a timely manner to prevent potential or actual interruption in services and to meet the total care needs of all residents admitted to and/or retained in the facility. CEO #805 stated the facility had three options, keep going like they were, find new staff to timely complete resident care and billing or shut down the facility.</p> <p>Review of the Deposit Accounts bank statement dated 04/01/24 revealed the skilled nursing facility had a current balance in its general fund operations account of \$6,971.18.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 04/02/24 at 2:29 P.M. an interview with the Administrator revealed she was resigning her position as administrator at the facility effective 04/22/24. The Administrator also revealed Rehab Director #824 had recently resigned his position due to the instability of the facility.</p> <p>On 04/03/24 at 11:16 A.M. interview with CEO #805 revealed he realized late on 04/02/24 Business Office Manager (BOM) #831 was not completing her duties as required and had not sent out billing in a timely manner for the months of 01/2024 and 02/2024. CEO #805 then stated this was the reason the facility had cash flow issues. There was no evidence this had been identified by the facility as a potential reason for cash flow issues prior to 04/02/24 during the onsite survey investigation.</p> <p>On 04/03/24 at 11:38 A.M. an interview with the Administrator and the Director of Nursing (DON) revealed CEO #805 talked to all staff on 04/02/24 during the evening shift and told them the State agency had identified monetary concerns. The Administrator and DON revealed they felt the CEO created increased anxiety and panic with the staff because of his communication and even stated to staff that all of the facility bank accounts were frozen.</p> <p>On 04/03/24 at 12:08 P.M. an interview with Board Member #866 revealed the most recent board meeting was held on 03/21/24 which was an executive session due to an employee grievance. The meeting prior to this was held on 03/13/24 which himself, CEO #805, Board Member #867 and Board Member #868 were in attendance for. He stated during this meeting, the financial side of the building was discussed. He stated he was aware several vendors were not getting paid timely but stated he was not aware of any disconnection notices. Board Member #866 revealed it was his understanding CEO #805 worked out payment arrangements with the vendors including the food vendor. He stated he was aware therapy services discontinued their service and was also aware that the phones were not working. Board Member #866 revealed Plan B regarding the phones was arranged to include changing phone providers. No additional information was provided as to why the plan did not include paying the current phone service. He stated he comes to some of the facility QAPI meetings, but not all of them. He stated the boards stance on the facility money issues included trying to get a loan on the property or selling some of the property to an interested buyer.</p> <p>On 04/11/24 at 11:16 A.M. an interview with the Administrator revealed beginning over the previous two months she had increased concerns related to her ability to effectively function as the administrator in the facility due to conflict that was occurring with CEO #805. The Administrator indicated there had been some concerns during the entire time of her employment that had escalated during the recent months and included concerns the CEO was not providing effective leadership or managing the facility finances properly.</p> <p>As of 04/01/24, during an on-site investigation, the facility and/or vendors provided information of outstanding balances included but were not limited to the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Balances of \$2205.00 and \$2,632.50 owed to Registered Dietitian (RD) #829, a balance of \$2,099.71 for Supply Vendor #853, a balance of \$56,348.62 for Staffing Vendor #854, a balance of \$23,795.48 for Pharmacy Collections #842, a balance of \$7,028.43 for Medical Supply #859, a balance of \$10,132.04 for Supply Vendor #860, a balance of \$12,722.19 for Food Vendor #858, a balance of \$40,259.27 for Food Vendor #852, a balance of \$11,091.80 for Information Technologies (IT) #843, a balance of \$55,180.95 for Therapy #847, a balance of \$3,170.00 for Phone #848, a balance of \$33,278.93 for Supply Vendor #857, a balance of \$1,175.74 for Monitoring Vendor #861, a balance of approximately \$5,200.00 to Oxygen Vendor #862 and a balance of \$5,642.97 to Water/Sewer Vendor #863. These balances totaled \$271,963.63.</p> <p>a. Review of the master therapy list revealed 20 residents were currently on therapy caseload/services including Resident #3, #4, #6, #7, #8, #12, #13, #14, #19, #20, #23, #26, #30, #37, #44, #51, #55, #106, #107 and #108.</p> <p>Review of an email from Therapy Credit Manager #847 from the facility contracted therapy department dated 03/28/24 at 1:53 P.M. revealed this vendor had not heard from anyone (from the facility) regarding payment or a plan to get current.</p> <p>On 04/01/24 at 1:50 P.M. an interview with Therapy Credit Manager #847 revealed the facility was outside their contracted terms due in part to money owed the therapy vendor. Therapy Credit Manager #847 revealed the facility had made a payment on 03/04/24 for \$6,000 and an additional payment on 03/11/24 for \$30,000. However, she stated the facility was supposed to make payments every thirty days and the facility was past due in the amount of \$20,072.15 for 01/2024 and \$35,108.80 for 02/2024 for a total of \$55,180.95.</p> <p>On 04/03/24 at 2:25 P.M. interview with Physical Therapy Assistant (PTA) #869 revealed the contracted therapy vendor was terminating therapy services from the building on 04/05/24 due to lack of payment.</p> <p>On 04/04/24 at 11:31 A.M. an interview with Administrator revealed of the 20 residents on therapy, seven residents, Resident #6, #7, #8, #13, #106, #107 and #108 requested to be transferred or sent home due to lack of therapy services.</p> <p>On 04/10/24 at 9:24 A.M. a telephone interview with the Administrator revealed CEO #805 was in negotiations with another therapy company to provide therapy services. No additional information was provided related to the status of the residents affected by the termination of therapy provider and their therapy needs between 04/06/24 and 04/10/24.</p> <p>Interview on 04/11/24 at 9:40 A.M. with Resident #44 indicated she was ordered therapy services and was not getting it. Record review revealed the resident had been on therapy case load for speech therapy services for dysphagia. The resident's last documented therapy session was on 04/05/24.</p> <p>Interview on 04/11/24 at 9:35 A.M. with Resident #51 revealed she was not receiving therapy services and was getting rusty. Record review revealed the resident had been on therapy case load for physical therapy services for gait training. The resident's last documented therapy session was on 04/05/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 04/11/24 at 4:30 P.M. the Administrator provided information CEO #805 had met with a new therapy company for possible new merger/contract for services and new therapy director. However, the Administrator indicated the date for implementation was unknown as of this time. In addition, CEO #805 was unavailable to provide any additional information related to therapy services at of this time.</p> <p>On 04/12/24 at 11:30 A.M. the facility provided a list of residents, including Resident #6, #7, #8, #13, #106, #107 and #108 who had actually discharged from the facility between 04/05/24 and 04/09/24 per their request due to the lack of therapy services available in the facility. Resident #12 discharged home on 04/06/24 after completing therapy services on 04/05/24.</p> <p>On 04/15/24 at 10:22 A.M. during an interview with the DON, the DON revealed the facility had not contracted with a therapy company to provide therapy services to residents as of this date.</p> <p>On 04/15/24 at 11:10 A.M. an interview with the Administrator revealed CEO #805 informed her that a meeting with a therapy company was held on 04/12/24 but as of this date, services for therapy/contracted provider was not confirmed.</p> <p>On 04/15/24 at 12:52 P.M. during a follow-up interview with the Administrator, the Administrator indicated CEO #805 had replied to a text message she had sent him regarding therapy. The Administrator revealed CEO #805 indicated they would have a new therapy company within 10 days. The Administrator revealed CEO #805 did not provide the name/phone number of the new therapy service and stated she was not aware if there was an actual contract yet.</p> <p>b. On 04/02/24 at 1:52 P.M. a telephone interview with Water/Sewer Vendor #863 revealed the facility had a current balance of \$8,868.78 which included a past due balance of \$5,642.97. Water/Sewer Vendor #863 revealed the facility was issued a disconnect notice effective 04/12/24 if payment in the amount of at least \$5,642.97 was not made.</p> <p>On 04/03/24 at 1:25 P.M. a follow up telephone interview with Water/Sewer Vendor #863 with CEO #805 and Licensed Practical Nurse (LPN) 701 (the Wellness Director for the Assisted Living) in attendance revealed the facility owed \$8,868.78 with a past due balance of \$5,642.97 which had to be paid by 04/12/24 or the water would be disconnected.</p> <p>The facility provided evidence of a payment made to the water company dated 04/03/24 (during the onsite survey).</p> <p>On 04/09/24 at 12:55 P.M. an additional follow up interview with Water/Sewer #877 confirmed a payment was made and the disconnection notice was removed from the account (based on the payment).</p> <p>c. Review of an email from Staffing Vendor #854 dated 03/18/24 at 8:54 P.M. indicated the staffing vendor attempted to reach the facility by phone on 03/18/24 without success. The email included the facility account would be pending on 03/20/24 due to non-payment. The email instructed the facility to please provide a payment update on the identified invoice by 03/19/24 to prevent the account from being pended. An amount of \$35,551.18 was now past due with \$20,797.44 due 03/19/24 for a total past due balance in the amount of \$56,348.62.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 03/26/24 at 8:36 A.M. an interview with Scheduler #821 revealed the facility required the use of agency nursing staff to adequately staff all shifts in the facility. However, if this current staffing agency used by the facility would discontinue providing staff as of 04/01/24 they would not have enough nurses to cover all shifts. Scheduler #821 also revealed the facility did not have sufficient staff to cover a shift if one of their regular staff members called off.</p> <p>On 03/26/24 at 9:45 A.M. an interview with CEO #805 verified the facility did not have enough facility employed nurses to cover all open shifts. CEO #805 confirmed the facility had used nurses from a staffing agency to fill these shifts.</p> <p>On 04/01/24 at 9:07 A.M. a telephone interview with Staffing Agency #837 revealed the facility owed a total of \$116,924.69 to this staffing agency and no payment arrangements had been made as of this date. Staffing Agency #837 revealed the facility account had been suspended as of 03/27/24 due to non-payment and no agency staff would be provided to the facility moving forward.</p> <p>On 04/01/24 an interview beginning at 10:35 A.M. with Scheduler #821 indicated the facility started using staffing agency in 06/2023 and the facility had previously used five different staffing agencies that were all terminated/discontinued due to nonpayment. Scheduler #821 indicated the current staffing agencies (noted above) would no longer send staff because of a delay in or lack of payments. Scheduler #821 revealed for the April 2024 schedule there were 49 open shifts that did not have nurse scheduled due to the lack of facility employed staff and/or the inability to use agency staffing.</p> <p>On 04/01/24 at 10:35 A.M. review of the facility staffing schedules with Scheduler #821 verified the 49 unfilled nursing shifts from 04/01/24 to 04/30/24 in which there was no nurse scheduled for the shift. This included seven shifts from 04/01/24 to 04/06/24 which the Director of Nursing (DON) indicated the administrative staff would have to fill and they would take the staffing week by week.</p> <p>On 04/03/24 at 11:40 A.M. an interview with the DON revealed her last day in the facility was going to be 04/18/24 as she was an interim DON and had requested another assignment. During the interview the DON revealed as of this date, the facility did not have enough nursing staff to cover 04/06/24 or 04/07/24. The DON indicated she was going to try to call nursing staff to see if she could find coverage for the weekend.</p> <p>On 04/11/24 at 10:21 A.M. interview with the Interim DON revealed staff nurses had picked up the open shifts and/or worked over on 04/06/24 and 04/07/24.</p> <p>Review of the Facility Wide Assessment form dated 05/2018 and last updated 05/23/23 revealed the facility supplied resident support/care needs including activities of daily living, mobility and fall/fall with injury prevention, bowel/bladder, skin integrity, mental health and behavior services, medication administration, pain management, infection control and prevention, management of medical conditions, therapy services and nutrition services. Nurse management included a full-time DON, two full time unit managers, a full time MDS coordinator, a scheduling coordinator, three-day nurses, two-night nurses, seven STNA's for dayshift, seven STNA's for second shift and five STNA's for nightshift. The staffing also included a full-time Administrator, transportation director, registered dietitian, full time maintenance/housekeeping/laundry director, full time activities director, full time social services director, full time admissions/marketing director, full time billing office manager, full time human resources, full time therapy director and contracted medical director.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>d. Review of Food Vendor #858's (a previous food supplier) billing invoice dated 04/01/24 revealed the facility had a past due balance for a total amount of \$12,722.19. The total past due balance included a past due amount of \$931.02 for thirty days and \$11,791.17 sixty days past due.</p> <p>Review of Food Vendor #852's (the current food supplier) invoice dated 04/01/24 from service of 12/12/23 through 03/29/24 revealed the facility owed a total of \$95,098.80 which included \$54,839.53 of the bill that was current and an additional \$40,259.27 that was past due.</p> <p>On 04/01/24 at 10:53 A.M. telephone interview with Food Supplier #838 (for Food Vendor #852) with Dietary Kitchen Manager #830 in attendance verified a balance to Food Vendor #852 in the amount of \$95,098.80 which included a past due amount of \$40,259.47. Food Supplier #838 indicated the facility bill of \$40,259.47 was greater than 60 days past due and the facility payments included \$5,000 the week prior, a promised \$10,000.00 on 04/08/24 and an additional promised \$10,000.00 on 04/15/24. Food Supplier #838 indicated the vendor had requested the facility initiate a better payment plan to pay off the past due balance.</p> <p>On 04/01/24 at 10:47 A.M. an interview with Dietary Kitchen Manager #830 revealed the facility had difficulty paying vendors. Dietary Kitchen Manager #830 stated vendors had put their account on hold and they could not order general resident care supplies, she could not remember the exact dates but stated it was at some point in 01/2024 or 02/2024.</p> <p>On 04/01/24 at 10:55 A.M. interview with the Credit Management Staff (Food Supplier #851 and Food Supplier #838) associated with Food Vendor #852 with Dietary Kitchen Manager #830 in attendance revealed the last couple payments from the facility included a payment on 03/05/24 for \$8,000.00 and a payment on 03/18/24 of \$5,000.00. Credit Manager for Food Supplier #851 indicated a plan was requested to bring the payments current and the plan had not been addressed yet even though she tried to discuss the plan to bring the overdue invoices current with CEO #805. Credit Manager for Food Supplier #851 confirmed the facility began using them as a vendor for the second time around 09/2023.</p> <p>On 04/01/24 at 11:44 A.M. an interview with Kitchen Dietary Manager #830 revealed Credit Manager for Food Supplier #851 text her at this time and stated the vendor was considering holding the food order for the order date of 04/02/24 due to lack of payment.</p> <p>On 04/02/24 at 10:27 A.M. interview with Food Supplier #838 for Food Vendor #852 revealed she was physically in the facility to pick up a \$10,000.00 check the facility was going to provide. She stated the food vendor decided to hold all future food orders until another \$30,000.00 (total \$40,000.00) was paid. She stated this would put the facility about sixty days past due and they would still owe another \$65,000.00 to the vendor. She stated Dietary Kitchen Manager #830 reported the facility had approximately three weeks of food supplies available.</p> <p>On 04/02/24 at 11:14 A.M. interview with Dietary Kitchen Manager #830 revealed the facility would be able to follow the approved menu from the dietitian from 04/01/24 to 04/13/24 with the food they had on hand and without the food vendor delivering food. After that, she stated she would have to piece meal the meals by the available food supply. She indicated she was provided a facility credit card on this date to purchase fresh items including milk, eggs, and bread. During the interview, she shared she had resigned her position in the facility effective 05/01/24 but did not provide a reason why.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 04/03/24 at 1:41 P.M. a telephone interview with Food Supplier #838 and Credit Manager for Food Supplier #851 with CEO #805 in attendance revealed the facility agreed upon amount of payment of \$10,000.00. Credit Manager for Food Supplier #851 stated they needed a plan to go forward of when the account would be made current and could not release a shipment of food until a concrete plan was put in place. Credit Manager for Food Supplier #851 stated their company could not allow the account to be over the 60-day term.</p> <p>On 04/09/24 at 10:03 A.M. an interview with Dietary Kitchen Manager #830 indicated she conducted an audit of food supplies on 04/02/24 and determined the facility actually had enough food to provide meals to residents per the menus or appropriate substitutions until 04/20/24. She stated after that time, she would have to piece meal the dinners with minimal food to pick from. Dietary Kitchen Manager #830 indicated she was provided a credit card to be able to go and buy fresh food supplies when needed (between this time and 04/20/24) with a \$2500.00 limit.</p> <p>On 04/09/24 at 10:42 A.M. an interview with the Administrator indicated the facility was no longer going to use Food Vendor #852 and were reviewing options including Food Vendor #878 and Food Vendor #879 pending reviews on pricing, menu selection and delivery.</p> <p>On 04/10/24 at 4:23 P.M. information provided from the Administrator revealed the facility had decided to stay with Food Vendor #852 based upon a mutual agreement for delivery and payment (cash on delivery). The Administrator indicated delivery would resume next week.</p> <p>On 04/11/24 a tour of the facility kitchen revealed the facility had food available to serve meals as planned from 04/11/24 to 04/14/24. During the tour, Dietary Kitchen Manager #830 provided receipts for food purchases made, using the credit card she was issued on 04/05/24 and 04/09/24. On 04/05/24 \$757.31 was spent and on 04/09/24 \$1055.97 was spent for a total of \$1813.28.</p> <p>On 04/11/24 at 7:59 A.M. interview with representatives from Food Vendor #852 with the Administrator present revealed they had spoken with CEO #805 on 04/10/24 to provide an offer on how to continue with their services as a food vendor. The CEO was informed the facility would need to pay by credit card, check or ACH with any order being cash on delivery (COD), plus a payment of \$2500.00 per week to pay the outstanding back balance owed. The representative indicated the CEO stated he was still looking at other vendors and they (Food Vendor #852) would get paid at some point and he would let them know. The representative indicated CEO #805 then hung up on them. The representatives revealed there was no current order or delivery scheduled for the facility as of this date/time.</p> <p>On 04/11/24 at 10:07 A.M. and 11:16 A.M. interview with the Administrator revealed she was not part of the conversation between Food Vendor #852 and CEO #805 on 04/10/24 and was only reporting (on 04/10/24) to the State agency what she had been told (by CEO #805). The Administrator verified the facility did not have a current food vendor and indicated she had no authority to make decisions about this as it was being handled by CEO #805. The Administrator then shared that CEO #805 had since gone out of state, she was having trouble reaching him and did not know when he would return other than hearing rumor of him being back on 04/16/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 04/12/24 at 10:40 A.M. interview with the Administrator revealed the facility was in the process of resuming services with Food Vendor #858 (one of their previous food vendors who had terminated due to non-payment). However, as of this date there was no evidence a first payment had been made to the vendor (per the vendors request) or evidence of confirmation of an actual food delivery being scheduled. The Administrator revealed the facility was in the beginning phases of the process with securing Food Vendor #858. Dietary Kitchen Manager #830 revealed she had approximately \$300.00 left on the credit card available to purchase food supplies as of this date/time.</p> <p>On 04/15/24 at 9:04 A.M. interview with Dietary Kitchen Manager #830 revealed she had been told by the Administrator that Food Vendor #858 was going to be the facility food vendor. Dietary Kitchen Manager #830 revealed she had been attempting to reach their food representative from this vendor since Friday with no success. She indicated CEO #805 was supposed to make payment and supposed to get an order, but stated she was unaware of what the status of this was as of this date/time. During the interview, Dietary Kitchen Manager #830 revealed the credit card she had been given to purchase food items with was no longer usable as it had been maxed out.</p> <p>On 04/15/24 at 9:11 A.M. a follow-up interview with Dietary Kitchen Manager #830 revealed she had spent \$78.00 to purchase milk this morning (previous milk supply from 04/12/24). She was unable to use the credit card to purchase anything else as of this time. During this interview, Dietary Manager #830 revealed a dietary cook had submitted a resignation, effective 04/24/24. Dietary Manager #830 confirmed her last date of employment would be 05/01/24.</p> <p>On 04/15/24 at 10:08 A.M. observation of the freezer and dry storage area with Dietary Kitchen Manager #830 revealed for the lunch meal on 04/15/24, which was scheduled to be spaghetti and meatballs, the facility was substituting meatballs and cream sauce.</p> <p>On 04/15/24 at 12:32 P.M. an interview with Resident #29's son with Dietary Kitchen Manager #830 in attendance revealed he comes in daily to visit his mother and the mother had not been receiving her ice cream every meal since 04/11/24. He stated his mother practically lives off of ice cream and coffee and he was upset that she was private pay and he had to stop at the store to get ice cream for his mother.</p> <p>Interview on 04/15/24 at 12:36 P.M. with Dietary Kitchen Manager #830 indicated she was aware they were out of ice cream since 04/10/24 and Resident #29 did not receive ice cream as ordered. She stated she went this morning, and the credit card she had been given to purchase food (in the absence of a food vendor) would not work to buy ice cream because the credit card had reached it max limit.</p> <p>In addition, review of RD #829's billing statement dated 01/31/24 with a due date of 02/22/24 revealed 49 hours were billed for consultant dietitian services for 01/2024 in the amount of \$2,205.00. The bill was unpaid as of 04/01/24.</p> <p>Review of RD #829's billing statement dated 02/26/24 with a due date of 03/22/24 revealed the facility owed 58.5 hours of consultant dietitian services for 02/24 in the amount of \$2,632.50. The bill was unpaid as of 04/01/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 04/01/24 at 11:09 A.M. interview with RD #829 with Kitchen Dietary Manager #830 in attendance indicated she had not been paid by the facility for 01/2024 and 02/2024 for a total amount due of \$4,630.00 which was due on 03/21/24. She indicated she provides the facility a 21-day grace period and sometimes it takes 45 days or 60 days for a payment, but she stated she does eventually receive payment. She stated she never knew when she would get paid.</p> <p>e. On 04/01/24 at 9:30 A.M. an attempt to contact the facility by telephone was unsuccessful. The call could not be completed as dialed. Interviews with staff during the investigation verified the facility phone system was not currently working and they could not receive incoming calls or make outgoing calls using the facility phone system. The staff interviewed revealed they had to use their own personal cell phones to make calls, including calls to physicians.</p> <p>On 04/01/24 at 2:18 P.M. telephone interview with Phone Representative #848 revealed telephone service in the building had been initiated in May 2022 and was not working on this date due to a technical issue. Phone Representative #848 revealed the facility had an outstanding current balance owed of \$3,170.00 for the rental of telephone equipment and this balance would have to be paid before the company would come out to service the phones. Phone Representative #848 revealed the facility broke their 5-year contract (end date 04/01/27) due to non-payment and now the full amount due must be paid in the amount of \$31,700.00 to resume services.</p> <p>On 04/01/24 from 2:43 P.M. to 3:00 P.M. interviews with Resident #15, #23, #24, and #52 revealed they used the facility phone to contact their family members.</p> <p>Review of the Telephone Rental bill dated 04/02/24 revealed the facility owed \$3,170.00 due on 03/01/24 and total amount owed as of 04/01/24 was \$31,700.00.</p> <p>On 04/02/24 at 12:20 P.M., an interview with the Administrator and the DON revealed the facility had begun receiving emails from family, vendors and dialysis centers regarding residents because the facility phones were not working. The Administrator indicated she</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure initial comprehensive assessments were completed timely and as required. This affected seven residents (#3, #5, #11, #22, #45, #130 and #133) of 24 residents reviewed for comprehensive assessments.</p> <p>Findings include:</p> <p>1. Review of Resident #3's medical record revealed the resident was admitted on [DATE] with diagnoses including non-traumatic subarachnoid hemorrhage, diabetes and hypertension.</p> <p>Review of Resident #3's Admission Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed the assessment was in progress.</p> <p>Interview on 04/01/24 at 8:10 A.M. with Business Office Manager (BOM) #831 confirmed Resident #3's comprehensive assessment was not completed timely.</p> <p>2. Review of Resident #5's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including acute kidney failure with acute cortical necrosis, chronic obstructive pulmonary disease and hypertension.</p> <p>Review of Resident #5's Admission MDS 3.0 comprehensive assessment dated [DATE] revealed the assessment was in progress.</p> <p>Interview on 04/01/24 at 8:10 A.M. with BOM #831 confirmed Resident #5's comprehensive assessment was not completed timely.</p> <p>3. Review of Resident #11's medical record revealed the resident was admitted on [DATE] with diagnoses including end stage renal disease, polyneuropathy and legal blindness.</p> <p>Review of Resident #11's Admission MDS 3.0 comprehensive assessment dated [DATE] indicated the assessment was in progress.</p> <p>Interview on 03/27/24 at 9:10 A.M. with the Administrator confirmed Resident #11's Comprehensive MDS 3.0 assessment was due 03/15/24 and it was not completed timely.</p> <p>4. Review of Resident #22's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia without behavioral disturbance, hyperlipidemia and essential hypertension.</p> <p>Review of Resident #22's Admission MDS 3.0 comprehensive assessment dated [DATE] revealed the assessment was in progress.</p> <p>Interview on 04/01/24 at 8:25 A.M. with BOM #831 confirmed Resident #22's MDS 3.0 comprehensive assessment dated [DATE] was not completed timely as required.</p> <p>(continued on next page)</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Review of Resident #45's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including type two diabetes, unsteadiness on the feet and other lack of coordination.</p> <p>Review of Resident #45's Admission MDS 3.0 comprehensive assessment dated [DATE] indicated the assessment was in progress.</p> <p>Interview on 03/27/24 at 9:10 A.M. with the Administrator confirmed Resident #45's Comprehensive MDS 3.0 assessment was due 03/15/24 and it was not completed timely.</p> <p>6. Review of Resident #130's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Crohn's disease of the large intestine, age-related physical debility and other lack of coordination.</p> <p>Review of Resident #130's MDS 3.0 comprehensive assessment (discharge assessment) dated 03/01/24 revealed the assessment was in progress.</p> <p>Interview on 04/01/24 at 8:25 A.M. with BOM #831 confirmed Resident #130's MDS 3.0 comprehensive assessment dated [DATE] was not completed as required.</p> <p>7. Review of Resident #133's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including other diseases of the tongue, bipolar disorder and dysphagia.</p> <p>Review of Resident #133's Admission/Discharge Return Not Anticipated MDS dated [DATE] revealed the assessment was in progress.</p> <p>Interview on 04/01/24 at 8:25 A.M. with BOM #831 confirmed Resident #133's MDS 3.0 comprehensive assessment dated [DATE] was not completed timely as required.</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure comprehensive assessments were completed quarterly as required. This affected four residents (#13, #33, #90 and #126) of 24 residents reviewed for comprehensive assessments.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of Resident #13's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure with hypoxia, other lack of coordination and diabetes. <p>Review of Resident #13's Quarterly Minimum Data Set (MDS) 3.0 comprehensive assessment dated [DATE] revealed the comprehensive assessment was in progress.</p> <p>Interview on 04/01/24 at 8:10 A.M. with Business Office Manager (BOM) #831 confirmed Resident #13's comprehensive assessment was not completed timely.</p> <ol style="list-style-type: none"> Review of Resident #33's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, muscle wasting and major depressive disorder. <p>Review of Resident #33's Quarterly MDS 3.0 assessment dated [DATE] revealed the comprehensive assessment was in progress.</p> <p>Interview on 03/27/24 at 9:10 A.M. with the Administrator confirmed Resident #33's quarterly comprehensive assessment was not completed timely.</p> <ol style="list-style-type: none"> Review of Resident #90's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Parkinson's disease, heart failure and anemia. <p>Review of Resident #90's Discharge MDS 3.0 assessment dated [DATE] revealed the comprehensive assessment was in progress.</p> <p>Interview on 03/27/24 at 9:10 A.M. with the Administrator confirmed Resident #90's discharge comprehensive assessment was not completed timely.</p> <ol style="list-style-type: none"> Review of Resident #126's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease, lack of coordination and unsteadiness on the feet. <p>Review of Resident #126's Discharge Return Anticipated comprehensive assessment dated [DATE] revealed the assessment was in progress.</p> <p>Interview on 04/01/24 at 8:10 A.M. with BOM #831 confirmed Resident #126's discharge comprehensive assessment was not completed timely.</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review, facility policy review and interview, the facility failed to ensure Resident #90's discharge summary included the reconciliation of the resident's medications upon discharge. This affected one resident (#90) of one resident record reviewed for discharge.</p> <p>Findings include:</p> <p>Review of Resident #90's medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including Parkinson's disease, heart failure and anemia.</p> <p>Review of Resident #90's progress note dated 11/24/23 at 8:59 P.M. revealed the resident arrived at the facility alert times two with confusion.</p> <p>Review of Resident #90's progress note dated 02/16/24 authored by Social Service Designee (SSD) #828 revealed the resident was discharged to an assisted living by the wife and son. Hospice was updated.</p> <p>Review of Resident #90's Discharge Plan of Care form (Discharge Summary) dated 02/16/24 revealed the resident's medications were not reconciled to include the resident's current medications as well as the last dose administered. The list was not provided to the resident and/or resident representative upon discharge.</p> <p>Interview on 03/28/24 at 11:15 A.M. with the Administrator confirmed Resident #90's Discharge Plan of Care form was not complete and accurate and did not include the resident's medication reconciliation list.</p> <p>Interview on 03/28/24 at 11:13 A.M. with Resident #90's wife revealed at the time of the resident's discharge, the facility handed her paperwork and told her to sign the form. She indicated staff did not go over the discharge part of the paperwork including the resident's medication list.</p> <p>Review of the undated Discharge Policy and Procedure revealed the resident had the right to be informed of the policies at the time of admission, transfer, and/or discharge. Additionally, written communication at the time of admission, re-admission, transfers, or discharge would be provided to ensure a safe and orderly process.</p> <p>This deficiency represents past non-compliance investigated under Complaint Number OH00151839.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>34297</p> <p>Based on record review, review of the facility assessment, policy review and interview, the facility failed to maintain sufficient levels of staff to meet the total care needs of all residents due to a hostile work environment and insufficient funds to maintain staffing agency contracts. This had the potential to affect all 56 residents residing in the facility.</p> <p>Findings include:</p> <p>Interview on 03/26/24 at 8:36 A.M. with Scheduler #821 revealed with the use of agency staff, there was enough nursing staff as of this date but the facility was not paying the staffing agency bills and they would no longer be able to use agency staff as of 04/01/24. Scheduler #821 indicated the facility did not have enough of their own employed nurses to cover open shifts from 04/01/24 to 04/30/24.</p> <p>Interview on 03/26/24 at 9:45 A.M. with Chief Executive Officer (CEO) #805 revealed the facility had cash flow problems. CEO #805 revealed the facility had enough State tested Nursing Assistants (STNAs) but relied on agency staffing for open nursing shifts.</p> <p>Interview on 03/26/24 at 10:39 A.M. with Former Minimum Data Set (MDS) #826 revealed there was not enough staff and as a result resident care was not completed timely including answering call lights timely and providing incontinence care.</p> <p>Interview on 03/26/24 at 12:54 P.M. with Receptionist #849 confirmed Former MDS #826 terminated employment and indicated the facility was in the process of hiring a new MDS nurse. Receptionist #849 did not know who was completing resident MDS 3.0 comprehensive assessments during this time period.</p> <p>Interview on 03/27/24 at 9:10 A.M. with the Administrator revealed Former MDS #826 quit via text on 02/25/24.</p> <p>Interview on 03/27/24 at 1:44 P.M. with Business Office Manager (BOM) #831 revealed concerns that an administrative staff member retaliated against her because she brought up alleged fraud concerns involving Medicaid. BOM #831 indicated the facility was a hostile work environment and she had filed a grievance with the facility board of directors.</p> <p>Telephone interview on 03/28/24 at 11:13 A.M. with Resident #90's wife indicated the facility did not have a Director of Nursing (DON) and the facility was going through a lot of new people. Resident #90's wife felt they were short-handed and did not provide timely care.</p> <p>Telephone interview on 04/01/24 at 9:07 A.M. with Staffing Agency #837 indicated the facility owed a total of \$116,924.69 and the facility did not arrange a payment plan. Staffing Agency #837 indicated the vendor discontinued staffing services on 03/27/24 due to lack of sufficient payments.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 04/01/24 at 10:35 A.M. with Scheduler #821 indicated the facility started using Staffing Agency #871 in 06/2023 and four other staffing agencies. Scheduler #821 indicated she canceled all of them and started using Staffing Vendor #854 (Staffing Agency #837). Scheduler #821 revealed there were 49 nursing shifts from 04/01/24 to 04/30/24 that did not have a nurse scheduled for the shift. This included seven shifts from 04/01/24 to 04/06/24 which the DON indicated the administrative staff would have to fill in and they would take the staffing week by week.</p> <p>Review of the facility staffing schedules on 04/01/25 at 10:35 A.M. with Scheduler #821 verified the 49 nursing shifts from 04/01/24 to 04/30/24 that did not have a nurse scheduled for the shift. This included seven shifts from 04/01/24 to 04/06/24 which the Director of Nursing (DON) indicated the administrative staff would fill and they would take the staffing week by week.</p> <p>Interview on 04/01/24 at 10:39 A.M. with the interim DON and the Administrator indicated they were made aware Staffing Vendor #854 discontinued staffing services due to non-payment on 03/27/24.</p> <p>Interview on 04/02/24 at 2:29 P.M. with the Administrator indicated she had resigned her position and her last day was 04/22/24. The Administrator also revealed Rehab Director #824 had resigned his position with a last day of work on 04/05/24 due to the instability in the facility. The Administrator revealed a couple of the facility department heads had reported concerns of an administrative staff member's bad behaviors to the governing board but the board swept the bad behaviors under a rug.</p> <p>Interview on 04/03/24 at 2:08 P.M. with Board Member #866 revealed the board usually had meetings monthly which included three board members and CEO #805. Board Member #866 indicated an executive session meeting was held on 03/21/24 related to employee relations. Board Member #866 verified an employee had filed a grievance related to the work environment of the facility.</p> <p>On 04/03/24 at 11:38 A.M. an interview with the Administrator and the Director of Nursing (DON) revealed CEO #805 talked to all staff on 04/02/24 during the evening shift and told them the State agency had identified monetary concerns. The Administrator and DON revealed they felt the CEO created increased anxiety and panic with the staff because of his communication and even stated to staff that all of the facility bank accounts were frozen. The interim DON and Administrator indicated staff began calling off and had reported concerns about not getting a paycheck following the meeting. The Administrator indicated she felt the facility staffing was a concern.</p> <p>Interview on 04/04/24 at 11:10 A.M. with Dietary Kitchen Manager #830 indicated she resigned with a last day of 05/01/24 because an administrative staff member's ethics did not match hers and she was tired of being screamed at.</p> <p>Interview on 04/04/24 at 11:05 A.M. with Human Resources (HR) #822 confirmed the previous business office manager (BOM #870) resigned on 12/29/23 and BOM #831 was hired on 12/27/23 and then terminated by CEO #805 on 04/02/24. HR #822 also confirmed Former MDS Nurse #826 was hired on 01/02/24 and resigned on 02/25/24 and Former Marketing and Admissions Director #825 was hired on 11/27/23 and resigned on 03/17/24.</p> <p>Interview on 04/04/24 at 11:31 A.M. with the Administrator revealed her first day of work at the facility was 03/20/23 and her last day of work would be 04/22/24. Administrator indicated she was treated like she was dumb and she had extreme conflict between her and another administrative staff member. She stated she brought her concerns to the board of directors who dismissed them.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 04/04/24 at 11:15 A.M. with the interim DON revealed her last date of work in the facility would be 04/18/24. She indicated she would usually not request another assignment but CEO #805 came into her office on her first day of work and wanted to know how much she would take in compensation to quit her job at the staffing agency. The DON indicated she felt uncomfortable with the questioning and requested a new assignment.</p> <p>Interview on 04/04/24 at 12:03 P.M. with Social Services Designee (SSD) #828 revealed the facility phones had been disconnected and family members were calling her personal cell phone voicing concerns about their family members. She stated she put in her resignation notice on 03/04/24 with a last day of work to be on 04/05/24. She also confirmed she recently received a raise due to a change in her job description and it should have been reflected on her next paycheck dated 03/29/24. She stated on 04/01/24, CEO #805 came into her office and asked if she would take an Amazon gift card in lieu of the raise on her paycheck dated 03/29/24. She stated she informed CEO #805 that she could not pay her bills with an amazon gift card and needed the money.</p> <p>Telephone interview on 04/06/24 at 11:01 A.M. with the Administrator revealed a new Interim Administrator would start in the facility on 04/16/24. She also stated Activity Director #804 and Scheduler #821 both put in their resignations with the facility with a last date of work to be on 04/28/24. The Administrator also confirmed LPN Assistant Director of Nursing (ADON) #819 who was the facility infection preventionist was terminated on 04/05/24 due to an executive decision.</p> <p>Review of the Facility Wide Assessment form dated 05/23/23 revealed nursing management included a full-time DON, two full time unit managers, a full time MDS coordinator, a scheduling coordinator, three dayshift nurses, two nightshift nurses, seven STNAs for dayshift, seven STNAs for second shift and five STNAs for nightshift. The staffing also included a full-time Administrator, a transportation director, a registered dietitian, a full time maintenance/housekeeping/laundry director, a full time activities director, a full time SSD, a full time admissions/marketing director, a full time BOM, a full time HR director, a full time therapy director and contracted medical director.</p> <p>Review of the facility undated Nursing Home Admission Agreement revealed the facility would provide furnished room and board, routine nursing care and supplies for resident's use and such other personal services as may be necessary for resident's health, well being, and grooming. The facility would also provide meals, linens, housekeeping, social services, and activities, and other services as required by law.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152329 and Complaint Number OH00152153.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>34297</p> <p>Based on record review and interview, the facility failed to ensure a registered nurse (RN) served as a full-time director of nursing (DON). This had the potential to affect all 56 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the facility Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) form from 12/01/23 to 12/31/23 revealed the previous DON worked 7.50 hours on 12/01/23 and 6.75 hours on 12/02/23.</p> <p>Interview on 03/26/24 at 7:38 A.M. with the Administrator confirmed the facility was without a DON from 12/03/23 to 03/18/24 when another (interim) DON was brought into the building. The Administrator confirmed the RN staff currently working in the building did not want to take on the role as a full-time DON.</p> <p>Interview on 03/26/24 at 1:10 P.M. with the current Interim DON confirmed her first day worked in the facility was 03/18/24.</p> <p>Interview on 04/03/24 at 11:40 A.M. with the Interim DON revealed her last date of work in the facility was scheduled to be 04/18/24 and she requested her staffing agency to provide her with a new assignment.</p> <p>On 04/04/24 at 11:15 A.M. interview with the Interim DON revealed she did not usually request a new assignment but CEO #805 came in to her office during the first couple of days she was in the facility and asked her the monetary amount it would take to quit her job at the staffing agency and take the full time DON position. The Interim DON indicated she felt uncomfortable with CEO #805's questioning and requested that her staffing agency provide a new assignment.</p> <p>During a follow-up interview on 04/11/24 at 9:27 A.M. with the Interim DON, she indicated she was assigned to work at the facility as the Interim DON through a staffing agency. She stated she always signed up for a 30-day contract with the option to renew and her contract at the facility was from 03/18/24 to 04/18/24. She stated her agency contacted the facility and the Administrator told her agency that she did not want to extend her contract for another 30-days per her request. There was no evidence the facility had a plan in place to secure a new DON or Interim DON after 04/18/24.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00152205 and OH00152153.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Geriatric Center of Mansfield		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Blymyer Avenue Mansfield, OH 44903	

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to provide Resident #29 food items as ordered/planned. This affected one resident (#29) of three residents reviewed for dietary services.</p> <p>Findings include:</p> <p>Review of Resident #29's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anemia and dysphagia oropharyngeal phase.</p> <p>Review of Resident #29's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of Resident #29's physician's orders revealed an order dated 10/12/23 for a regular diet, pureed texture, thin liquids with no straw. The resident also had a physician's order, dated 01/26/23 for ice cream with all meals.</p> <p>Review of Resident #29's Nutritional Risk Assessment 10/15/23 revealed the resident was on a mechanical soft/thin liquids diet and continued Hospice services. Ice cream was offered at every meal with three ounces of med pass four times a day to prevent weight loss.</p> <p>Interview on 04/15/24 at 12:32 P.M. with Resident #29's son with Dietary Kitchen Manager #830 in attendance revealed the resident was ordered ice cream with every meal. The son indicated his mother lived off of coffee and ice cream. He was upset the resident had not been receiving the ice cream since 04/11/24.</p> <p>Interview on 04/15/24 at 12:36 P.M. with Dietary Kitchen Manager #830 confirmed the facility ran out of ice cream as of 04/10/24 and she was unable to purchase more ice cream on the morning of 04/15/24 due to a maxed out credit card. Dietary Kitchen Manager #830 confirmed Resident #29's ice cream would be delivered with the food delivery truck on 04/17/24.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152329.</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on record review and interview, the facility failed to ensure residents were provided with rehabilitative services such as but not limited to physical therapy, speech-language pathology and occupational therapy. This affected 19 residents (#3, #4, #6, #7, #8, #12, #13, #14, #19, #20, #23, #26, #30, #37, #44, #51, #55, #106, #107 and #108) and had the potential to affect all 56 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Review of the master therapy list revealed 20 residents were currently on therapy caseload/services including Resident #3, #4, #6, #7, #8, #12, #13, #14, #19, #20, #23, #26, #30, #37, #44, #51, #55, #106, #107 and #108.</p> <p>Review of an email from Therapy Credit Manager #847 from the facility contracted therapy department dated 03/28/24 at 1:53 P.M. revealed this vendor had not heard from anyone (from the facility) regarding payment or a plan to get current.</p> <p>On 04/01/24 at 1:50 P.M. an interview with Therapy Credit Manager #847 revealed the facility was outside their contracted terms due in part to money owed the therapy vendor. Therapy Credit Manager #847 revealed the facility had made a payment on 03/04/24 for \$6,000 and an additional payment on 03/11/24 for \$30,000. However, she stated the facility was supposed to make payments every thirty days and the facility was past due in the amount of \$20,072.15 for 01/2024 and \$35,108.80 for 02/2024 for a total of \$55,180.95.</p> <p>On 04/03/24 at 2:25 P.M. interview with Physical Therapy Assistant (PTA) #869 revealed the contracted therapy vendor was terminating therapy services from the building on 04/05/24 due to lack of payment.</p> <p>On 04/04/24 at 11:31 A.M. an interview with Administrator revealed of the 20 residents on therapy, seven residents, Resident #6, #7, #8, #13, #106, #107 and #108 requested to be transferred or sent home due to lack of therapy services.</p> <p>On 04/10/24 at 9:24 A.M. a telephone interview with the Administrator revealed CEO #805 was in negotiations with another therapy company to provide therapy services. No additional information was provided related to the status of the residents affected by the termination of therapy provider and their therapy needs between 04/05/24 and 04/10/24.</p> <p>On 04/11/24 at 4:30 P.M. the Administrator provided information CEO #805 had met with a new therapy company for possible new merger/contract for services and new therapy director. However, the Administrator indicated the date for implementation was unknown as of this time. In addition, CEO #805 was unavailable to provide any additional information related to therapy services at of this time.</p> <p>(continued on next page)</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/12/24 at 11:30 A.M. the facility provided a list of residents, including Resident #6, #7, #8, #13, #106, #107 and #108 who had actually discharged from the facility between 04/05/24 and 04/09/24 per their request due to the lack of therapy services available in the facility. Resident #12 discharged home on 04/06/24 after completing therapy services on 04/05/24.</p> <p>On 04/15/24 at 10:22 A.M. during an interview with the DON, the DON revealed the facility had not contracted with a therapy company to provide therapy services to residents as of this date.</p> <p>On 04/15/24 at 11:10 A.M. an interview with the Administrator revealed CEO #805 informed her that a meeting with a therapy company was held on 04/12/24 but as of this date, services for therapy/contracted provider was not confirmed.</p> <p>On 04/15/24 at 12:52 P.M. during a follow-up interview with the Administrator, the Administrator indicated CEO #805 had replied to a text message she had sent him regarding therapy. The Administrator revealed CEO #805 indicated they would have a new therapy company within 10 days. The Administrator revealed CEO #805 did not provide the name/phone number of the new therapy service and stated she was not aware if there was an actual contract yet.</p> <p>2. Review of Resident #44's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, diabetes and cerebral infarction.</p> <p>Review of Resident #44's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of Resident #44's last speech therapy (ST) visit note dated 04/05/24 revealed the resident was receiving ST for dysphagia. The summary indicated the facility was transitioning to a new therapy provider to be responsible for the plan of care (POC) effective 04/06/24. Therapy services last day in the facility was 04/05/24. Record review revealed as of 04/11/24 no new therapy provider had been secured and the resident had received no therapy between 04/06/24 and 04/12/24.</p> <p>Interview on 04/11/24 at 9:40 A.M. with Resident #44 indicated she was ordered therapy services and was not getting it.</p> <p>3. Review of Resident #51's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including other cerebral infarction, chronic obstructive pulmonary disease and hemiplegia affecting the right dominant side.</p> <p>Review of Resident #51's MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.</p> <p>Review of Resident #51's last physical therapy (PT) note dated 04/05/24 revealed the resident was receiving gait training. Therapy services last day in the facility was 04/05/24. Record review revealed no evidence of any additional therapy services being provided between 04/06/24 and 04/12/24.</p> <p>Interview on 04/11/24 at 9:35 A.M. with Resident #51 revealed she was not receiving therapy services and was getting rusty.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152329.</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>34297</p> <p>Based on record review, facility policy review, administrator agreement review, and interview, the facility failed to ensure an effective governing body, legally responsible to establish and implement policies regarding the management and operation of the facility, including but not limited to compliance with all financial obligations for the delivery of care. This had the potential to affect all 56 residents in the facility.</p> <p>Findings include:</p> <p>Interview on 03/26/24 at 7:38 A.M. with the Administrator revealed she began her employment with the facility on 03/20/23. During the interview she indicated she did not handle any financial aspects of the facility. The Administrator indicated the facility was a non-profit facility with a Board of Directors and Chief Executive Officer (CEO) #805 was responsible for the financial aspect of the facility including paying vendors.</p> <p>Interview on 03/26/24 at 9:45 A.M. with CEO #805 revealed the facility had cash-flow problems and the facility was on payment plans with multiple vendors. CEO #805 stated he handled the financial aspect of the facility along with a board of directors.</p> <p>On 03/27/24 at 1:44 P.M. a telephone interview with Business Office Manager (BOM) #831 revealed during routine audits she noted the facility was unable to process payments for resident care and the facility bills were not paid timely (date(s) not provided). BOM #831 indicating she reported these concerns to CEO #805 (date(s) not provided).</p> <p>As of 04/01/24, during an on-site investigation, the facility and/or vendors provided information of outstanding balances included but were not limited to the following:</p> <p>Balances of \$2205.00 and \$2,632.50 owed to Registered Dietitian (RD) #829, a balance of \$2,099.71 for Supply Vendor #853, a balance of \$56,348.62 for Staffing Vendor #854, a balance of \$23,795.48 for Pharmacy Collections #842, a balance of \$7,028.43 for Medical Supply #859, a balance of \$10,132.04 for Supply Vendor #860, a balance of \$12,722.19 for Food Vendor #858, a balance of \$40,259.27 for Food Vendor #852, a balance of \$11,091.80 for Information Technologies (IT) #843, a balance of \$55,180.95 for Therapy #847, a balance of \$3,170.00 for Phone #848, a balance of \$33,278.93 for Supply Vendor #857, a balance of \$1,175.74 for Monitoring Vendor #861, a balance of approximately \$5,200.00 to Oxygen Vendor #862 and a balance of \$5,642.97 to Water/Sewer Vendor #863. These balances totaled \$271,963.63.</p> <p>Delinquent balances owed to the water company resulted in a shut off notice issued 04/01/24 with water services to end 04/12/24, delinquent balances owed to the phone leasing company resulted in phone service interruption on 04/01/24, delinquent balances owed to the facility current food vendor resulted in food delivery being placed on hold on 04/02/24, and delinquent balances owed to the contracted therapy provider resulted in therapy services terminating on 04/05/24.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/03/24 at 12:08 P.M. an interview with Board Member #866 revealed the most recent board meeting was held on 03/21/24 which was an executive session due to an employee grievance. The meeting prior to this was held on 03/13/24 which himself, CEO #805, Board Member #867 and Board Member #868 were in attendance for. He stated during this meeting, the financial side of the building was discussed. He stated he was aware several vendors were not getting paid timely but stated he was not aware of any disconnection notices. Board Member #866 revealed it was his understanding CEO #805 worked out payment arrangements with the vendors including the food vendor. He stated he was aware therapy services discontinued their service and was also aware that the phones were not working. Board Member #866 revealed Plan B regarding the phones was arranged to include changing phone providers. No additional information was provided as to why the plan did not include paying the current phone service. He stated he comes to some of the facility QAPI meetings, but not all of them. He stated the board's stance on the facility money issues included trying to get a loan on the property or selling some of the property to an interested buyer.</p> <p>An additional interview on 04/09/24 at 10:42 A.M. with the Administrator indicated she did not handle any of the financial aspect of the facility and CEO #805 did not coordinate or discuss the financial part of the facility billing and payment of vendors with her. The Administrator confirmed she did not govern or manage the business office manager or human resources manager. She stated these two positions reported to CEO #805 and she could not effectively administer the facility including ensuring vendors were paid, billing was completed timely and resident assessments were completed timely.</p> <p>Review of the Administrator-Skilled Nursing/Assisted Living agreement form dated 09/2017 revealed the Administrator was responsible for the successful, ongoing overall operation of a Skilled Nursing Facility and assisted living community. The Administrator performs a variety of duties which support the community operations including planning, operating and directing the community in compliance with policies and procedures; developing an effective management team; overseeing continued development and implementation of the community strategic plan; overseeing the care provided through daily rounds, observations and interactions; assisting the CEO in developing operating budget and was responsible for keeping operations within the budget; and in charge of all financial aspects of the facility working with accounting, payroll, and accounts receivable.</p> <p>A request was made for the facility's policy on governing body and the facility did not have one to provide.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152329, Complaint Number OH00152205 and Complaint Number OH00152153.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>34297</p> <p>Based on record review, staff interview and policy review, the facility failed to ensure continuous evaluations were in place to verify financial obligations were met as planned to prevent a potential disruption in resident care and services through the Quality Assurance Performance Improvement (QAPI) program committee. This had the potential to affect all 56 facility residents.</p> <p>Findings include:</p> <p>A telephone interview on 04/01/24 at 1:41 P.M. with the Medical Director revealed he was not aware of the facility in arrears in payments. He denied concerns with residents having enough supplies, food, medications, or resident care. The Medical Director confirmed he had a quarterly Quality Assurance/Performance Improvement (QAPI) meeting the week prior and the facility did not bring up any issues with the inability to pay vendors. The Medical Director stated he was not involved in the financial side of the facility.</p> <p>Interview on 04/01/24 at 4:06 P.M. with Chief Executive Officer (CEO) #805 revealed the facility had a cash flow issue due to changes in management. CEO #805 indicated the Minimum Data Set (MDS) person quit recently and the Business Office Manager (BOM) quit recently, and the facility had a difficult time finding replacements. CEO #805 stated resident MDS 3.0 comprehensive assessments were not being completed in time and the facility was not generating payments for resident care due to late MDS assessments. He denied the facility initiated a QAPI meeting to develop a QAPI plan which would ensure vendors were paid in a timely manner to prevent actual or potential interruption in services and to meet the total care needs of all residents admitted to and/or retained in the facility. He stated the facility had three options, keep going like they were, find new staff to timely complete resident care and billing or shut down the facility.</p> <p>An additional interview on 04/01/24 at 4:24 P.M. with CEO #805 indicated the facility was contacting staff from the staffing agencies who worked in the facility to see if they would pick up shifts outside of their agency hours at a set rate. He stated the facility had to think outside the box and the residents were not affected at this point because the residents did not go without staff, food or supplies. He denied the facility did a Quality Assurance/Performance Improvement (QAPI) plan related to the facility's financial solvency issues and inability to pay bills.</p> <p>Review of the Deposit Accounts bank statement dated 04/01/24 revealed the skilled nursing facility had a current balance in its general fund operations account of \$6,971.18.</p> <p>As of 04/01/24, during an on-site investigation, the facility and/or vendors provided information of outstanding balances included but were not limited to the following:</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Balances of \$2205.00 and \$2,632.50 owed to Registered Dietitian (RD) #829, a balance of \$2,099.71 for Supply Vendor #853, a balance of \$56,348.62 for Staffing Vendor #854, a balance of \$23,795.48 for Pharmacy Collections #842, a balance of \$7,028.43 for Medical Supply #859, a balance of \$10,132.04 for Supply Vendor #860, a balance of \$12,722.19 for Food Vendor #858, a balance of \$40,259.27 for Food Vendor #852, a balance of \$11,091.80 for Information Technologies (IT) #843, a balance of \$55,180.95 for Therapy #847, a balance of \$3,170.00 for Phone #848, a balance of \$33,278.93 for Supply Vendor #857, a balance of \$1,175.74 for Monitoring Vendor #861, a balance of approximately \$5,200.00 to Oxygen Vendor #862 and a balance of \$5,642.97 to Water/Sewer Vendor #863. These balances totaled \$271,963.63.</p> <p>Delinquent balances owed to the water company resulted in a shut off notice issued 04/01/24 with water services to end 04/12/24, delinquent balances owed to the phone leasing company resulted in phone service interruption on 04/01/24, delinquent balances owed to the facility current food vendor resulted in food delivery being placed on hold on 04/02/24, and delinquent balances owed to the contracted therapy provider resulted in therapy services terminating on 04/05/24.</p> <p>Review of the facility Performance Improvement Committee policy and procedure revised 07/2007 revealed the facility shall establish and maintain a performance improvement committee which identified and addresses quality issues, and implements corrective improvement action plans as necessary. The Administrator may delegate the necessary authority for actions and processes inherent in the performance improvement program to the Performance Improvement Committee. The committee shall be a standing committee of the facility, and its chairperson shall have direct access and reporting ability to the Administrator and governing board (body). The primary goals of the Performance Improvement Committee are to monitor and evaluate the appropriateness and quality of care provided within the framework of the Performance Improvement Plan; and to provide a means whereby negative outcomes relative to resident care can be identified and resolved through an interdisciplinary approach, and positive outcomes can be reinforced through education and monitoring.</p>		