STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365411	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andover Village Retirement Community	486 S Main St Andover, OH 44003

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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 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** 39973 Based on observation, interview, record review, and review of facility policy the facility did not ensure range of motion (ROM) restorative nursing programs were completed for Residents #11 and #43 as ordered. This affected two residents (#11 and #43) of two residents reviewed for ROM. This had the potential to affect 48 residents (#1, #2, #3, #4, #5, #6, #7, #10, #11, #13, #15, #17, #19, #18, #20, #21, #22, #23, #24, #25, #26, #28, #29, #30, #31, #32, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #50, #52, #53, #54, #56, #58, #59, and #120) identified on a restorative ROM program. The facility census was 64. Findings included: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including muscle weakness, spastic hemiplegia affecting left nondominant side, multiple sclerosis, quadriplegic, and contractures to right and left hands. Review of the care plan dated 03/27/17 revealed Resident #11 had limited joint mobility per ROM assessment. Interventions included applying bilateral resting hand splints on each night during hours of sleep and as needed, report changes and abnormalities to nurse, and review progress quarterly and as needed. Review of the care plan dated 12/23/19 revealed Resident #11 refused a passive range of motion (PROM) restorative program. Interventions included accepting his right to refuse and show respect for his decision, explaining the importance of completing the program to prevent decline, re-approach in approximately 15 minutes to encourage compliance, and contact physician as needed. Review of the care plan dated 10/22/23 revealed Resident #11 had a self-care deficit as evidence by impaired mobility, impaired balance, and assistance needed with activities of daily living (ADL) tasks. Interventions included bilateral resting hand splints for contractual management and performing ROM exercises daily during ADL tasks. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had intact cognition. He was totally dependent on staff for most all his ADL tasks including rolling left and right, personal hygiene, transfers, and bathing. He received one day in the last seven days during the assessment period of passive ROM (PROM) per restorative. (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 Occupational Therapy Discharge Summary dated 05/20/24 and completed by Occupational Therapist (OT) #400 revealed Resident #11 was discontinued from therapy as he achieved his maximum potential. OT #400 referred Resident #11 to restorative to have a bilateral upper extremity PROM program implemented. Review of the restorative documentation from 06/02/24 to 07/01/24 for Resident #11 revealed he was to have a restorative PROM program to his bilateral lower extremities that included 15 repetitions of two sets for 15 minutes, six to seven times per day. The documentation revealed the program was completed and/ or refused 06/02/24, 06/04/24, 06/06/24, 06/08/24, 06/09/24, 06/14/24, 06/20/24, 06/22/22, 06/23/24, 06/25/24, and 06/27/24 (total 11 times). There was no other documented evidence that the program was completed and/ or that he refused per his medical record. Review of the Restorative Therapy Referral dated 06/06/24 revealed Resident #11 was to have an active/ passive ROM program to his bilateral upper extremities and neck that included joint compression to each upper extremity 20 times each, and a scooter board with hand strap across table that included 30 times horizontal adduction and abduction of each bilateral upper extremity. Review of the restorative documentation from 06/06/24 to 07/02/24 revealed Resident #11 had a restorative active/ passive ROM program to his bilateral upper extremities and neck that included joint compression to each extremity joint 20 times each movement. The program also included a scooter board with hand strap across table as able 30 times horizontal adduction and abduction to bilateral upper extremities for 15 minutes six to seven times a week. The documentation revealed the program was only completed on 07/02/24. Interview and observation on 07/01/14 at 9:42 A.M. with Resident #11 revealed he was supposed to get restorative several times a week, but stated he was lucky to get it once a week as the facility often had the restorative State tested Nursing Assistants (STNAs) work on the floor instead of completing the restorative programs. He revealed he was concerned his fingers were going to get more contracted without receiving restorative as recommended. Observation revealed he was unable to move his extremities independently as he was a quadriplegic. Interview on 07/03/24 at 8:34 A.M. with Restorative STNA #371 revealed there were a lot of residents on restorative programs and stated, I try to hit everyone up as much as I can, but I cannot get to everyone. She verified there were some days she was unable to complete Resident #11's restorative ROM program. Interview on 07/03/24 at 9:11 A.M. with Restorative Registered Nurse (RN) #314 verified Resident #11's restorative ROM programs were not completed as recommended per therapy to his upper and lower extremities per the documentation. She verified each program was to be completed six to seven days a week. Interview on 07/03/24 at 10:47 A.M. with Rehabilitation Director #401 revealed Resident #11 was discharged from OT on 05/20/24 as he reached his maximum potential. He revealed therapy referred Resident #11 to restorative to have a ROM program to his bilateral upper extremities and neck as well as to continue his already in place restorative ROM program to his bilateral lower extremities. He revealed the programs were to be completed six to seven days a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #43's admitted was 03/10/23 with diagnoses including dislocation of internal left hip prosthesis, Alzheimer's disease, and heart failure. Review of the care plan dated 03/17/24 revealed Resident #43 had the potential/ actual limitations to his bilateral legs. Interventions included nursing restorative active ROM program to bilateral lower extremities six to seven days a week, restorative nurse to assess ROM quarterly and as needed, and report and pain and/ or discomfort to nurse or physician. Review of the quarterly MDS assessment dated [DATE] revealed Resident #43 had impaired cognition. He required staff supervision with transfers and ambulation. He required substantial to maximum staff assist with bathing. He received two days of a restorative ROM program during the seven-day assessment reference period. Review of the Physical Therapy Discharge Summary dated 05/20/24 and completed by Physical Therapist (PT) #402 revealed Resident #43 was discontinued from therapy as he met his maximum potential and was referred to restorative for ROM program to facilitate maintaining current level of performance and to prevent decline. Review of the Restorative Therapy Referral dated 05/20/24 revealed Resident #43 was to have active ROM to his bilateral lower extremities while seated that included 15 repetitions times two sets using one pound weight and green TheraBand (thick elastic band that provides a way to exercises and strengthen muscles) six to seven days a week. Review of the care plan dated 05/30/24 revealed Resident #43 refused his restorative active ROM and ambulation programs. Interventions included accepting his right to refuse, explaining potential of negative outcomes, re-approaching in approximately 15 minutes to encourage compliance, and contact physician as needed. Review of the restorative documentation dated from 06/04/24 to 07/01/24 revealed Resident #43 was to have active ROM to his bilateral lower extremities while seated using a one pound weight and green TheraBand 15 repetitions of two sets 15 minutes six to seven times per week. This was documented as completed and/ or the resident refused on: 06/04/24, 06/06/24, 06/07/24, 06/08/24, 06/09/24, 06/14/24, 06/20/24, 06/22/24, 06/23/24, 06/24/24, 06/25/24, 06/27/24, and 07/01/24 (total 13 times). Interview and observation on 07/01/24 at 9:40 A.M. revealed Resident #43 was lying in bed and was unable to provide any information regarding his ROM restorative program due to cognitive ability. Interview on 07/03/24 at 8:34 A.M. with Restorative STNA #371 revealed there were a lot of residents on restorative programs and stated, there are days I just do not get to him. She verified Resident #43 was not seen six to seven times a week as ordered. Interview on 07/03/24 at 9:11 A.M. with Restorative RN #314 verified Resident #43's restorative ROM program was not documented as completed as ordered. She verified he was to have restorative ROM six to seven days a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/03/24 at 10:47 A.M. with Rehabilitation Director #401 revealed Resident #43 was discharged from PT on 05/20/24 as he reached his maximum potential. He revealed therapy referred Resident #43 to restorative to have a ROM program to his bilateral lower extremities and verified the program was to be completed six to seven days per week to maintain his current level and prevent decline. Review of the facility policy labeled; Restorative Nursing, dated March 2017, revealed restorative nursing programs would be provided for any resident who was identified as having a need for service. These services would include consistent and structured programs designed by the restorative nurse and carried out by staff as scheduled. The policy revealed documentation would include the date of service that was provided, the type of service, and total minutes provided. The documentation would be completed before the end of the staff member's shift. Review of the facility policy labeled; Resident Mobility and Range of Motion, dated July 2017, revealed residents would not experience an avoidable reduction in ROM. The policy revealed residents with limited range of motion would receive treatment and services to increase and/ or prevent a further decrease in ROM. The policy revealed the care plan would include specific interventions, exercises and therapies to maintain, prevent avoidable decline in and improve mobility and range in motion. The care plan would include the type, frequency, and duration of interventions, as well as measurable goals and objectives.

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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** 41526 Based on observation, interview, record review, and facility policy review the facility failed to provide adequate tracheostomy care including timely respiratory evaluations as ordered for Resident #45. This affected one resident (#45) of four residents reviewed for tracheostomy care. The facility identified 11 residents (#15, #22, #38, #45, #47, #51, #54, #55, #57, #118 and #119) with tracheostomies. The facility census was 66. Findings include: Review of the medical record for Resident #45 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure with hypoxia, diabetes mellitus type II, nontraumatic intracerebral hemorrhage, and tracheostomy status. Review of Resident #45's physician orders effective July 2024 revealed oxygen 21 to 50 percent to maintain oxygen saturation at 92 percent or greater every shift, change tracheostomy as needed, suction as needed, place a bag valve mask and oxygen emergency tank in room and check at the beginning of every shift, check breath sounds every shift and as needed, oxygen saturation every four hours and see respiratory flow record for documentation every shift, and evaluation by respiratory therapists per report of oxygen saturation by pulse oximetry and recommendations for pulmonary care as needed. Review of Resident #45's medication and treatment administration records from May to July 2024 revealed no documented evidence that tracheostomy related care was completed. Review of the Quarterly Minimum Data Set (MDS) assessment completed 06/14/24 indicated Resident #45 was in a persistent vegetative state with no discernible consciousness. Review of the care plan initiated 12/13/22 revealed Resident #45 was at risk for respiratory distress due to respiratory failure, tracheostomy, and oxygen. Interventions included administering oxygen as ordered, maintaining tracheostomy as ordered, and suctioning as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/01/24 at 10:35 A.M. with Resident #45's mother complained of having an issue with the respiratory therapists (RT). They were required to enter Resident #45's room three times each twelve-hour shift to complete tracheostomy care and assess his needs, but the RTs were not checking on him. The mother asked RT to come into the room every two hours, especially because Resident #45 was unable to use a call light and there was no alarm for staff to identify respiratory distress or low oxygenation levels. The mother described having witnessed Resident #45 struggle with breathing via the in-room camera with inability to call staff for assistance and no alarms to alert staff, so the mother called staff on the telephone to request assistance for Resident #45. Due to this concern, the mother requested RT to check on Resident #45 every two hours, but they refused and maintain routine checks of three times each 12-hour shift. The mother indicated feeling no other choice but to drive one hour each way to the facility daily to sit with Resident #45 for 12 hours each day to complete more frequent checks since the RTs refused. The mother expressed feeling grateful she was a nurse and could advocate for him. She continued to state that now because of intervening, the RTs were just checking oxygenation without assessing him for needs, telling nurses not to bother providing tracheostomy care because the mother did it, or no longer coming into the room at times and just documenting the mother completed the care. The mother complained of feeling hopeless for a resolution because even after talking to the Administrator, Director of Nursing (DON) and Ombudsman, nothing had changed. She indicated feeling afraid and unsupported, so she was obligated to be with Resident #45 as much as possible to ensure he breathed without difficulty and received the necessary respiratory care. The mother continued stating she should not have to do it but believed there were no other options thinking the staff expected her to do the care, so she used the camera to watch when not in the facility. The mother requested the surveyor watch the RT on the next check and stated it would either not get done, or the RT would check the oxygenation level then leave without checking Resident #45 for respiratory care needs like suctioning or even speaking to the mother. The mother denied ever telling staff not to perform respiratory care or a desire to complete it in place of them but admitted requesting to assist the staff. The mother also denied documenting any respiratory care on the flow record or having access to or using a stethoscope to hear breath sounds to determine suctioning needs but described just listening for audible wheezing or congestion. The mother explained leaving the door closed when visiting to keep out the surrounding noise but stated it should not stop the staff from coming in and checking on Resident #45, indicating there were times the RT would only come in once during the shift while she was there and let the mother do the rest. The mother again stated she does the care because the staff did not, and expressed talking with the pulmonologist who refused to increase respiratory checks to every two hours but did not understand why especially when there were no safety interventions in place like a respiratory alarm to alert staff with respiratory distress or since Resident #45 was unable to request needs. Observation on 07/01/24 at 11:18 A.M. of Resident #45 with the mother present in the room revealed audible quiet crackling noises mixed with wheezing during respirations. Interview at the time of the observation with the mother indicated hearing congestion and wheezing and believed Resident #45 probably needed suctioned but was not confident the RT would assess him for it. Observation on 07/01/24 at 11:24 A.M. of Resident #45 with the mother present revealed RT #382 entered the room, placed a pulse oximeter onto Resident #45's left finger, then moved over to the respiratory log and wrote down some information. Once completed, RT #382 removed the oximeter and exited the room. RT #382 did not engage the resident, the mother or the surveyor, and did not perform an evaluation of Resident #45's respiratory status including breath sounds to identify needs for suctioning or provide any type of tracheostomy care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/01/24 at 11:26 A.M. with RT #382 reported respiratory therapy was available 24 hours daily, and each RT worked 12 hours shifts. Residents with tracheostomies or ventilators were monitored through evaluations completed at least every four hours or three times during each shift. RT #382 indicated residents were checked with each visit, and tracheostomy care was provided including suctioning if needed. RT #382 confirmed entering Resident #45's room to obtain a pulse oxygenation reading without performing a respiratory evaluation or related care during the routine every four-hour visit. RT #382 explained Resident #45's mother did the care, so it was not needed, but Resident #45 was the only one for whom care was skipped. RT #382 described only doing the care once in the morning then the mother completed it the rest of the 12-hour day shift, and it was because the mother was present, so RT #382 only documented oxygenation levels and oxygen settings. RT #382 further confirmed not engaging Resident #45 or the mother while in the room to question about whether the mother had completed any respiratory care to determine Resident #45's status or ask the mother if there were any needs or concerns and did not evaluate Resident #45's need for suctioning or tracheostomy care including listening to breath sounds. RT #382 complained Resident #45's mother did not speak to her but knew the mother suctioned Resident #45 every two hours whether it was needed or not, so RT #382 just lets her do the care. RT #382 admitted it was assumed the care was completed by the mother. RT #382 stated she had once talked to the mother and was mostly told nothing was needed so the mother was told to let RT know if care was needed, but RT #382 insisted the mother did not ask for any care. When questioned about routine monitoring of Resident #45 to ensure adequate breathing and oxygenation since Resident #45 was unable to call for assist and there were no alarms to alert staff of difficulties, RT #382 responded the staff did monitor Resident #45 but with the doors open to clearly see. RT #382 indicated the mother kept the door shut all the time, so the staff relied on the mother to report any concerns, and re-stated the mother did the care anyway. RT #382 complained that the mother took over the care and then turned her into the Ombudsman. RT #382 implied the mother changed everything on what was wanted, and so respiratory care including suctioning could not be tracked because the mother did all the care. Interview on 07/01/24 at 11:35 A.M. in Resident #45's room with the mother explained after RT #382 and the surveyor left, the mother completed suctioning because RT #382 did not evaluate him for respiratory care, so she had to do it. The mother also pointed out Resident #45's tracheostomy dressing was wet and needed changed. Observation at the time of the interview of Resident #45's tracheostomy dressing revealed the dressing was visibility wet. The mother stated she would have to change it too because it would not be done otherwise. Resident #45's mother denied staff had provided education regarding respiratory care, observation to ensure the mother's competency or monitor her completion of the care or discuss an arrangement for the mother's participation in the care. Interview on 07/01/24 at 11:38 A.M. with Licensed Practical Nurse (LPN) #333 reported Resident #45's mother was a nurse and over the top, having her own expectations but indicated Resident #45 was stable and had no medical issues. The mother was very involved and completed his care, but the staff also assisted with that care. LPN #333 stated the aides enter the room every two hours on the nose to provide turning, repositioning, and any personal care with the mother because there was a specific way she liked it not wanting it any other way. LPN #333 indicated nursing would provide suctioning if needed. The mother stays 12 hours daily, so staff ask if any care was needed. RT are in and out of rooms frequently and aides check frequently enough so alarms are not needed but confirmed RT was expected to provide care in conjunction with the mother because that was how she liked it, although staff was ultimately responsible to ensure respiratory care was completed appropriately as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/01/24 at 11:45 A.M. with DON and Administrator indicated Resident #45's mother was over the top and wanted things done her way which included tracheostomy care and suctioning completed every two hours even when it was not needed. They reported recently talking to the Ombudsman regarding concerns from the mother about RT and trying to appease the mother. Respiratory care and suctioning were every four hours but it did not satisfy the mother, despite the physician saying suctioning too frequently or more than needed would cause damage. They stated the mother wanted to do the care and the staff to do the care to assist her. The mother would inform staff when it was done or explain what still needed to be done. If staff did not go into the room at the two-hour mark, the mother would complete the care herself. Resident #45 was treated like everyone else. The staff completed care and drove the care so she needed to let us do the care and she could help. We talked to the mother and the Ombudsman about RT #382 because the mother complained about an issue with RT, but the mother told RT #382 not to do the care. The Administrator and DON verified they had not made any written agreements or understandings with the mother or directed the staff including RT on what actions to take if the mother refused to let staff provide the needed or ordered care, or how to approach the situation. The Administrator emphasized the staff provided respiratory care, but when informed of the surveyor observation when RT #382 did not complete a respiratory evaluation, confirmed it should have been provided. Interview on 07/02/24 at 7:48 A.M. with RT #383 reported only residents with ventilators had alarm systems to alert staff of any respiratory concerns. Most residents without ventilators were able to call for help or if not able, staff would let RT know if care was needed. RT #383 explained the standard of care was no less than once each shift for tracheostomy care and every four hours to complete pulse oximetry coupled with an assessment or evaluation to determine if any respiratory care needs were required like suctioning by using breath sounds or changing tracheostomy dressings if wet or soiled. Resident #45 had a flow record with variations to the flow record depending on resident needs, and it was completed only by RT or the nurse. Resident #45's mother was not expected to perform any assessments to determine care need or expected to complete the care or document any respiratory care provided but wanted to be involved in the care. RT #383 indicated if the mother completed respiratory related care like suctioning prior to the RT going into the room, the RT was required to go behind the mother and still check to ensure the care was completed correctly, and then perform any additional care needed as a result. RT would never expect the mother to complete any respiratory care in place of the RT's responsibility. Tracheostomy inner cannula changes and dressing changes were usually completed at the beginning of the 12-hour shift then evaluated during the following routine checks, and the dressing was changed if wet like a paper towel to prevent irritation even if there was no visible sputum. Additional evaluations completed at each four-hour visit included breath sounds to determine suctioning, pulse oxygenation levels, and water levels for humidification. RT #383 reported checking Resident #45 every two hours because the staff knew the mother desired it because Resident #45 cannot ask for any respiratory related care. Resident #45 did not necessarily need it so frequently, but it was not detrimental to just do it. The mother usually wanted RT to perform the care. RT #383 described knowing there was an issue between RT #382 and the mother and not being certain if RT #382 talked to the mother but would go into the room once and then not return to complete evaluations until the mother left. RT #383 verified completing evaluations on Resident #45 in the room and engaging the mother to make sure the mother was comfortable with the care and Resident #45's needs were met. RT #383 denied receiving any direction from administration on how to handle the issues between the mother and RT. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/02/24 at 11:23 A.M. with MDS Coordinator #301 and MDS Coordinator #314 verified having no knowledge of Resident #45's mother providing tracheostomy related care, the physician being aware, or evidence of the mother demonstrating competent skills, or being educated of risks/effects to providing care more often than needed, and it was not included in the plan of care. Upon review of Resident #45's respiratory flow records from 06/30/24 to 07/01/24 showed multiple columns to reflect the dates and times of completed respiratory evaluations which included assessment and/or provision of the oxygen flow rate, respiratory rate, oxygenation levels, heart rate, breath sounds, suctioning amount including consistency and color, tracheostomy care, inner cannula change, collar change, equipment changes, and emergency equipment at the bedside. The flow records revealed Resident #45's mother completed suctioning in lieu of a RT on 06/01/24 at 8:30 A.M. and 11:30 A.M., 06/02/24 at 11:30 A.M and 6:55 P.M., 06/03/24 at 7:30 P.M., 06/04/24 at 8:00 P.M., 06/05/24 at 11:30 A.M., 06/06/24 at 7:00 A.M., 06/07/24 at 8:15 P.M., 06/08/24 at 7:54 P.M., 06/09/24 at 8:12 P.M., 06/10/24 at 6:50 P.M., 06/12/24 at 3:30 P.M. and 7:49 P.M., 06/13/24 at 8:00 P.M., 06/17/24 at 8:30 P.M., 06/18/24 at 7:50 P.M., 06/19/24 at 12:00 P.M. and 4:15 P.M., 06/21/24 at 8:00 P.M., 06/22/24 at 7:49 P.M., 06/23/24 at 8:05 P.M., 06/24/24 at 3:45 P.M., 06/25/24 at 11:30 A.M. and 3:15 P.M., 06/26/24 at 11:30 A.M., 3:30 P.M. and 8:00 P.M., 06/27/24 at 8:00 P.M., 06/29/24 at 3:30 P.M., 06/30/24 at 3:30 P.M., and 07/01/24 at 12:30 P.M. Resident #45's mother completed breath sounds in lieu of a RT on 06/05/24 at 3:30 P.M., 06/06/24 at 3:30 P.M., 06/07/24 at 1:20 P.M., and 06/10/24 at 11:30 A.M. and 3:30 P.M. Resident #45's mother completed tracheostomy care in lieu of a RT on 06/03/24 at 7:30 P.M., 06/04/24 at 8:00 P.M., 06/07/24 at 8:15 P.M., 06/08/24 at 7:54 P.M., 06/09/24 at 8:12 P.M., 06/12/24 at 7:49 P.M., 06/13/24 at 8:00 P.M., 06/17/24 at 8:30 P.M., 06/18/24 at 7:50 P.M., 06/21/24 at 8:00 P.M., 06/22/24 at 7:49 P.M., 06/23/24 at 8:05 P.M., 06/26/24 at 8:00 P.M., and 06/27/24 at 8:00 P.M. RT evaluations were not completed every four hours as ordered on 06/01/24 at 3:30 A.M. and not again until 8:30 A.M., and at 12:40 P.M. and not again until 7:20 P.M., on 06/02/24 at 7:00 A.M. and not again until 11:30 A.M. and not again until 7:55 P.M., on 06/03/24 at 3:30 A.M. and not again until 8:25 A.M., on 06/04/24 at 3:25 P.M. and not again until 8:00 P.M., on 06/05/24 at 7:00 A.M. and not again until 11:30 A.M., on 06/06/24 at 7:00 A.M. and not again until 11:30 A.M., on 06/07/24 at 7:00 A.M. and not again until 1:20 P.M. and not again until 8:15 P.M., on 06/09/24 at 3:15 P.M. and not again until 8:12 P.M., on 06/10/24 at 7:00 A.M. and not again until 11:30 A.M., on 06/10/24 at 6:50 P.M. and not again until 11:25 P.M., on 06/11/24 at 7:00 A.M. and not again until 11:30 A.M. and not again until 4:40 P.M., on 06/12/24 at 7:10 A.M. and not again until 11:35 A.M., on 06/13/24 at 3:15 P.M. and not again until 8:00 P.M., on 06/14/24 at 6:45 P.M. and not again until 11:35 P.M., on 06/15/24 at 6:55 P.M., and not again until 11:35 P.M., on 06/17/24 at 3:10 P.M. and not again until 8:30 P.M., on 06/21/24 at 5:10 A.M. and not again until 11:20 A.M., on 06/21/24 at 3:15 P.M. and not again until 8:00 P.M., on 06/23/24 at 3:20 P.M. and not again until 8:05 P.M., on 06/24/24 at 11:15 A.M. and not again until 3:45 P.M., on 06/26/24 at 3:30 P.M. and not again until 8:00 P.M., on 06/27/24 at 3:15 P.M. and not again until 8:00 P.M., on 06/29/24 at 6:30 A.M. and not again until 11:30 A.M., and on 07/01/24 at 7:00 A.M. and not again until 11:30 A.M. The daily inner cannula change with tracheostomy care was not completed on 06/12/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365411	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andover Village Retirement Community	486 S Main St Andover, OH 44003

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's care plan updated on 07/03/24 after surveyor intervention revealed the mother was involved in all aspects of care, assisted with bathing, turning, suctioning, and caring for the tracheostomy. The mother was a nurse, competent in the skills and had given return demonstration. The mother preferred to do as much as possible for Resident #45 and was at the facility normally 12 hours daily. The mother had pillows marked for placement, diagrams on the wall, and often requested tasks to be completed more frequently than needed. Education regarding this related to suctioning and tracheostomy care was ineffective and at times provided care on her own and did not allow staff to do it. During night hours, the mother and boyfriend would often watch care through the in-room camera and speak out if they wanted something done differently. They would call and make aides wait for RT before turning and repositioning could be completed. The mother requested certain staff members and at times would demand assignments be changed to have those staff. The goal was for Resident #45's needs to be met by staff with assistance of the mother per her preference. Interventions included to continue to offer and provide care through the mother and boyfriend's visitation hours; continued education with the mother related to frequency of tasks needing to be completed; and education to the mother that all staff were trained to care for Resident #45 when she insisted assignments be changed. Review of progress notes and list of assessments from 06/01/23 to 07/03/24 revealed a note on 06/14/23 which indicated Resident #45's mother provided care when in the facility with assistance from staff as requested. On 07/29/23 the pulmonologist indicated Resident #45's mother and father were used to suctioning Resident #45 without any difficulty so this would continue the same. On 08/19/23 the pulmonologist indicated RT reported getting calls at night from the family using a video system in Resident #45's room to report suctioning was needed despite RT making rounds and determining there were not enough secretions to suction. This issue was discussed with RT who were directed that a normal amount of secretions was okay and sometimes frequent suctioning was of no benefit and may cause harm, irritation or blood-stained mucous with the mother being a nurse should understand it. The mother was directed to notify RT of concerns related to secretions. On 11/03/23 and 12/18/23, the primary care physician (PCP) indicated Resident #45's mother was very involved in his care and provided a lot of care herself. There was no evidence of education to the mother regarding standards of care, risk/effects of providing tracheostomy care too often, or staff observation to determine the mother's competency or to monitor what or how much respiratory care was provided. Interview on 07/03/24 at 12:10 P.M. with RT #383 indicated having once seen Resident #45's mother in process of changing a tracheostomy gauze dressing when Resident #45 was first admitted but had not observed her to determine any competency. RT #383 verified the above respiratory flow records findings and indicated the tracheostomy inner cannula needed changed daily to prevent infections, continuing that it was not a good standard of practice to go longer than once daily. RT #383 explained respiratory orders were written mostly on an as needed basis to allow for variances in care, but the standard of care should be met. Tracheostomy collars were changed on bath days or at least weekly or when needed if soiled. Resident #45's oxygenation checks were ordered for Resident #45 every four hours, but RT approached it to evaluate three times during each shift, so the respiratory log reflected that concept. Interview on 07/03/24 at 3:10 P.M. with DON and Administrator revealed additional oxygenation levels were recorded by various staff in the electronic medical record under vitals, however the results were not on the respiratory flow records as ordered with a RT evaluation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of emails between Ombudsman and Administrator from 06/04/24 to 07/02/24 revealed the Ombudsman requested Resident #45's physician orders and then the respiratory flow records because it was referenced in the physician order as the place where four-hour oxygenation levels were to be recorded. The Administrator also confirmed to Ombudsman the pulmonologist was the director or person who oversaw the respiratory department, gave orders and directed the care of residents who required respiratory services. Interview on 07/08/24 at 10:50 A.M. with DON, Administrator, and Assistant Director of Nursing (ADON) #304 confirmed there was no additional RT documentation to meet the four-hour requirement as ordered, and verified there was no evidence in the medical record of the mother performing return demonstration as documented in the updated care plan. They agreed the pulmonologist directed all respiratory related care and indicated the physician was aware of the mother providing care for Resident #45. However, there was no documented evidence that the pulmonologist approved of the mother's provided care to replace the ordered RT evaluation of every four-hour oxygenation level and needed respiratory care. Review of the facility policy, Tracheostomy Care, revised August 2013, tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and each shift for residents with unhealed tracheostomies; remove supplemental oxygen mask from tracheostomy, inspect skin and stoma site for signs or symptoms of infection, leakage, subcutaneous crepitus or dislodged tube; assess resident for respiratory distress by measuring resident's oxygen saturation with pulse oximeter, listen to lung sounds with a stethoscope and observe for asymmetrical chest expansion.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review, and review of facility policy revealed the facility did not ensure Resident #13 was free of significant medication error. This affected one resident (#13) out of seven residents reviewed for medication administration. The facility census was 64. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including constipation, vitamin D deficiency, cardiac murmur, hypertension, and spinal stenosis. Review of the Admission Assessment/ Baseline Care Plan dated 06/03/22 and completed by Assistant Director of Nursing (ADON)/ Registered Nurse (RN) #304 revealed Resident #13 does not want to self-administer her medications. Review of the care plan dated 06/29/22 revealed Resident #13 refused care including medications at times. Interventions included accepting the resident's right to refuse, allowing resident choices as able, re-approaching in approximately 15 minutes to encourage compliance, and re-educating after each episode of care refusal. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had intact cognition. Review of July 2024 Medication Administration Record (MAR) revealed RN #321 had documented she had administered Resident #13 the following medications that were scheduled on 07/01/14 at 8:00 A.M.: Amlodipine besylate 5 milligram (mg) give one tablet by mouth for hypertension, aspirin enteric coated delayed release 81 mg give two tablets by mouth for prevention of cardiac symptoms, calcium carbonate-vitamin D 600-400 mg/ unit one tablet by mouth as a supplement, Colace 100 mg give one capsule by mouth for constipation, glucosamine-chondroitin capsule give two capsules by mouth for osteoarthritis, vitamin C 500 mg tablet by mouth as a vitamin supplement, and ferrous sulfate 325 mg by mouth for anemia. Observation on 7/1/24 at 9:28 A.M. revealed there was a medication cup sitting on Resident #13's bedside table that contained nine tablets and/ or capsules: one red capsule, two white capsules, one green tablet, one dark green tablet, two yellow tablets, and two white tablets. Interview on 07/01/14 at 9:28 A.M. with Resident #13 revealed when the nurse had brought her morning medications, she did not feel like taking them until after she ate her breakfast. Resident #13 revealed she had forgotten then to take them as she did not realize the medications were still sitting on her table. Resident #13 revealed she should have taken her medication especially since her heart medication was one of the tablets. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/01/24 at 9:31 A.M. with RN #321 verified she was the nurse that had given Resident #13 her medication this morning, 07/01/24. She verified she had left the medication cup with Resident #13 as Resident #13 had stated she was going to take the medications after breakfast. RN #321 verified she should not have left the medications on her table as she should have come back after she had eaten her breakfast to offer the medications again. RN #321 also verified she had documented that she had administered the medications on the MAR even though Resident #13 had not taken the medication. Review of the facility policy labeled, Medication Administration, dated 06/21/17, revealed medications would be administered in accordance with local, state and federal laws and consistent with accepted standards of practice. The policy revealed the nurse was to remain with the resident while the medication was swallowed and never leave a medication in a resident's room without orders to do so. The nurse was to document medication administration with initials on the MAR immediately after administering the medication to each resident. The policy revealed if a resident refused medications document on the MAR.