

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Wauseon		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W Leggett St Wauseon, OH 43567	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on medical record review, staff interview, and policy review, the facility failed to ensure residents were provided a timely written discharge notice. This affected one (#30) of two residents reviewed for discharges from the facility. The facility census was 45.</p> <p>Findings included:</p> <p>Review of Resident #30's medical record revealed the resident was admitted on [DATE]. Diagnosis included schizoaffective disorder, asthma, congestive heart failure, dementia, bipolar, and benign lipomatous neoplasm of skin and subcutaneous tissue.</p> <p>Review of Resident #30's quarterly Minimum Data Set assessment dated [DATE] revealed the resident had a moderate cognitive function.</p> <p>Review of Resident #30's medical record revealed on 04/19/24 the resident was transferred to a behavioral unit in the local hospital due to increased behaviors throughout the day where the resident was admitted . The physician ordered a hospital/psychiatric evaluation.</p> <p>Interview with Business Office Manager #348 on 08/21/24 at 11:20 A.M. verified Resident #30, nor his family or financial power of attorney, received a written transfer notification. Business Office Manager #348 revealed she was unaware one was required.</p> <p>Review of the facility policy titled, Transfer and Discharge (including AMA), dated November 2021, revealed for emergency transfers/discharges the facility must provide a transfer notice as soon as practicable to resident and representatives.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation, staff interview, medical record review, review of fall investigations, review of facility guidelines, and review of the facility policy, the facility failed to ensure neurological checks were performed per facility guidelines, and failed to ensure fall interventions were in place as care planned. This affected one (#31) of one resident reviewed for falls. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses of anxiety and Alzheimer's disease.</p> <p>Review of the annual comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had impaired cognition, used a walker and wheelchair for mobility, required substantial/maximal assistance for transfers, and was able to ambulate ten feet with supervision or touching assistance. Further review revealed Resident #31 had two or more falls without injury since the previous assessment dated [DATE].</p> <p>Review of a progress note dated 12/29/23 revealed Resident #31 was found on the floor sitting next to her bed at 2:00 A.M. Resident #31 was assessed and found to have no injuries. Further review revealed the facility implemented a scoop mattress and updated the care plan.</p> <p>Review of Resident #31's current care plan revealed she was at risk for falls. Interventions to prevent further falls included a scoop mattress on her bed, implemented 12/29/23.</p> <p>Review of the fall risk assessment completed 06/07/24 revealed Resident #31 used a walker and wheelchair for ambulation and had at least one fall in the previous month.</p> <p>Review of a progress note dated 06/23/24 revealed Resident #31 fell on her way to the bathroom. Further review revealed Resident #31 indicated she had pain to the back of her head.</p> <p>Review of the neurological evaluation assessments revealed neurological assessments were performed on Resident #31 on 06/23/24 at 1:45 P.M., at 2:05 P.M., at 2:20 P.M., and at 4:41 P.M.</p> <p>Review of a progress note dated 07/28/24 revealed Resident #31 was found on the floor in her room by her bed.</p> <p>Review of the fall investigation dated 07/28/24 revealed Resident #31 was observed sleeping in her bed on 07/27/24 at 11:55 P.M. and was found on the floor next to her bed on 07/28/24 at 12:01 A.M. Further review revealed Resident #31 was assessed and found to have no injuries. Additional review revealed no indication the scoop mattress was in place at the time of the fall.</p> <p>Observation and interview on 08/20/24 at 9:15 A.M. with Licensed Practical Nurse (LPN) #516 confirmed Resident #31's mattress was a standard mattress and not a scoop mattress.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 08/21/24 at approximately 8:30 A.M. revealed Resident #31 sitting in a chair next to her bed. Further observation revealed the mattress on her bed was a scoop mattress.</p> <p>Interview on 08/21/24 at 10:09 A.M. with the Director of Nursing (DON) revealed neurological assessments should be completed initially after a fall and then hourly for four hours. The DON further confirmed the neurological assessments were not completed per facility protocol after Resident #31's fall on 06/23/24.</p> <p>Interview on 08/21/24 at 10:13 A.M. with the DON confirmed Resident #31 had an intervention on her care plan from 12/2023 for a scoop mattress. The DON could not explain why the scoop mattress was not in place during the observation on 08/20/24, and confirmed the facility replaced the scoop mattress during the survey.</p> <p>Review of the Utilization Data Assessment (UDA) Guidelines provided by the facility, revised 08/16/24, revealed neurological assessments should be completed initially after a fall and then hourly for four hours as indicated.</p> <p>Review of the policy titled, Falls and Fall Risk; Managing, revised 03/2018, revealed the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on medical record review, review of a hemodialysis communication binder, staff interview, and review of the facility policy, the facility failed to ensure hemodialysis access sites were monitored as care planned, and failed to ensure communication between the hemodialysis clinic and the facility regarding a resident's hemodialysis and services was maintained. This affected one (#200) of one resident reviewed for hemodialysis. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #200 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and end stage renal disease.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #200 had intact cognition, received hemodialysis, and was on a therapeutic diet.</p> <p>Review of the current care plan for Resident #200 revealed he received hemodialysis. Interventions included monitoring the hemodialysis site for signs or symptoms of infection or bleeding.</p> <p>Review of the physician order dated 08/12/24 revealed Resident #200 attended hemodialysis every Monday, Wednesday, and Friday.</p> <p>Review of the undated Pre-Dialysis communication assessment revealed staff assessed Resident #200's vitals signs and hemodialysis site.</p> <p>Review of the undated Post Dialysis communication assessment revealed staff assessed Resident #200's vital signs and hemodialysis site.</p> <p>Review of the electronic medical record for Resident #200 revealed no Pre-Dialysis communication assessment or Post Dialysis communication assessment were completed on Monday, 08/12/24 or Wednesday, 08/14/24. Further review of Resident #200's medical record revealed no documentation of staff monitoring the resident's hemodialysis site.</p> <p>Review of the Treatment Details Report dated 08/12/24 and 08/14/24 confirmed Resident #200 received hemodialysis treatments both days.</p> <p>Interview on 08/20/24 at 3:33 P.M. with Nurse Supervisor (NS) #428 and concurrent review of Resident #200's hemodialysis communication binder revealed no communication sheets were completed by the facility and sent to the hemodialysis clinic on 08/12/24 or 08/14/24.</p> <p>Interview on 08/20/24 at 3:57 P.M. with Assistant Director of Nursing (ADON) #472 confirmed the Pre and Post Dialysis communication assessments were not completed on 08/12/24 and 08/14/24 for Resident #200. ADON #472 stated the assessments were not initiated upon his admission.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/22/24 at 9:36 A.M. with the Director of Nursing (DON) confirmed there was no evidence of assessments of Resident #200's hemodialysis site were contained in the resident's medical record between 08/10/24 and 08/16/24.</p> <p>Review of the policy, Hemodialysis Access Care, revised September 2010, revealed staff should check for signs of infection at the access site when performing routine care and at regular intervals.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation, medical record review, resident and staff interview, review of the menu, review of the menu spreadsheet, review of food product information, and review of facility policies, the facility failed to ensure food was served per the facility menu and spreadsheets. This directly affected one (#23) resident who was ordered a mechanical soft diet, directly affected one (#33) resident who received a pureed diet, and had the potential to affect all 45 residents residing in the facility who received food from the facility. The census was 45.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and gastroesophageal reflux disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had intact cognition and was not on a therapeutic diet.</p> <p>Review of a physician order dated 01/16/23 revealed Resident #23 received a regular diet with double protein at breakfast.</p> <p>Observations during breakfast meal service on 08/20/24 beginning at 7:24 A.M. revealed [NAME] #312 was plating meals for breakfast. Observation on 08/20/24 at 7:31 A.M. revealed [NAME] #312 plated Resident #23's breakfast. Observation of the resident's meal ticket revealed he was to receive double protein portions. Further observation revealed [NAME] #312 plated one scoop of eggs, the regular standard portion.</p> <p>Interview on 08/20/24 at 7:34 A.M. with [NAME] #312 confirmed she did not put two servings of eggs on Resident #23's plate because Resident #23 received yogurt as his second portion of protein.</p> <p>Interview and observation on 08/20/24 at 11:59 A.M. with Registered Dietitian (RD) #542 revealed the yogurt provided to Resident #23 as a second protein portion contained three grams (g) of protein.</p> <p>Interview on 08/20/24 at 4:03 P.M. with RD #542 revealed the standard portion of eggs, two ounces, provided 14 g of protein and stated a double portion of protein should provide a total of 28 g protein. RD #542 confirmed Resident #23 received only 17 g protein with the single serving of eggs and the yogurt, and confirmed Resident #23 did not receive the additional 11 g protein he should have per physician order.</p> <p>2. Review of the weekly menu revealed the regular meal for lunch on 08/20/24 was meatballs and spaghetti with sauce, California blend vegetables, a breadstick, a peanut butter cookie, milk, and coffee or hot tea.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the menu spreadsheet for lunch on 08/20/24 revealed a regular texture diet would receive three meatballs and one-half (1/2) cup of pasta with sauce. Further review revealed residents on a mechanical soft (ground meat) diet would receive four ounces of meat and 1/2 cup of pasta with sauce.</p> <p>Interview on 08/19/24 at 9:33 A.M. with Resident #30 revealed he thought meal portion sizes were too small.</p> <p>Interview on 08/20/24 at approximately 11:20 A.M. with [NAME] #312 revealed two of the steam wells in her steam table were broken; therefore, she mixed the spaghetti noodles, sauce, and meatballs together into one pan. [NAME] #312 stated she would normally keep the spaghetti noodles and meatballs in separate pans.</p> <p>Observations during meal service on 08/20/24 beginning at approximately 11:30 A.M. revealed [NAME] #312 plating meals. [NAME] #312 was observed to use a four-ounce ladle (1/2 cup) to scoop two meatballs and noodles with sauce out of the pan. [NAME] #312 pressed the contents of the scoop tight against the pan to ensure she provided the total 1/2 cup.</p> <p>Additional observation during meal service on 08/20/24 beginning at approximately 11:30 A.M. revealed [NAME] #312 using a two-ounce scoop to portion ground meatballs for residents on a mechanical soft diet.</p> <p>Interview on 08/20/24 at 11:59 A.M. with [NAME] #312 confirmed she used a two-ounce scoop for the ground meatballs and provided only one scoop for residents on a mechanical soft diet, unless they had an order for double protein, in which case she would use two scoops of ground meatballs.</p> <p>Interview on 08/20/24 at 12:21 P.M. with [NAME] #312 confirmed she scooped two meatballs and noodles together in the 1/2 cup scoop for residents on a regular diet.</p> <p>Interview on 08/20/24 at approximately 1:15 P.M. with Resident #44 revealed the noon meal tasted good and she wished the portion size was larger.</p> <p>Interview on 08/20/24 at 4:03 P.M. with the DM #540 and concurrent review of the menu spreadsheet confirmed residents on a regular diet did not receive the correct portion of spaghetti noodles due to [NAME] #312 using the 1/2 cup scoop to portion the meatballs together with the spaghetti noodles. Further interview confirmed residents on a mechanical soft diet received two ounces of protein rather than the four ounces defined on the spreadsheet.</p> <p>Interview on 08/21/24 at approximately 3:00 P.M. with DM #540, along with review of meatball product information, revealed the meatballs served were two-ounce meatballs rather than the one-ounce meatballs defined in the recipe. Therefore, residents on a regular diet received two meatballs rather than three as specified in the menu. Additional review of the meatball product information and spreadsheet revealed the substituted meatballs were nutritionally equivalent.</p> <p>Interview on 08/21/24 at approximately 5:00 P.M. with DM #540 confirmed Resident #19 had a diet order for ground meat and would have received ground meatballs and was therefore affected by the undersized portion of protein provided during the noon meal on 08/20/24.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnosis of dysphagia (swallowing difficulty). Resident #33 was under the care of hospice.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #33 had impaired cognition and required supervision or touching assistance for eating.</p> <p>Review of a physician order dated 08/06/24 revealed Resident #33 received a regular diet with pureed textures and thin liquids.</p> <p>Review of the menu spreadsheet for lunch on 08/20/24 revealed residents on a pureed diet would receive pureed meat, pureed spaghetti with sauce, pureed vegetables, pureed breadstick, and a pureed dessert.</p> <p>Observation during meal service 08/20/24 at 12:13 P.M. revealed [NAME] #312 plating Resident #33's pureed meal. Observation revealed [NAME] #312 placed noodles and vegetables on the plate.</p> <p>Observation on 08/20/24 at 12:40 P.M. revealed Resident #33 received her tray with three bowls contained pureed food, one of which was pudding.</p> <p>Interview on 08/20/24 at 12:41 P.M. with DM #540 and concurrent observation of Resident #33's delivered meal confirmed Resident #33 received only vegetables and noodles and did not receive the pureed meatballs.</p> <p>Interview on 08/20/24 at approximately 12:42 P.M. with [NAME] #312 and concurrent observation of Resident #33's delivered meal confirmed Resident #33 did not receive a pureed breadstick with her meal. [NAME] #312 further confirmed she did not puree the breadstick for Resident #33's meal.</p> <p>Review of the policy titled, Portion Control, updated 03/07/21, revealed individuals will receive the appropriate portions of food as outlined on the menu spreadsheets.</p> <p>Review of the policy titled, Food and Nutrition Services, dated 10/2017, revealed each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>44815</p> <p>Based on observation, staff and resident interviews, review of a test tray, and review of the facility policy, the facility failed to ensure meals were palatable, delivered at the proper temperature, and had an attractive appearance. This had the potential to affect all 45 residents in the facility. The census was 45.</p> <p>Findings include:</p> <p>1. Interview on 08/19/24 at 9:06 A.M., with Resident #5 revealed the food the facility served was usually cold.</p> <p>Interview on 08/19/24 at 9:19 A.M., with Resident #36 revealed the food was always cold.</p> <p>Interview on 08/19/24 at 9:22 A.M., Resident #10 stated the food was sub-par lately. Resident #10 stated the plates and food were cold.</p> <p>Interview on 08/19/24 at 11:16 A.M., Resident #29 revealed food which should be hot was usually served cold.</p> <p>Observation prior to meal service on 08/20/24 at 7:24 A.M. revealed [NAME] #312 taking food temperatures. The temperature of the scrambled eggs was 175 degrees Fahrenheit (F) and the temperature of the French toast was 169 degrees F.</p> <p>Observation during meal service on 08/20/24 at 7:41 A.M. revealed a test tray was plated. Further observation revealed the tray was placed on the tray cart at 7:42 A.M., and the cart left the kitchen at 7:43 A.M. Observation revealed the first meal tray was passed to residents at 7:44 A.M. Continued observation revealed staff passing meal trays until 7:52 A.M. Further observation revealed the test tray was removed from the cart at 7:52 A.M. and carried to the conference room by Dietary Manager (DM) #540.</p> <p>Observation on 08/20/24 beginning at 7:52 A.M. of a meal test tray with DM #540 revealed the eggs were 100 degrees F and the French toast was 85 degrees F. The eggs and French toast were not palatable to taste and temperature.</p> <p>Interview on 08/20/24 at 7:57 A.M., DM #540 agreed the French toast and eggs were not warm enough and revealed she was going to try and warm the plate warmers (a device that, when heated, maintains the temperature of the food on the plate placed in it) in the dishwasher before plating the food to help hold the food temperatures. DM #540 stated the facility did not have a machine to warm the plate warmers.</p> <p>Interview on 08/20/24 at 8:06 A.M., with Resident #5 revealed the eggs were cold again that morning.</p> <p>Interview on 08/20/24 at 8:08 A.M., with Resident #4 revealed her breakfast food was cold that morning.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 08/20/24 at 8:11 A.M., with Resident #23 revealed the eggs were cold that morning.</p> <p>Interview on 08/20/24 at 8:29 A.M., with Resident #36 revealed her breakfast was cold that morning.</p> <p>Interview on 08/20/24 at 10:42 A.M., Resident #10 stated his eggs were cold that morning.</p> <p>2. Observation on 08/20/24 at 12:40 P.M. revealed Resident #33 received a pureed meal of noodles, vegetables, and pudding. The pureed noodles appeared to be thick with a crack in the smooth surface.</p> <p>Interview on 08/20/24 at 12:41 P.M. with Registered Dietitian (RD) #542 and concurrent observation of Resident #33's tray revealed when RD #542 attempted to confirm the texture of Resident #33's noodles, a thick skin of puree had to be peeled back to access the soft pureed noodles underneath. RD #542 stated the noodles should be replaced with freshly prepared noodles.</p> <p>Review of the policy titled, Food Temperatures, updated 03/07/21, revealed all hot food items must be served to the customer at a temperature of at least 135 degrees F.</p> <p>Review of the policy, Food and Nutrition Services, revised 10/2017, revealed food and nutrition services staff will inspect food trays to ensure the food appeared palatable and attractive.</p> <p>The deficiency represents non-compliance investigated under Complaint Number OH00157049. The deficiency is a recite and represents continued non-compliance to the complaint survey completed on 08/01/24.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on observation, resident and staff interview, and medical record review, the facility failed to ensure resident's food preferences were followed. This affected two (#20 and #26) of seven residents reviewed for food preferences. The facility census was 45.</p> <p>Findings Included:</p> <p>1. Review of Resident #26's medical record revealed an admitted [DATE]. Diagnosis included diabetes mellitus, absence of right toes, and iron deficiency anemia.</p> <p>Review of Resident #26's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was intact. The resident had no natural teeth and required set up or clean up assistance for eating.</p> <p>Review of Resident #26' most recent care plan revealed she suffered from anemia and diabetes mellitus type two. The resident was at risk for hyper/hypoglycemia episodes related to diabetes mellitus type two.</p> <p>Review of Resident #26's physician order revealed an order dated 01/18/24 for a regular diet, regular texture, and thin consistency. No chips or sharp foods were to be served.</p> <p>Interview with Resident #26 on 08/20/24 at 8:21 A.M. revealed her meals have not been served per her preferences. She stated she needed to loose 100 pounds and requested a low carbohydrate diet due to the diabetes mellitus. For lunch she ordered a hot dog, salad, fruit, and gelatin. Resident #26 requested hot dogs for lunch and dinner.</p> <p>Observation on 08/20/24 at 11:59 A.M. in the kitchen during meal service revealed [NAME] #312 plating Resident #26's meal. [NAME] #312 stated Resident #26 always asked for a hot dog, but none were available. [NAME] #312 decided to send Resident #23 spaghetti. Concurrent interview with [NAME] #312 confirmed the facility did not have hot dogs for Resident #23 who always requested hot dogs.</p> <p>Review of Resident #26's meal ticket which was located on her meal tray on 08/20/24 at 12:22 P.M. revealed she preferred hot dogs with no bun, applesauce, tossed salad with French dressing, plain gelatin and no lemonade. Her dislikes were carrots, green beans, ham, sandwiches and chili powered items.</p> <p>Observation of Resident #26's meal tray on 08/20/24 at 12:22 P.M. revealed she was served spaghetti with one meatball, a long bread stick, gelatin, applesauce, salad with French dressing and milk.</p> <p>Interview with Dietary Manager (DM) #540 on 08/20/24 at 12:38 P.M. revealed Resident #26 failed to receive the requested menu items due to the facility being out of hot dogs.</p> <p>44815</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Wauseon		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W Leggett St Wauseon, OH 43567	

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

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and mild protein-calorie malnutrition.</p> <p>Review of the annual comprehensive MDS assessment, dated 07/08/24, revealed Resident #20 had impaired cognition.</p> <p>Review of Resident #20's meal ticket revealed she disliked spaghetti.</p> <p>Observation on 08/20/24 at 12:23 P.M. during meal service revealed [NAME] #312 plating Resident #20's meal. [NAME] #312 placed spaghetti noodles on Resident #20's plate and began to portion out ground meatballs when [NAME] #312 verbally identified Resident #20's meal ticket indicated a dislike for spaghetti. Continued observation revealed [NAME] #312 was involved in a conversation with DM #540 and upon returning to plate meals, [NAME] #312 plated spaghetti for Resident #20.</p> <p>Interview and observation on 08/20/24 at 12:39 P.M. in the dining room with Licensed Practical Nurse (LPN) #456 confirmed Resident #20 received spaghetti. Further interview with concurrent observation of Resident #20's meal ticket confirmed it listed a dislike of spaghetti.</p> <p>Interview on 08/20/24 at 12:40 P.M. with Resident #20 confirmed she did not like spaghetti.</p> <p>Review of the policy, Food and Nutrition Services, dated 10/2017, revealed each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Reasonable efforts will be made to accommodate resident choices and preferences.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157049.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Wauseon		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W Leggett St Wauseon, OH 43567	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation, review of nutritional supplement directions for use, and staff interview, the facility failed to ensure nutrition supplements were not expired and were used within the appropriate timeframe. This had the potential to affect eight (#12, #17, #19, #25, #31, #38, #45, and #50) residents who received nutrition supplements. The facility census was 45.</p> <p>Findings include:</p> <p>Observation on [DATE] at 11:34 A.M. of the residents' snack refrigerator revealed a box of approximately 25 cartons of four-ounce liquid nutrition supplements. Observation of one carton revealed an expiration date of [DATE]. Observation of the additional cartons revealed they expired in 2025.</p> <p>Review of the directions on the supplement cartons revealed the item should be stored frozen, and thawed under refrigeration. Further review revealed the thawed supplement should be used within 14 days after thawing.</p> <p>Interview on [DATE] at 11:34 A.M. with Social Services Director (SSD) #474 confirmed the single container of nutrition supplement expired [DATE]. SSD #474 further confirmed the box of supplements was undated and therefore could not determine when the supplements were removed from the freezer to thaw. Additionally, SSD #474 confirmed the directions indicated the supplements should be consumed within 14 days after thawing.</p> <p>The facility identified eight residents (#12, #17, #19, #25, #31, #38, #45, and #50) had orders to receive the nutrition supplement stored in the residents' snack refrigerator.</p>		

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NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Wauseon		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W Leggett St Wauseon, OH 43567	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033</p> <p>Based on review of the medical record, observation, interview, and policy review, the facility failed to ensure a resident with an indwelling urinary catheter was placed on enhanced barrier precautions. This affected one (#5) of one resident reviewed for urinary catheters. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, urinary retention, neuromuscular dysfunction of the bladder, malignant neoplasm of right kidney, osteoarthritis, and venous insufficiency.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition.</p> <p>Review of a progress note dated 06/10/24 at 10:58 A.M. revealed Resident #5 would be returning from the hospital with an indwelling urinary catheter.</p> <p>Observation on 08/19/24 at 9:06 A.M. revealed Resident #5 had an indwelling urinary catheter. Further observation revealed the resident was not on enhanced barrier precautions (EBP). There was no EBP sign inside or outside the room and no personal protective equipment available outside the room.</p> <p>Interview on 08/19/24 at 11:43 A.M., the Director of Nursing (DON) revealed the resident had a urinary catheter since returning from the hospital. The DON revealed the resident should have been placed on enhanced barrier precautions.</p> <p>Review of the policy titled, Enhanced Barrier Precautions, dated 08/2022, revealed enhance barrier precautions should be implemented for residents with Multi Drug Resistant Organisms (MDRO) and residents with wounds and/or indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy, ventilator) regardless of MDRO colonization status.</p>		