STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365152	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schoenbrunn Healthcare	2594 East High Avenue New Philadelphia, OH 44663

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, policy review and interview, the facility failed to develop a discharge plan of care. This affected one resident (#75) of four sampled residents. The facility census was 73. Findings include: Closed medical record review revealed Resident #75 was admitted on [DATE] with diagnoses including cerebral infarction, diabetes mellitus type-1, tracheostomy and anoxic brain injury. Resident #75 was discharged from the facility on 08/14/24. Review of the electronic mail correspondence (dated 07/12/24) between Resident #75's power of attorney and Social Service Designee (SSD) #177 revealed additional information was needed from a home care provider of products/services regarding any and all orders being placed that SSD #177 had placed. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment (dated 07/31/24) revealed Resident #75 was moderately impaired for daily decision-making and had no active discharge planning or referrals made regarding discharge for the resident. Review of the Nursing Note dated 08/14/24 revealed Resident #75 was discharged from facility with her significant other, supplies and medications. Review of the record revealed no evidence of a discharge plan of care. On 09/16/24 at 2:49 P.M., interview with Social Service Designee (SSD) #177 revealed Resident #75 was admitted in April (2024) and upon admission the plan was to discharge back to the community. The resident and her power of attorney had decided to return to North Carolina and SSD #177 began working on setting up supplies and equipment in North Carolina. SSD #177 verified she had been speaking with providers trying to set things up and provided emails sent including one dated 07/12/24. SSD #117 verified she did not develop a discharge plan of care for Resident #75 because she was afraid she would forget to update it. SSD #177 stated she normally does one upon admission but it was undecided as to the resident's discharge plans at that time. SSD #177 verified she had been working on discharge plans for about a month prior to Resident #75's discharge, had not developed a discharge plan of care and the MDS assessment dated [DATE] was not accurate for discharge planning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy: Discharge Planning Process (dated 2023) revealed the facility was to develop and implement an effective discharge planning process that focused on the resident's discharge goals. The expected goals and outcomes regarding discharge was to be determined upon admission, routinely with the comprehensive assessment and as needed. Subsequent assessment information and discharge goals were to be included in the resident's comprehensive plan of care. If discharge to community is a goal, an active discharge care plan will be implemented an will involve the interdisciplinary team, including the resident and/or representative. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156997.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review and interview, the facility failed to ensure comprehensive care plans were revised with resident preferences. This affected one resident (#75) of four sampled residents. The census was 73. Findings include: Closed medical record review revealed Resident #75 was admitted on [DATE] with diagnoses including cerebral infarction, diabetes mellitus type-1, tracheostomy and anoxic brain injury. Resident #75 was discharged from the facility on 08/14/24. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #75 was cognitively intact for daily decision-making and frequently incontinent of urine and bowel. Review of the care plan: Preferences (initiated 04/11/24 and revised 08/09/24) revealed Resident #75 had the right to make lifestyle choices as evidenced by preferring to appear more masculine and desiring to grow a beard. Resident #75 also preferred to be addressed as they/them pronouns during stay and keep the room warmer regardless of outside temperature. Interventions included staff would assist the resident with preferences as able. On 09/16/24 at 1:29 P.M., interview with the Director of Nursing (DON) revealed the facility had a male agency State tested Nursing Aide (STNA) #502 who worked on 05/30/24 and provided care to the resident on the nightshift. No concerns from the resident was voiced at that time regarding the care provided. The DON stated the facility was later notified by Resident #75's power of attorney that the resident did not want male caregivers. It was not until that time the facility became aware that Resident #75 did not want male caregivers, and all male staff were removed from the unit as not to provide care to the resident. On 09/16/24 at 3:10 P.M., interview with the DON verified the resident's preference care plan had not been revised to reflect she did not want male caregivers providing care. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156997.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on closed record review, policy review and interview, the facility failed to ensure tracheotomy care was completed as ordered. This affected two residents (#64, #75) reviewed for tracheostomy care. The facility identified no residents currently in the facility with a tracheostomy. The census was 73. Findings include: 1. Closed medical record review revealed Resident #64 was admitted on [DATE] with diagnoses including cerebral infarction, epilepsy, acute tracheitis without obstruction, hypertension and acute kidney failure. Resident #64 was discharged from the facility on 09/13/24. Review of the admission Minimum Data Set 3.0 assessment (MDS) (dated 07/16/24) revealed the resident received oxygen, suctioning and tracheostomy care. Review of the electronic Physician Orders (dated 07/09/24) revealed tracheostomy care was to be completed every shift, aerosol and cool mist was to be changed weekly, oxygen tubing and set up was to be changed weekly, and 35% trach collar 5 liters of oxygen via cool mist was to be checked every shift. Review of the Treatment Records (dated July, August and September 2024) revealed the following: a. Tracheostomy care was not completed as ordered on 07/17/24, 08/05/24, 08/14/24 and 09/05/24. b. Aerosol/cool mist and oxygen tubing/set up was not changed as ordered on 07/17/24. Review of the care plan: Tracheostomy (dated 07/15/24) revealed the resident was able to do his own tracheostomy care with partial assist of staff and providing equipment. There were no interventions regarding changing or cleaning of equipment. 2. Closed medical record review revealed Resident #75 was admitted on [DATE] with diagnoses including cerebral infarction, diabetes mellitus type-1, tracheostomy and anoxic brain injury. Resident #75 was discharged from the facility on 08/14/24. Review of the quarterly MDS assessment (dated 07/31/24) revealed Resident #75 was moderately impaired for daily decision-making, received oxygen, suctioning and tracheostomy care. Review of the electronic Physician Orders 04/08/24 revealed tracheostomy care was to be completed every shift, aerosol and cool mist was to be changed weekly, oxygen tubing and set up was to be changed weekly. Review of the Treatment Records (dated June and July 2024) revealed the following: a. Aerosol/cool mist and oxygen tubing/set up was not changed as ordered on 06/10/24 or 06/26/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Disposable respiratory equipment was not changed on 06/10/24. c. Daily tracheostomy care was not completed on 07/10/24, 07/11/24 or 07/17/24. Review of the care plan: Tracheostomy related to complications of CVA (cerebral vascular accident) (dated 04/26/24) revealed no interventions regarding cleaning of equipment or daily care. Review of the policy: Tracheostomy Care (dated 2023) revealed the facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheostomy care was also to be provided according to the physician's orders and general considerations included to provide tracheostomy care at least twice daily. On 09/16/24 at 3:21 P.M., interview with the Director of Nursing verified there was no evidence Resident #64 and #75's tracheostomy and respiratory orders were completed as ordered as indicated above. This deficiency represents non-compliance investigated under Complaint Number OH00156997.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure proper gloving and hand washing was completed during incontinence care. This affected one resident (#26) observed for incontinence care. The facility identified 41 incontinent residents. The census was 73. Findings include: Medical record review revealed Resident #26 was admitted on [DATE] with diagnoses including dementia, obstructive and reflux uropathy and functional incontinence. On 09/16/24 between 2:00 P.M. and 2:05 P.M., observation of Resident #26's incontinence care revealed State tested Nurse Aide (STNA) #144 and Housekeeping Aide #155 gathered supplies, washed their hands and applied gloves. Resident #26's incontinence product was removed and observed to be urine soaked. STNA #144 cleansed and rinsed the perineal area, rolled the resident on her right side and cleansed and rinsed the anus and buttocks. STNA #144 placed a clean incontinence product on the resident, adjusted the resident's gown, call light and bed linens while wearing the same soiled gloves worn for incontinence care. STNA #144 gathered her soiled supplies and then removed her gloves. STNA #144 walked the soiled supplies down the hallway to the shower room, placed them in a bin for laundry and went to the sink and washed her hands. On 09/16/24 at 2:05 P.M., interview with STNA #144 verified she had not changed her gloves during incontinence care or adjusting the resident's gown, call light or bed linens, and did not wash her hands prior to leaving the resident's room stating she hadn't given it a thought. Review of the policy: Hand Hygiene (dated 2024) revealed all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The use of gloves does not replace hand hygiene and if your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the policy: Perineal Care (dated 2023) revealed to cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes. Thoroughly dry and re-position resident in supine position. Change gloves if soiled and continue with perineal care. Once resident was cleansed, reposition as desired and cover resident. Remove gloves and discard. Perform hand hygiene, ensure call light is within reach and replace all equipment used. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156997.