STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365361	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Manor	2535 Fort Amanda Road Lima, OH 45804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on observation, staff interview, and record review, the facility failed to ensure call lights were within reach for the residents. This affected three residents (#31, #104, and #235). The facility census was 119. Findings include: 1. Record review revealed Resident #31 was admitted on [DATE]. Diagnoses included spastic hemiplegia affecting left nondominant side, abnormal posture, contracture on left elbow, and convulsions. Review of the care plan dated 11/29/24 revealed Resident #31 was at risk to make basic needs known on a daily basis with goal to monitor effectiveness of communication strategies and assistive devices. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was cognitively impaired. Observation on 02/10/25 at 7:21 P.M. revealed Resident #31 was laying on her left side in bed. Call light was on the right side of the bed wrapped around the handrail and stuck tightly between the mattress and handrail. Resident #31 was not able to see or reach the call light for assistance. Interview on 2/10/25 at 7:22 P.M. with Certified Nursing Assistant (CNA) #509 verified call light was stuck in between mattress and handrail and was out of Resident #31's reach. 2. Review of the medical record for Resident #235 revealed an admitted [DATE]. Diagnoses included displaced fracture of base of neck of left femur, cerebral palsy and intellectual disabilities. Review of the plan of care revealed Resident #235 was at risk for falls which included the intervention for a reachable call light. Observation on 02/11/25 at 4:44 P.M. revealed Resident #235 was lying in her bed with her touch call light on the night stand out of reach. Interview with Registered Nurse #437 verified the call light was not within reach of the resident and placed the touch call light by her hand. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of medical record for Resident #104 revealed an admitted [DATE]. Diagnoses included cognitive communication deficit, unsteadiness on feet, major depressive disorder, and mood disorder. Review of the care plan dated 11/19/24 revealed Resident #104 was at risk for falls which included the intervention of visually stimulating call light to remind and encourage use and be sure call light was within reach. Observation on 02/12/25 at 3:42 P.M. revealed Resident #104 lying in bed with call light at the foot of the bed on the floor out of the residents reach. Interview on 02/12/25 at 3:46 P.M. with Certified Nursing Assistant (CNA) #450 verified the call light was not in reach of Resident #104. CNA #450 picked the call light up from the floor and placed it in reach of the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34745 Based on medical record review, observation, and staff interview, the facility failed to ensure a resident who was dependent on staff for bathing received the necessary services to maintain good hygiene. This affected one (Resident #97) of one resident reviewed for activities of daily living (ADL). The facility census was 119. Findings include: Review of the medical record for Resident #97 revealed an admitted [DATE]. Diagnoses included infection of the skin, diabetes mellitus (DM), pressure ulcer of left and right buttocks, and spinal stenosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 was cognitively intact. Resident #97 was impaired bilateral lower extremity and required assistance from staff with bathing and had three pressure ulcers. Review of the plan of care revealed Resident #97 was at risk for decline of ADL related to cellulitis, injury to right knee, morbid obesity, noncompliance, spinal stenosis, gait and or balance problems, incontinence, unaware of safety needs. Interventions included being totally dependent on staff for toileting and required one to two staff for bathing. Observation on 02/12/25 at 10:30 A.M. revealed Certified Nursing Assistant (CNA) #404 and #623 were performing bathing on Resident #97. CNA #623 washed her hands, filled a tub of warm water and placed five washcloths in the water. CNA #623 placed gloves on then retrieved a washcloth from the basin, placed liquid soap on it and washed the back and legs of Resident #97, which had blood on it due to open wounds. CNA #623 placed the blood-soiled washcloth into the basin and retrieved another washcloth to rinse soap off the resident. This was repeated to wash the buttocks of the resident. CNA #404 was helping to hold Resident #97 on his left side during the bathing. CNA #623 took the basin to the bathroom and cleaned out replaced with warm water. CNA #404 performed the perineal care on Resident #97 with clean wash cloths and put soiled washcloths in a plastic bag after using. Interview on 02/12/25 at 11:00 A. M. with CNAs #404 and #623 verified during bathing of Resident #97, CNA #623 did place soiled washcloths back into the basin of warm water during this bathing. CNAs #404 and #623 verified the washcloths should have not been placed back into the basin of warm water and should have been placed in a plastic bag so it would contaminate the water and would ensure infection control measures were followed. Review of the facility's undated policy titled Quality of Care Policy/ADL revealed each resident will receive and the manner will provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. In the area of ADL; a resident's abilities in ADL will not diminish unless circumstances of the individual's clinical condition demonstrate the diminution was unavoidable.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 36303 Based on medical record review, observation, and staff interview, the facility failed to ensure a resident's treatment for a skin tear was completed as physician ordered. This affected one (#12) of three residents reviewed for non-pressure related skin concerns. The facility census was 119. Findings include: Review of Resident #12's medical record revealed an admitted [DATE]. Diagnoses included carpal tunnel syndrome, type two diabetes mellitus, cognitive heart failure, and major depressive disorder. Review of a quarterly Minimum Data Set (MDS) assessment revealed Resident #12 was cognitively intact. Review of a skin issue assessment dated [DATE] revealed Resident #12 was noted with skin tear measuring 2.5 centimeters (cm) in length by 1.5 cm wide to the left forearm. Review of the physician orders dated 01/24/25 revealed an order to cleanse skin tear on left forearm with normal saline (NS), apply triple-antibiotic ointment (TAO), and covered with bordered gauze every day shift. Review of the treatment administration record (TAR) revealed Resident #12's left forearm dressing was documented as being completed on 02/09/25, 02/10/25, and 02/11/25. Observation of Resident #12's left forearm on 02/11/25 at 8:48 A.M. revealed the dressing was dated 01/08/25. Interview with Licensed Practical Nurse (LPN) #605 on 02/11/25 at 8:53 A.M. confirmed the dressing on Resident #12's left forearm was dated 01/08/25. LPN #605 confirmed the treatment was documented as being completed on 02/11/25. LPN #605 confirmed she had documented the treatment as being completed, but had not yet completed the treatment. LPN #605 stated the dressing was probably incorrectly dated 01/08/25 instead of 02/08/25. LPN #605 confirmed Resident #12's dressing was not changed as ordered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, observation, staff interview, and policy review, the facility failed to ensure hand and foot splints were applied per physician order. This affected one (Resident #1) of two residents reviewed for splints. The facility census was 119. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included dementia, schizoaffective disorder, type two diabetes mellitus, extrapyramidal and movement disorder, osteoarthritis, intellectual disabilities, contracture of right shoulder and right elbow, and contracture of muscle right hand. Review of the care plan dated 01/09/25 revealed Resident #1 used a left wrist hand finger orthosis (WHFO), right c-splint elbow brace, PRAFO boots (a custom-fitted ankle foot orthosis that helps support the foot and ankle), palm protectors due to muscle weakness, contractures, and pain. Interventions included braces as ordered with no signs and symptoms of skin irritation and pain and no further decline through next review. Provide passive range of motion to affected were before and after application. Certified Nursing Assistants (CNAs) to apply braces per plan of care. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had severe cognitive impairment. Resident #1 was dependent on staff for activities of daily living and had impairment on both upper and lower extremities. Review of the current physician orders revealed bilateral hand splints on in the morning and off in the afternoon as tolerated, right elbow brace on in the afternoon and off in the evening. Review of CNA tasks in the electronic medical record revealed there was no documentation regarding bilateral hand splints on in the morning and off in the afternoon (bilateral hand rolls to be in place when splints were not being worn) for the past 30 days. Review of the treatment administration record from 02/01/25 to 02/11/25 revealed braces were signed off for 02/11/25. Review of the progress notes for February 2025 revealed no documentation of resident refusing braces on 02/11/25. Observations on 02/11/25 at 7:11 A.M. and 9:00 A.M. of Resident #1 revealed the resident up in the wheelchair in the hallway. No braces or splints noted on hands, elbows, or lower extremities. Interview on 02/11/25 at 9:10 A.M. with Business Office Manager (BOM) #635 verified Resident #1 did not have any splints or braces on hands or elbows at this time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Range of Motion Policy revised 04/2016 revealed a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Residents will be monitored for decline in range of motion on admission and quarterly thereafter.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 a fall intervention was in place when a resident fell . This affected one (Resident #335) of four residents reviewed of accidents. The facility census was 119. Findings include: Review of Resident #335's closed medical record revealed an admitted [DATE]. Diagnoses included depression, chronic kidney disease, malnutrition, atrial fibrillation, and seizures. Resident #335 was discharged from the facility on 01/20/25. Review of a five-day [NAME] Data Set (MDS) assessment dated [DATE] revealed Resident #335 was severely cognitively impaired and has had repeated falls. Review of a care plan dated 10/24/24 revealed Resident #335 was at risk for falls related to deconditioning, gait/balance problems, incontinence, cerebrovascular accident (CVA), and history of repeated falls. Interventions included to encourage the resident to rest after lunch as tolerated was added on 01/14/25 and wheel resident uses has her name name on it for identification was added on 01/20/25. Review of progress notes dated 01/12/25 at 11:56 P.M. revealed Resident #335 was found observed lying on the floor in front of a chair in her room. No injuries were noted. Review of an interdisciplinary team (IDT) note dated 01/14/25 at 7:35 P.M. revealed a root cause analysis of determined Resident #335's fall was caused from her being tired after lunch. The IDT discussed and determined the appropriate intervention was changing Resident #335's wheelchair to assist in comfort and security along with encouraging Resident #335 to rest after lunch. The progress notes dated 01/18/25 at 11:13 A.M. revealed Resident #335 was found by a nurse laying on the floor in the dining room underneath a table. Resident #335 was noted with a small abrasion and bleeding to the corner of her right eye. Resident #335 was sent to the emergency room (ER) for evaluation per request of family. The progress notes dated 01/18/25 at 5:30 P.M. revealed Resident #335 returned to the facility with no new orders. Review of the IDT noted dated 01/20/25 at 9:36 A.M. revealed a root cause analysis of determined Resident #335's fall was caused from not being in a tilt and space wheelchair. Further discussion with the IDT team determined the appropriate intervention to be labeling the correct wheelchair with her name. Interview with the Director of Nursing (DON) on 02/13/24 at 1:07 P.M. stated after Resident #335 slid out of her wheelchair on 01/12/25, it was determined she needed a tilted wheelchair. On 01/18/25, when Resident #335 fell in the dining room she was not in a tilt wheelchair. Staff had put her in the wrong wheelchair. It was believed the wheelchair had been sat at in the hallway. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON, Administrator, and Therapy Director (TD) #306 on 02/13/25 at 2:20 P.M. confirmed Resident #335 was not in the correct wheelchair when she fell in the dining room on 01/18/25. Review of the facility's Fall Reduction Policy revealed it is the facility's policy to identify residents at risk for falls and to implement a fall reduction program to reduce the risk of falls and possible injury. A fall risk reduction plan will be incorporated into the resident's plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00162227 and Complaint Number OH00161841.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, observation, and staff interview, the facility failed to ensure a resident's respiratory equipment was changed as physician ordered. This affected one (#12) of three residents reviewed for respiratory care. The facility census was 119. Findings include: Review of Resident #12's medical record revealed an admitted [DATE]. Diagnoses included cognitive heart failure and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #12 was cognitively intact. Review of the physician orders dated 04/07/24 revealed an order for oxygen maintenance, change oxygen (O2) tubing and supply bag weekly. Wipe down the concentrator and clean filter weekly. Change water jug weekly. Observation of Resident #12's oxygen concentrator humidification bottle on 02/11/25 at 8:48 A.M. revealed it was dated 12/29/24. Interview with Licensed Practical Nurse (LPN) #605 on 02/11/25 at 8:53 A.M. confirmed the dressing on Resident #12's O2 humidification bottle was dated 12/29/24. Review of the facility's policy titled Respiratory Service Disposable Supply Changes dated 05/01/24 revealed disposable supplies need to be dated when changed. O2 humidifier bottles needed to be changed weekly or as needed (PRN).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51516 Based on observation, staff interview, and policy review, the facility failed to ensure food products were not stored in medication carts near biologicals, ensure medication was stored in the original packaging and labeled with resident identification, failed to ensure all prepackaged medication remained in their resident labeled box, and failed to ensure insulin and medications were dated upon opening. This affected three of six medication carts and two of two medication rooms. This had the potential to affect 23 residents who received medications from the D-hall medication cart, 24 residents who received medications from the A-hall cart, one resident receiving ear drops from the F-Hall cart, and five resident receiving insulin from insulin pens from the A-hall cart. The facility census was 119. Findings include: 1. Observation and interview on 02/12/25 at 9:03 A.M of the F-hall medication cart revealed one opened bottle of a generic ear drops, for wax build-up, with no open date in the third drawer. Interview with Licensed Practical Nurse (LPN) #533 verified the ear drops had no open date. 2. Observation and interview on 02/12/25 at 9:20 A.M. of the A-hall medication cart revealed an unmarked, clear, plastic medication cup with nine various tablets and/or capsules located in the top drawer. There was Resident #84's Basaglar Insulin pen, opened, without an open date. Interview with LPN #424 at 9:25 A.M. stated medications should be stored in their original package until they were ready to be administered to the resident and confirmed the Resident #84's insulin pen did not have an open date. 3. Observation and interview on 02/12/25 at 9:25 A.M. of the medication room in the memory care unit revealed one opened vial of tuberculin derivative dated 01/07/25. Interview with Staff Developer #411 verified the opened vial of tuberculin derivative was dated 01/07/25 and should be disposed of because it has been greater than 30 days. 4. Observation on 02/12/25 at 9:45 A.M. revealed bananas, bags of hot flaming onion chips, potato chips, cookies, Cheese-Its, Cheese-O's, and different types of crackers were noted in the bottom, left drawer of the D-hall medication cart along with opened containers of biologicals, including hemorrhoidal cream. Also there were 11 unopened, individual packages of Cymbalta (antidepressant) 20 milligram, with no resident's name, found in the back of the fourth drawer, behind boxes of resident medication. Two open bottles of artificial tears eye drops, undated, were located in the top drawer. Interview with License Practiced Nurse (LPN) #440 at 9:50 A.M. verified food was stored with biologicals, 11 packages of Cymbalta, and artificial eye drops were undated. Review of the policy titled Medication Storage in the Facility dated 12/19/24 revealed medications are stored in containers that meet legal requirements. Outdated medications are immediately removed.

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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** 34745 Based on medical review review, observations, resident interview, staff interviews, and review of facility's policy's, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) during catheter and ostomy care. This affected one (Resident #79) of residents reviewed for catheter care. The facility census was 119. Findings include: Review of the medical record for Resident #79 revealed admitted [DATE]. The resident was admitted with diagnoses including urinary tract infection, multiple sclerosis, neuromuscular dysfunction of bladder, pressure ulcer to left hip, stage three, colostomy status, pressure ulcer to left buttock and dementia. Review of the physician's orders revealed an order dated 01/08/25 for changing ostomy appliance every three days and as needed (PRN). An oder dated 02/12/25 for indwelling Foley catheter 16 french with catheter care every shift. The Minimum Data set (MDS) assessment dated [DATE] revealed Resident #79 was cognitively intact and required extensive assistance for bed mobility, and totally dependent on staff for toileting. Resident #79 had an indwelling catheter and ostomy. A care plan relative to catheter and having multidrug - resistant organisms (MDRO) infection revealed the interventions included Resident #79 may be in EBP while residing at the facility. Resident #79 will understand that staff may be wearing appropriate Personal Protective Equipment (PPE) when they are completing high contact resident care activities. Interview and observation with Resident #79 on 02/12/25 at 9:00 A.M. stated the nurses and certified nursing aides wear gowns when performing his wound care but never wear a gown when changing the ostomy or catheter. The resident explained they only need to wear gowns for the wound due to the risk of infection. Observation of the sign above Resident #79's bed revealed EBP precautions and PPE included gowns and gloves to be used when performing any care during high contact resident care activities which included infection or colonized with an MDRO infection and for indwelling medical devices which included examples such as urinary catheter regardless of MDRO colonization status. Observation on 02/12/25 at 11:12 A.M. revealed Registered Nurse (RN) #402 was preparing to perform ostomy replacement on Resident #79. The nurse gathered all equipment needed, cleaned tray and washed her hands. The nurse placed gloves on and took off old ostomy bag and placed new ostomy by following physician's orders. The nurse gathered soiled ostomy bag and placed in garbage bag. The nurse did not put on a gown (PPE) during this procedure. Interview with RN #402 on 02/12/25 at 11:33 A.M. verified there was no other PPE (gown) used during the care for the ostomy due to Resident #79 was no longer on any kind of precaution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/12/25 at 3:15 P.M. revealed CNA #520 was performing catheter care on Resident #79. CNA #520 gathered basin of warm water, wash cloths and garbage bag. CNA #520 washed her hands and put on gloves then proceeded to perform the catheter care per physician's orders. CNA #520 did not place a gown on at any time during this care. CNA #520 verified gloves were on but did not put on a gown to perform the catheter care. Review of the facility's undated policy titled Standard Precautions revealed it is the intention of this facility to use EBP in addition to standard precautions to prevent transmission of MDRO in our community. An impervious gown should be worn when high-contact resident care activities are being performed. EBP may be considered for the following situations which included infection or colonized with an MDRO when contact precautions do not apply and for indwelling medical devices such as urinary catheter regardless of MDRO colonization status. High contact resident care activities included device care or use wound care or any skin opening.