

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Wilmington Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Hale Street Wilmington, OH 45177	

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 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>44412</p> <p>Based on resident and staff interviews and review of the resident right's handbook, the facility failed to ensure residents received mail on the weekends. This had the potential to affect all 63 residents residing in the facility.</p> <p>Findings include:</p> <p>Interviews on the annual survey on 07/08/24, 07/09/24, and 07/10/24 with Residents #18, #21, #27, #47, #52, and #53 revealed mail was not delivered on the weekends, only Monday through Friday.</p> <p>Interview on 07/11/24 at 10:49 A.M. with Business Office Manager (BOM) #155 revealed residents were supposed to receive mail on Saturdays except insurance related mail. BOM #155 reported the activities department was who passed out the mail.</p> <p>Interview on 07/11/24 at 11:13 A.M. with Activities Director #125 verified mail was not handed out on Saturdays, but only Monday through Friday.</p> <p>Review of the resident rights handbook revealed the resident had the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility for the resident thought a means other than a postal service including privacy of such communication consistent with this section, and access to stationary, postage, and writing implements at the resident's own expense.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44412</p> <p>Based on record review, resident and staff interviews, and policy review, the facility failed to complete quarterly care conferences for residents residing in the facility. This affected four (#18, #21, #29, and #52) of five residents reviewed for care conferences. The facility census was 63.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease (COPD), convulsions, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had moderate cognitive impairment.</p> <p>Review of the medical record for care conferences for the last 12 months revealed Resident #18 only had two care conferences dated 09/27/24 and 04/10/24.</p> <p>Interview on 07/09/24 at 2:40 P.M. with Social Services Designee (SSD) #145 verified Resident #18 had only received two care conferences in the last 12 months.</p> <p>2. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, emphysema, anxiety disorder, and bronchiectasis. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had intact cognition.</p> <p>Review of the care conferences for the last 12 months for Resident #21 revealed he had one care conference completed on 09/01/23.</p> <p>Interview on 07/09/24 on 2:41 P.M. with Social Services Designee (SSD) #145 verified Resident #21 had only had one care conference in the last 12 months.</p> <p>3. Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis affecting right dominant side, congestive heart failure, and depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had intact cognition.</p> <p>Review of the medical record for care conferences for the last 12 months revealed Resident #52 had only received one care conference on 08/23/23.</p> <p>Interview on 07/09/24 at 2:42 P.M. with Social Services Designee (SSD) #145 verified Resident #52 had only received one care conference in the last 12 months.</p> <p>31404</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #29's medical record revealed an admitted [DATE]. Diagnoses included cerebral infarction, type two diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction, hypertensive heart disease, dysphagia following cerebral infarction, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact.</p> <p>Review of Resident #29's medical record for the last 12 months revealed there was only two care conferences in the last year on 08/02/23 and 03/20/24.</p> <p>Interview with Resident #29 on 07/08/24 9:49 A.M. revealed she can not remember having care conferences every three months.</p> <p>Interview with Social Services Designee (SSD) #145 on 07/10/24 at 3:57 P.M. verified the residents should have care conferences every three months. SSD #145 verified Resident #29 only had two care conferences in the last year on 08/02/23 and 03/20/24.</p> <p>Review of the facility's Comprehensive Care Planning Policy dated 03/02/21 revealed a comprehensive care plan must be developed by the interdisciplinary care planning team within seven days after completion of the comprehensive assessment (MDS). The comprehensive care pan is reviewed and updated at least every 90 days by the interdisciplinary team.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Based on medical record review, resident and staff interviews, observation, and policy review, the facility failed to ensure residents received timely foot care. This affected one (#18) of three residents reviewed to activities of daily living. The facility census was 63.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus (DM II), chronic obstructive pulmonary disease (COPD), convulsions, and anxiety disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had moderate cognitive impairment. Resident #18 was dependent on staff with bathing.</p> <p>Review of the podiatry note dated 10/27/23 revealed Resident #18 was seen and needed to follow up in two to three months. The podiatry note dated 01/12/24 revealed Resident #18 refused to be seen. The podiatry appointment dated 03/29/24 revealed Resident #18 was supposed to be seen but the podiatrist canceled.</p> <p>The podiatry appointments dated June 2024 revealed Resident #18 was not seen in June 2024.</p> <p>Observations on 07/08/24 at 11:12 A.M. and 07/10/24 at 9:34 A.M. revealed Resident #18's toenails were overgrown and curling under his toes. They were thick and yellow and the surrounding skin was dry and peeling.</p> <p>Interview on 07/10/24 at 9:24 A.M. with Resident #18 revealed he wanted his toenails cut because they were extremely long and curling under his toes.</p> <p>Interview on 07/10/24 at 9:33 A.M. with Assistant Director of Nursing (ADON) verified Resident #18's toenails were overgrown and curling under his toes, which could put Resident #18 at risk for skin impairment.</p> <p>Interview on 07/10/24 at 10:34 A.M. with Social Services Designee (SSD) #145 verified Resident #18 was scheduled to be seen in March, but the podiatrist canceled. SSD #145 stated Resident #18 was not scheduled to be seen in June 2024 because she had troubles with 360 care not rescheduling residents when appointments were scheduled. SSD #145 verified she did not follow up on Resident #18 to ensure he was rescheduled.</p> <p>Review of the facility policy titled Social Services Policy dated 03/01/24 revealed social services would ensure follow up to any ancillary services.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069</b></p> <p>Based on record review, staff interview, and policy review, the facility failed to ensure residents were free from significant medication errors. This affected one (#39) of one resident reviewed for significant medication errors. The facility census was 63.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included acute embolism and thrombosis of deep veins of lower extremity and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had severely impaired cognition.</p> <p>Review of Resident #39's progress note dated 01/30/24 revealed an order was received to increase Warfarin (blood thinner) to six milligrams (mg) on Monday and Thursday, and continue five mg on Saturday, Sunday, Tuesday, Wednesday, and Friday.</p> <p>Review of Resident #39's physician orders revealed an order dated 01/30/24 to 02/15/24 for Warfarin five mg once a day with special instructions for Sunday, Tuesday, Wednesday, Friday, and Saturday. The physician orders dated 02/01/24 to 02/15/24 was for Warfarin six mg once a day with special instructions for Monday and Thursday.</p> <p>Review of the Medication Administration Record (MAR) from 02/01/24 to 02/29/24 revealed Resident #39 was administered both doses of Warfarin five mg and Warfarin six mg on eight days (02/03/24, 02/04/24, 02/05/24, 02/06/24, 02/08/24, 02/09/24, 02/10/24, and 02/11/24).</p> <p>Review of the progress note dated 02/13/24 revealed the MAR displayed double orders for two different doses of Warfarin with special instructions for different days, but the orders were entered to be repeated every day.</p> <p>Interview on 07/11/24 at 12:53 P.M. with the Director of Nursing (DON) confirmed Resident #39 was administered both doses of Warfarin five mg and Warfarin six mg on 02/03/24, 02/04/24, 02/05/24, 02/06/24, 02/08/24, 02/09/24, 02/10/24, and 02/11/24.</p> <p>Review of the facility policy titled General Dose Preparation and Medication Administration, revised 04/30/24, revealed facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, and for the correct resident.</p>		