Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Wapakoneta Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Lincoln Ave Wapakoneta, OH 45895	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on observations, record review, staff interviews, and policy review, the facility failed to ensure Resident #210's catheter bag was covered to promote dignity. This affected one (Resident #210) of one residents reviewed for dignity. The facility census was 62. Findings include: Review of Resident #210's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including acute kidney failure and benign prostatic hyperplasia without lower urinary tract symptoms. Review of Resident #210's physician's orders revealed an order dated 05/13/24 to use privacy bag for catheter bag every shift. Observation on 05/13/24 at 9:50 A.M. revealed Resident #210's Foley catheter bag, with urine present, hanging on the bed side dresser visible from the hallway. There was no privacy bag present. Observation on 05/14/24 at 9:40 A.M. revealed Resident #210 resting in bed with the Foley catheter bag, with urine present, hanging on bedframe on the right side of bed without a Foley privacy bag, visible from hallway. Observation on 05/15/24 at 11:38 A.M. revealed Resident #210 in therapy department for therapy services without a Foley catheter privacy bag, urine was present in Foley catheter bag. Interview on 05/15/24 at 11:38 A.M. with Certified Occupational Therapy Assistant (COTA) #408 confirmed Resident #210 was in the therapy department for therapy services without a Foley privacy bag with urine present. Interview on 05/15/24 at 11:46 A.M. with State tested Nursing Assistant (STNA) #275 confirmed Resident #210's Foley catheter bag with urine present was visible from the hallway and has not had a privacy bag all day. STNA #275 was not aware of where the privacy covers are. Review of the Quality of Life Policy dated 04/15/13 revealed, The Manor will care for the residents in a manner and in an environment that promotes maintenance or enhancement of each residents quality of life.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Wapakoneta Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Lincoln Ave Wapakoneta, OH 45895	

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** 36303 Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure resident comprehensive care plans had interventions for psychiatric disorders. This affected one (Resident #18) of two reviewed for care planning. The census was 62. Findings Include: Review of Resident #18's medical record revealed an admitted [DATE]. Diagnoses listed included Post-Traumatic Stress Disorder (PTSD), major depressive disorder, anxiety disorder, and type two diabetes mellitus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact with a diagnoses of PTSD. Interview with Resident #18 on 05/13/24 at 2:33 P.M. revealed she had not had a care conference since admission. Review of Resident #18's comprehensive care plan revealed PTSD was not listed and no interventions were in place. Interview with Corporate Registered Nurse (CRN) #361 on 05/14/24 at 3:50 P.M. confirmed a PTSD diagnosis and interventions were not listed on Resident #18's comprehensive care plan. Review of the facility's policy titled, Comprehensive Care Plan, revised 11/02/16 revealed the facility will develop a comprehensive person centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Wapakoneta Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Lincoln Ave Wapakoneta, OH 45895	

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 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** 36303 Based on medical record review and staff interview, the facility failed to hold care conferences with residents. This affected (Residents #07 and #18) of two residents reviewed for care conferences. Additionally, the facility also failed to implement fall interventions and update the care plan after falls. This affected one (Resident #209) of three reviewed for falls care planning. The census was 62. Findings Include: 1. Review of Resident #07's medical record revealed an admitted [DATE]. Diagnoses listed included type II diabetes mellitus, congestive heart failure, skin cancer, obesity, major depressive disorder, and stage four pressure ulcer of left heel. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #07 had a stage four pressure ulcer, lower extremity impairment to both sides, and was cognitively intact. Interview with Resident #07 on 05/14/24 at 8:28 A.M. revealed he had not had any recent care conferences. Further review of Resident #07's medical record revealed a care conference was last held on 11/06/23. 2. Review of Resident #18's medical record revealed an admitted [DATE]. Diagnoses listed included Post-Traumatic Stress Disorder (PTSD), major depressive disorder, anxiety disorder, and type two diabetes mellitus. Review of the admission MDS dated [DATE] revealed Resident #18 was cognitively intact. Interview with Resident #18 on 05/13/24 at 2:33 P.M. revealed she had not had a care conference since admission. Further review of Resident #18's medical record revealed no documentation of a care conference being held with Resident #18. Interview with Corporate Registered Nurse (CRN) #361 on 05/14/24 at 2:50 P.M. revealed care conferences were not held with Resident #07 since November 2023. CRN #361 confirmed a care conference had not been held with Resident #18. 48570 3. Review of Resident #209's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation and unspecified dementia, unspecified severity, with psychotic disturbance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wapakoneta Manor	1010 Lincoln Ave Wapakoneta, OH 45895

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #209 was cognitively intact. Resident #209 required assistance with showers, dressing, bed mobility, transfers, and ambulating. Review of Resident #209's physician orders revealed an order dated 04/27/24 for a high low bed every shift for fall risk. Review of the progress note dated 04/28/24 at 3:04 P.M. revealed Resident #209 yelling out for help. The resident was found lying on the floor between the wall and his bed. Resident #209 stated he was trying to pull the covers back on his bed and lost his balance. The resident was reminded to use call light for assistance with ambulation and transfers. Further review of the progress note dated 05/12/24 at 5:47 A.M. revealed Resident #209 found on floor in the bathroom. Resident #209 stated he was getting dizzy after pulling up pants. The resident was found between the toilet and wall. The resident's call light was pinned onto pants and he was educated to use call light when getting up or have any need or assistance. Review of Resident #209's care plan revealed the facility did not update the resident's care plan with interventions after the falls on 04/28/24 and 05/12/24. Interview on 05/16/24 at 9:01 A.M. with the Director of Nursing (DON) confirmed Resident #209 fell on [DATE] at 3:04 P.M. and on 05/12/24 at 5:47 A.M. and the facility failed to update the care plan with interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Wapakoneta Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Lincoln Ave Wapakoneta, OH 45895	

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, staff interview, observation, and review of facility policy, the facility failed to ensure interventions were in place to prevent the development of a pressure ulcer. This resulted in actual harm when Resident #07 acquired a stage four pressure ulcer to his left heel while at the facility. Additionally, the facility failed to ensure pressure ulcer treatments were completed as ordered. This affected two (#07 and #51) of three residents reviewed for pressure ulcers. The census was 62. Finding include: 1. Review of Resident #07's medical record revealed an admitted [DATE]. Diagnoses listed included type II diabetes mellitus, congestive heart failure, skin cancer, obesity, major depressive disorder, and stage four pressure ulcer of left heel. Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #07 had a stage four pressure ulcer, lower extremity impairment to both sides, and was cognitively intact. Review of the, Braden Scale for Predicting Pressure Sore Risk, dated 12/26/23 revealed Resident #07's score was 13 (moderate risk). Review of a care plan initiated 06/05/23 revealed Resident #07 had the potential for skin breakdown, slow wound healing and pressure ulcer/injury development related to impaired mobility, diabetes, myositis and incontinence of bowel and bladder. No pressure relieving interventions were added until 01/04/24. Review of facility wound assessments revealed an unstageable pressure ulcer measuring 2 centimeters (cm) by (x) 3 cm was discovered to Resident #07's left heel on 01/04/24. Further review of Resident #07's medical record revealed no interventions implemented to relieve pressure to heels or feet prior to 01/04/24. There was no documentation of any refusals of pressure relieving interventions for heels or feet by Resident #07. The only intervention was skin prep (liquid film-forming skin protectant) ordered on 12/20/23 and discontinued on 01/04/24. Review of wound physician progress notes dated 01/09/24 revealed Resident #07 had a stage four pressure ulcer on the left heel measuring 1.5 cm x 1.5 cm x 0.3 cm. The wound bed was covered with 100% slough (dead tissue, usually cream or yellow in color) which was debrided (removed). Review of wound physician progress notes dated 05/14/24 revealed Resident #07 continues to have the stage four pressure ulcer to the left heel. The ulcer now measures 1 cm x 0.6 cm x 0.3 cm with 20% slough and 80% granulation tissue (new tissue developed over a wound bed). Observation of Resident #07's pressure ulcer treatment on 05/14/24 at 3:58 P.M. revealed a pressure ulcer to the posterior heel. The wound was measured by Physician #407 to be 1 cm x 0.6 cm x 0.3 cm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Wapakoneta Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Lincoln Ave Wapakoneta, OH 45895	

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 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with Physician #407 on 05/14/24 at 4:07 P.M. revealed when Resident #07 was first assessed for the left heel pressure ulcer on 01/09/24, it was a stage four with visible bone. Physician #407 removed eschar on the initial visit on 01/09/24. The left heel pressure ulcer was debrided on multiple visits. Interview with the Director of Nursing (DON), Administrator, and Corporate Registered Nurse (CRN) #361 on 05/15/24 at 2:00 P.M. confirmed there was no documentation of interventions being implemented to prevent Resident #07's left heel stage four pressure ulcer. There was no documentation of Resident #07 refusing pressure ulcer prevention interventions. 2. Review of Resident #51's medical record revealed an admitted [DATE]. Diagnoses listed included malnutrition, type two diabetes mellitus, aphasia, hemiplegia, hemiparesis, pneumonia, and encephalopathy. Review of the admission MDS assessment dated [DATE] revealed Resident #51 was assessed by staff as being severely cognitively impaired and having a stage four pressure ulcer. Review of physician orders revealed an order dated 05/07/24 for sacrum: clean wound with wound cleaner, pat dry, apply Dakins (antiseptic wound solution) moistened gauze, cover with gauze island bordered dressing twice a day. An order for right heel was clean wound with wound cleaner, apply calcium alginate (absorbent wound dressing) to wound bed, cover with bordered gauze dressing, change daily and PRN (as needed). Observation of Resident #51's pressure ulcer treatment on 05/14/24 at 4:15 P.M. revealed Licensed Practical Nurse (LPN) #331 did not cleanse the right heel pressure ulcer or the sacral ulcer after removing old wound dressings and completing new wound treatments. Interview with LPN #331 on 05/14/24 at 4:41 P.M. confirmed she did not cleanse Resident #51's pressure ulcers after removing old dressings and completing new treatments. Review of the facility's policy titled, Pressure Ulcer Policy, dated approved 04/29/16 revealed a resident who enters the facility without a pressure ulcer will not develop a pressure ulcer unless the individual's clinical condition demonstrates they are unavoidable. All residents will be assessed for pressure ulcer risk on admission, monitored weekly and reviewed quarterly and as needed. Appropriate preventative interventions will be implemented. (i.e. wheelchair cushion, offloading heels, etc.) All residents will be placed on a pressure reducing mattress. The facility will use a Pressure Risk Assessment to assess each resident's degree of risk for developing a pressure ulcer. A resident with a pressure ulcer will receive interventions and monitoring to promote healing, prevent infection and prevent new ulcers from developing. All residents will be placed on a pressure reducing mattress upon entering the facility, and no photographs of pressure ulcers will be obtained by the facility. A stage IV pressure ulcer was defined as full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers. An unstageable pressure ulcer was defined as full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black). This deficiency represents non-compliance investigated under Complaint Number OH00153353.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Wapakoneta Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Lincoln Ave Wapakoneta, OH 45895	

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 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** 35035 Based on review of contract with dialysis center, review of facility policy, observation of care, interview with resident, and interview with staff, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented. This affected two (Residents #51 and #52) of three residents reviewed for EBP. The current census is 62. Findings include: 1. Review of the medical record for Resident #52 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #52 included peritonitis, diabetes type two, chronic kidney disease, dependence on peritoneal dialysis, and hypotension. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed the resident had no brief interview for mental status coded as no interview due to resident never understood. Per the assessment the resident was receiving peritoneal dialysis. Review of Resident #52's care plan dated 01/20/24 revealed a focus for receiving Peritoneal (PD) dialysis services through Fresenius. Interventions included encourage resident to attend appointments, monitor labs and report to physician, and monitor and report any signs or symptoms of infections to access site, redness, swelling, warmth or drainage. Review of Resident #52's physician orders dated 04/16/24 revealed an order for cycler starting 04/16/24, three bags of yellow 1.5% 6000 milliters (ml). Per the order dated 03/09/24 at 4:00 P.M. use one bag of 2500 ml 1.5% yellow one time a day. Interview on 05/13/24 at 10:30 A.M. with Resident #52 revealed the resident stated he was concerned regarding infections due to recent admissions to the hospital. Resident #52 stated some nursing staff do not follow the precautions, such as wearing gowns, while performing care. Observation on 05/14/24 at 7:30 A.M. with Licensed Practical Nurse (LPN) #276 ending the PD cycle for Resident #52's night time PD revealed the nurse did not put on a gown upon entry to the resident's room. LPN #276 was observed disconnecting Resident #52 from the PD cycler and applying a new cap to the catheter. LPN #276 was observed checking all connections and explaining each step of the procedure during care. EBP sign was visibly hanging above the head of the bed. LPN #276 verified Resident #52 was in EBP isolation due to the PD procedure and verified she did not put on a gown for the care being provided. Interview on 05/14/24 at 7:55 A.M. with Resident #52 revealed the resident stated he has not witnessed any staff wearing a gown during his PD procedures and stated he understood the reasoning behind the EBP isolation procedures. Review of the facility policy titled, 'Dialysis Care Policy,' dated 04/04/18, revealed the facility will provide the dialysis treatments using the appropriate infection control practices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Wapakoneta Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Lincoln Ave Wapakoneta, OH 45895	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the contract for the dialysis center with the facility dated 05/15/19 revealed the facility is responsible to follow infection control practices consistent with the infection control policies and practices. 36303 2. Review of Resident #51's medical record revealed an admitted [DATE]. Diagnoses included malnutrition, type two diabetes mellitus, aphasia, hemiplegia, hemiparesis, pneumonia, and encephalopathy. Review of an admission MDS assessment dated [DATE] revealed Resident #51 was assessed by staff as being severely cognitively impaired and having a stage four pressure ulcer. Resident #51 had a feeding tube. Observation on 05/14/24 at 4:15 P.M. revealed a sign was posted above the head of Resident #51's bed informing staff that Resident #51 was in EBP. Observation on 05/14/24 at 4:29 P.M. revealed State tested Nursing Assistant (STNA) #317 entered the room to assist LPN #331 with Resident #51's wound care, incontinence care, and repositioning. STNA #317 put on gloves but did not put on a gown. STNA #317 then assisted with turning and repositioning Resident #51 while LPN #331 provided wound and incontinence care. Interview with LPN #331 on 05/14/24 at 4:41 P.M. confirmed Resident #51 was in EBP due to pressure ulcer and a feeding tube. LPN #331 confirmed STNA #317 did not put on a gown when assisting with the care of Resident #51. Review of the facility's policy titled, Enhanced Barrier Precautions, dated August 2022 revealed an impervious gown should be worn when high-contact resident care activities are being performed. High contact resident care activities included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing Attends (incontinence briefs) or assisting with toileting, device care or use:, central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing.