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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365297	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Skilled Nursing and Rehabilitation	705 Fulton Street Sidney, OH 45365

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on medical record review, staff interview, and facility policy review, the facility failed to notify a physician of resident's weight loss. This affected one (#13) of two residents reviewed for nutrition. The census was 46. Findings include: Review of medical record for Resident #13 revealed admitted [DATE]. The resident was admitted with diagnoses including nontraumatic subarachnoid hemorrhage, hypothyroidism, epilepsy, history of Hodgkin lymphoma, and stroke. The resident was documented as hospitalized on [DATE] and returned on 08/14/24, and had a second hospitalization on [DATE] and returned on 08/23/24. The resident remained in the facility during the survey. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was assessed with moderately impaired cognition, required supervision for eating, and maximum assistance for transfers, bed mobility, and toileting hygiene. Review of Resident #13's electronic medical record revealed the resident weighed 225.0 pounds on 07/22/24. Subsequent weights revealed on 07/29/24 the resident weighed 198.8 pounds, on 08/05/24 the resident weighed 177.5 pounds, on 08/14/24 the resident weighed 185.0 pounds, on 08/17/24 the resident weighed 183.5 pounds, and on 08/25/24 the resident weighed 177.6 pounds. Resident #13 experienced a 21.07 percent (%) weight loss since admission. Further review revealed weight loss was documented on 07/31/24, 08/05/24, 08/14/24, 08/17/24 and 08/25/24 with no indication the physician was notified of the weight loss. Record review of Resident #13's electronic and paper chart revealed no documentation the physician had been informed of weight loss. Interview on 08/28/24 at 11:32 A.M. with Dietician Consultant (DC) #167 revealed she had not seen Resident #13 since the resident's 07/21/24 admission, explaining Resident #13 was at the hospital when she came to the facility on Wednesdays. DC #167 acknowledged she had access to the electronic charting for Resident #13 to review weights and meal intakes. DC #167 stated on 07/31/24 she requested another weight due to the significant change in weight. DC #167 stated she was unaware if the physician had been notified of Resident #13's weight loss explaining she informed the nursing staff of resident weight loss with the expectation they would provide the notification to the physician. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER: Shelby Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 705 Fulton Street Sidney, OH 45365	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/24 at 3:12 P.M. with the Administrator and DON revealed Resident #13 had fluctuating weights at the facility as well as during her two recent hospitalization s. The DON stated Physician #169 assessed Resident #13 on 08/26/24 and did not document a concern for weight loss, and acknowledged Physician #169 was not notified by the facility of the documented weight losses. Review of the facility policy titled, Nutrition unplanned weight loss, revised 2017, revealed the staff would report to the physician significant weight loss or gain or any abrupt or persistent change from baseline or food intake.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on medical record review and staff interview, the facility failed to timely implement treatment of a wound. This affected one (#13) of 12 residents reviewed for treatments. The facility census was 46. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE]. The resident was admitted with diagnoses including nontraumatic subarachnoid hemorrhage, hypothyroidism, epilepsy, history of Hodgkin's Lymphoma and stroke. The resident remained in the facility. Review of Resident #13's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with moderately impaired cognition, required supervision for eating, and maximum assistance for transfers, bed mobility and toileting hygiene. Review of Resident #13's current care plan revealed a focus area for impaired skin integrity related to fragile skin, altered sensations, and impaired mobility. Interventions included to inspect skin during routine care, pad and protect skin as needed, and pericare after each incontinent episode. An intervention for barrier cream/ointment after each incontinent episode and as needed was added on 08/28/24. Review Resident #13's progress note dated 08/23/24 at 3:05 P.M. revealed Resident #13 was readmitted to the facility with left buttock shearing. Review of Resident #13's admission skin assessment dated [DATE] revealed documentation of left buttock shearing measuring 1.0 centimeter (cm) long by (x) 0.5 cm wide x 0.1 cm deep. Review of Resident #13's physician orders revealed treatment orders to cleanse the left buttock wound with soap and water, pat dry, apply vitamin A and D (A&D) ointment every shift until resolved with a start date of 08/27/24. Interview on 08/27/24 at 3:56 P.M. with the Director of Nursing (DON) verified there were no treatments orders for Resident #13's skin condition upon readmission on 08/23/24 put into place until 08/27/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on observation, resident and staff interview, medical record review, and facility policy review, the facility failed to provide timely interventions to address resident weight loss. This affected one (#13) of two residents reviewed for nutrition. The census was 46. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE]. The resident was admitted with diagnoses including nontraumatic subarachnoid hemorrhage, hypothyroidism, epilepsy, history of Hodgkin lymphoma, and stroke. The resident was documented as hospitalized on [DATE] and returned on 08/14/24 and had a second hospitalization on [DATE] and returned on 08/23/24. Review of Resident #13's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with moderately impaired cognition, required supervision for eating, and maximum assistance for transfers, bed mobility, and toileting hygiene. Review of Resident #13's electronic medical record revealed the resident weighed 225.0 pounds on 07/22/24. Subsequent weights revealed on 07/29/24 the resident weighed 198.8 pounds, on 08/05/24 the resident weighed 177.5 pounds, on 08/14/24 the resident weighed 185.0 pounds, on 08/17/24 the resident weighed 183.5 pounds, and on 08/25/24 the resident weighed 177.6 pounds. Resident #13 experienced a 21. 07 percent (%) weight loss since admission. Further review revealed weight loss was documented on 07/31/24, 08/05/24, 08/14/24, 08/17/24 and 08/25/24 with no indication the physician was notified of the weight loss. Review of Resident #13's physician note dated 08/26/24 revealed the chief complaint was concerns of fatigue, decreased appetite, anxiety, and depression. Further review revealed during the assessment, Resident #13 reported having fatigue and a decreased appetite, and denied current nausea and vomiting although it had been an issue in the past. Information was sought from nursing staff about current concerns that may need addressed with no documentation of weight loss that was communicated, reviewed, or addressed. Observation and interview on 08/26/24 at 7:55 A.M. and again at 12:52 P.M. with Resident #13 revealed she only wanted yogurt and milk for breakfast, and she felt better later in the afternoon, and ate about 50% for lunch. Observation and interview on 08/27/24 at 7:53 A.M. revealed Resident #13 requested toast and milk for breakfast because it was all she was in the mood for. Further observation revealed the resident ate one half piece of the two pieces of toast provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/24 at 3:56 P.M. the Director of Nursing (DON) acknowledged Resident #13 had a poor appetite she attributed to nausea as a side effect of medication. The DON explained Physician #169 and/or his team were informed, and the anti-nausea medication Zofran and laboratory work was ordered. The DON stated Resident #13 had also been hospitalized twice during her short admission to the facility. The DON acknowledged the dietician had only seen the resident once since her 07/21/24 admission, and despite her poor appetite/intake, no additional nutritional interventions had been ordered. Interview on 08/28/24 at 11:32 A.M. with Dietician Consultant (DC) #167 revealed she had not seen Resident #13 since her 07/21/24 admission, explaining Resident #13 was at the hospital when she came to the facility on Wednesdays. DC #167 acknowledged she had access to the electronic charting for Resident #13 to review weights and meal intake, and stated on 07/31/24, she had requested another weight due to the significant change in Resident #13's weight. DC #167 explained Resident #13 was on her radar and the resident was discussed weekly with the DON during her resident assessment, and she recommended supplements upon her returns from the hospital. DC #167 verified it was her expectation Resident #13 should have been started on a supplement and the physician should have been informed of the resident's weight loss. Interview on 08/28/24 at 2:40 P.M. with the Administrator and the DON revealed the medical staff was aware of Resident #13's nausea and had ordered laboratory work and Zofran to address the nausea. The DON acknowledged nutritional supplements for Resident #13 were not ordered until 08/28/24 after the 08/27/24 interview. Review of the facility policy titled, Nutrition unplanned weight loss, revised 2017, revealed the staff and physician will identify pertinent interventions based on identified causes and overall resident condition. The physician would authorize appropriate interventions as indicated.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 35031 Based on personnel file review and staff interview, the facility failed to complete performance reviews of nurse aides at least every 12 months as required. This affected three of four state tested nurse aides (STNAs) reviews with potential to affect all residents residing in the facility. The facility census was 46. Findings include: 1. Review of STNA #115's personnel file revealed a hire date of 03/05/01. The file was absent of any performance review for the previous 12 months. 2. Review of STNA #118's personnel file revealed a hire date of 04/03/23. The file was absent of any performance review for the previous 12 months. 3. Review of STNA #133's personnel file revealed a hire date of 05/16/22. The file was absent of any performance review for the previous 12 months. Interview on 08/28/24 at 3:30 P.M. with Administrator verified STNA #115, STNA #118, and STNA #133 did not have performance reviews completed at least every 12 months as required.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, staff interview, and review of a policy, the facility failed to ensure a blood pressure medication was held per ordered parameters. This affected one (#93) of six reviewed for unnecessary medications. The census was 46. Findings include: Review of Resident #93's medical record revealed an admitted [DATE]. Diagnoses listed included skin cancer, enlarged lymph nodes, cerebral infarction, muscle weakness, and type two diabetes mellitus. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #93 was cognitively intact. Review of Resident #93's physician orders revealed an order dated 08/13/24 to give metoprolol tartrate (blood pressure medication) 50 milligrams (mg) one tablet via gastronomy tube (G-tube) three times a day for hypertension with instructions to hold if the heart rate (HR) was less than 65 beats per minute. Review of Resident #93's August 2024 medication administration record (MAR) revealed metoprolol tartrate 50 mg was administered to the resident on 08/16/24 at 2:00 P.M. with a HR of 60 beats per minute, on 08/20/24 at 6:00 A.M. with a HR of 56 beats per minute, and on 08/22/24 at 6:00 A.M. with a HR of 55 beats per minute. Interview with the Director of Nursing (DON) on 08/26/24 at 8:46 A.M. confirmed metoprolol tartrate was documented as being administered to Resident #93 on 08/16/24 at 2:00 P.M. with a HR of 60 beats per minute, on 08/20/24 at 6:00 A.M. with a HR of 56 beats per minute, and on 08/22/24 at 6:00 A.M. with a HR of 55 beats per minute. The DON confirmed metoprolol should have not been administered at those times due to Resident #93's HR being less than 65 beats per minute per physician order. Review of the facility's policy titled, Administering Medications, revised April 2019, revealed medications are administered in accordance with prescriber orders, including any required time frame.

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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** 44076 Based on medical record review, staff interview, and policy review, the facility failed to timely implement infection control precautions for residents with infections. This affected one (#13) of eight residents reviewed for infection control. The census was 46. Findings include: Review of medical record for Resident #13 revealed an admitted [DATE]. The resident was admitted with diagnoses including nontraumatic subarachnoid hemorrhage, hypothyroidism, epilepsy, history of Hodgkin's lymphoma, and stroke. Review of Resident #13's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with moderate cognitive impairment, required supervision for eating, and maximum assistance for transfers, bed mobility, and toileting hygiene. Review of Resident #13's nursing progress notes dated 08/23/24 revealed the resident was readmitted to the facility with a diagnosis of a bacterial infection, Extended-Spectrum Beta-Lactamase (ESBL). Review of the current plan of care revealed Resident #13 had a target area for isolation due to ESBL with interventions which included for isolation to be maintained by staff during the infection period and to monitor the resident for signs and symptoms of depression. Review of Resident #13's physician orders revealed an order for contact isolation with a start date of 08/25/24. Interview with the Director of Nursing (DON) on 08/27/24 at 3:56 P.M. confirmed Resident #13 returned to the facility on [DATE] with a diagnosis of ESBL and was not ordered contact precautions until 08/25/24. The DON verified it would be the expectation she would have been notified of the infection and the resident placed in contact isolation upon the readmission to the facility on [DATE]. Review of the facility policy, Isolation-Categories of Transmission-Based Precautions dated 2001, revealed contacted precautions are implemented for residents with known or suspected to be infected with microorganisms that can be transmitted by direct contact or indirect with environmental contact with environmental surfaces or resident-care items in the resident's environment.