

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Suburban Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 20265 Emery Rd North Randall, OH 44128	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, interview and record review the facility failed to provide adequate mouth care for dependent residents. This affected two (#22 and #88) of two residents observed for mouth care. The facility census was 112.</p> <p>Finding include:</p> <p>1. Review of Resident #22's medical records revealed an admitted [DATE]. Diagnoses included stroke with left sided weakness, paraplegia and respiratory failure.</p> <p>Review of Resident #22's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was dependent for mouth care, bathing and personal hygiene.</p> <p>Review of Resident #22's care plan dated 07/10/24 revealed Resident #22 had self care performance deficits related to paraplegia. Interventions included provide mouth care every shift and as needed.</p> <p>Observation on 09/03/24 at 9:01 A.M. of Resident #22 with the Assistant Director of Nursing (ADON) revealed Resident #22's mouth and lips were dry and cracked and Resident #22 had skin hanging from his lips. ADON confirmed Resident #22 required mouth care from staff due to his dry and cracked lips and stated mouth care should be completed daily. Resident #22 was not interviewable.</p> <p>Review of facility's undated policy Activities of Daily Living revealed appropriate care and services would be provided for residents who were unable to carry out ADLs independently including oral hygiene.</p> <p>2. Review of Resident #88's medical records revealed an admitted [DATE]. Diagnoses included quadriplegia, traumatic brain injury and muscle weakness.</p> <p>Review of Resident #88's MDS assessment dated [DATE] revealed Resident #88 was rarely understood. Resident #88 was dependent for mouth care, bathing and personal hygiene.</p> <p>Review of Resident #88's care plan dated 07/23/24 revealed Resident #88 had oral problems related to poor oral hygiene. Interventions included provide mouth care per activities of daily living (ADLs).</p> <p>(continued on next page)</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 09/03/24 at 12:41 P.M. of Resident #88 with the ADON revealed Resident #88's top lip was stuck to his upper teeth and his mouth was dry and lips were cracked. Resident #88 had a large amount of plaque build up on his upper and lower teeth. The ADON confirmed Resident #88 required mouth care and stated mouth care should be completed daily. Resident #88 was not interviewable.</p> <p>Review of facility's undated policy Activities of Daily Living revealed appropriate care and services would be provided for residents who were unable to carry out ADLs independently including oral hygiene.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155857.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, interview and record review the facility failed to provide timely incontinence care and adequate urinary catheter care. This affected one (#22) of three residents observed for incontinence care and urinary catheter care. The facility census was 112.</p> <p>Findings include:</p> <p>Review of Resident #22's medical records revealed an admitted [DATE]. Diagnoses included bladder dysfunction and stroke with left sided weakness.</p> <p>Review of Resident #22's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had impaired cognition, was incontinent of bowel and had a urinary catheter.</p> <p>Review of the care plan dated 07/10/24 revealed Resident #22 was incontinent of bowel. Interventions included provide pericare after incontinence episodes. Resident #22 had an indwelling urinary catheter. Interventions included check for incontinence and check tubing for kinks each shift.</p> <p>Observation of incontinence care on 08/28/24 at 11:53 A.M. for Resident #22 with State tested Nursing Assistant (STNA) #278 and STNA #328 revealed Resident #22's mattress pad underneath him was saturated with urine and stool that had dried in some areas and had soaked through the mattress pad onto the mattress. Further observation revealed Resident #22 had a urinary catheter. The urinary catheter had dried crusted debris around the insertion site and a thick white discharge, with a foul odor was observed. Interview with STNA #278 at time of observation, revealed she had not cared for Resident #22 since she had started her shift at 7:00 A.M. and was unaware when Resident #22 had last received incontinence care or catheter care. Resident #22 was unable to state when he had last received incontinence care or catheter care.</p> <p>Observation on 09/03/24 at 9:01 A.M. of Resident #22 with the Assistant Director of Nursing (ADON) revealed Resident #22's absorbent pad underneath him was saturated with urine that had soaked through to his sheets. At time of observation STNA #355 entered the room to provide assistance with incontinence care for Resident #22. STNA #355 stated she was not assigned to Resident #22 but had come to assist with providing Resident #22 with care. The ADON and STNA #355 stated they were unaware of when Resident #22 had last received incontinence care. Resident #22 was sleepy during care and did not answer questions appropriately.</p> <p>Review of facility's undated policy titled Activities of Daily Living revealed appropriate care and services would be provided for residents who were unable to carry out activities of daily living independently which included toileting.</p> <p>Review of facility policy Catheter Care revised 11/27/23 revealed catheter care would be performed every shift and as needed by nursing personnel.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155857.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, interview and record review the facility failed to provide appropriate care related to Resident #22's Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube inserted through the abdominal wall and into the stomach to provide nutrition and hydration). This affected one (#22) of two residents observed for PEG tubes. The facility census was 112.</p> <p>Findings include:</p> <p>Review of Resident #22's medical records revealed an admitted [DATE]. Diagnoses included dysphasia (difficulty swallowing), inhalation of food and stroke with left sided weakness.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had impaired cognition, had a feeding tube, and was dependent for feeding.</p> <p>Review of care plan dated 07/10/24 revealed Resident #22 required tube feedings. Interventions included checking feeding tube for placement, and monitoring for infection at the tube site.</p> <p>Observation of Resident #22 on 08/28/24 at 11:53 A.M. with State tested Nursing Assistant (STNA) #278 revealed Resident #22 had a PEG tube. Resident #22's PEG tube site had dark colored crusted debris surrounding the insertion site and the surrounding skin was reddened. Interview with STNA #278 at time of observation revealed she did not provide care for PEG tubes, the nurses were to provide the care.</p> <p>Observation of Resident #22 on 08/28/24 at 12:29 P.M. with Licensed Practical Nurse (LPN) #202 confirmed the crusted debris around Resident #22's PEG tube insertion site. LPN #202 stated she had not provided care of the PEG tube on this date and PEG tubes and the skin around the insertion site were to be cleaned daily and as needed.</p> <p>Observation on 09/03/24 at 9:01 A.M. of Resident #22 with the Assistant Director of Nursing (ADON) revealed Resident #22's PEG tube had a split gauze around the insertion site that had a large amount of dried brownish colored crusted debris. The ADON removed the split gauze and further observation revealed a large amount of dried crusted debris surrounding the insertion site. The ADON cleansed the PEG tube site with normal saline and the surrounding skin was reddened. The ADON stated PEG tube sites were to be cleaned daily and as needed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155857.</p>		