STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Health Care	1320 Mahoning Ave NW Warren, OH 44483

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, observation and interview the facility failed to maintain Resident #36's right to a dignified existence. This affected one resident (Resident #36) of the three residents reviewed for dignity. The facility census was 80. Findings include: Review of the medical record revealed Resident #36 was admitted [DATE] with diagnoses including memory deficit, morbid obesity, hypertensive congestive heart failure, and major depression. Review of the Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #34 had intact cognition and was always incontinent of urine and frequently incontinent of bowel. Review of the physician order dated 02/02/23 for Resident #36 revealed an order for Lasix (a diuretic) 40 milligrams by mouth daily. Interview on 08/20/24 at 9:00 A.M. with Licensed Practical Nurse (LPN) #513 revealed Resident #36 urinated frequently due to being on a diuretic and even with frequent incontinence care every two hours, she was frequently wet with urine which caused a strong odor of urine in her room and the urine odor was persistent. When LPN #513 was asked if any air freshener had been considered for use in this resident's room to help eliminate the odor of urine, LPN #513 did not respond to the question. Interview on 08/20/24 at 9:30 A.M. with State tested Nurse Aid (STNA) #520 verified Resident #36's room had an ongoing, strong urine odor. An observation was conducted on 08/20/24 at 10:30 A.M. of Resident #34's room. Resident #34 was present during the observation. The room had a very strong odor of urine that permeated the entire room upon entrance into the room. An interview with Resident #34 at the time of the observation confirmed her room smelled like urine. Review of facility policy titled Resident Rights, revised June 2015, revealed residents had a right to a dignified existence. This deficiency represents non-compliance investigated under Complaint Number OH00156094.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on record review, review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual, and interview, the facility failed to accurately code MDS assessments for five residents (#5, #11, #51, #71 and #73) of seven residents reviewed for resident assessments. The facility census was 80. Findings Include: 1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including cerebral atherosclerosis, chronic obstructive pulmonary disease (COPD), seizures, heart disease, gastric reflux, generalized anxiety disorder, and vascular dementia without behavioral disturbance. Review of the physician's orders for Resident #5 revealed she was admitted to hospice upon admission (07/19/22) with a diagnosis of end stage cerebral atherosclerosis. Review of the annual MDS 3.0 comprehensive assessment dated [DATE] revealed the resident was severely cognitively impaired. Review of Section J Health Conditions revealed Resident #5 did not have a life expectancy of less than six months. Review of Section O Special Treatment revealed the resident was receiving hospice services. 2. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease dependent on dialysis, COPD, congestive heart failure (CHF), sick sinus syndrome, placement of a pacemaker, generalized anxiety disorder, a colostomy, major depression, and atrial fibrillation. Review of the physician's orders for Resident #11 revealed he was admitted to hospice with a diagnosis of end stage CHF on 06/13/24. The physician's orders revealed the resident also remained a full code. Review of the significant change comprehensive MDS 3.0 assessment dated [DATE] revealed the resident was cognitively intact. Review of Section J Health Conditions revealed Resident #5 did not have a life expectancy of less than six months. Review of Section O Special Treatment revealed the resident was receiving hospice services. 3. Resident #51 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, chronic kidney disease, anemia, depression osteoarthritis, gastric reflux disease, and high cholesterol. Review of the physician's orders for Resident #51 revealed she was admitted to hospice with a diagnosis of end stage Alzheimer's disease on 09/08/23. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. Review of Section J Health Conditions revealed Resident #51 did not have a life expectancy of less than six months. Review of Section O Special Treatment revealed the resident was receiving hospice services. Review of the annual comprehensive MDS 3.0 assessment dated [DATE] revealed Section J Health Conditions was marked as not having a life expectancy of less than six months. Review of Section O Special Treatment revealed Resident #51 was receiving hospice services. All comprehensive MDS 3.0 assessments were coded incorrectly for Section J Health Conditions the admission assessment. 4. Resident # 71 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, fibromyalgia, hallucinations, lumbar radiculopathy, chronic viral hepatitis, high cholesterol, generalized anxiety disorder, and restlessness and agitation. Review of the physician's orders for Resident #71 revealed she was admitted to hospice with a diagnosis of end stage Parkinson's disease upon admission. Review of the quarterly comprehensive MDS 3.0 assessment dated [DATE] revealed J Health Conditions was marked as not having a life expectancy of less than six months. Review of Section O Special Treatment revealed Resident #71 was receiving hospice services. Review of the comprehensive quarterly MDS dated [DATE] revealed Section J Health Conditions was marked as not having a life expectancy of less than six months. Section O Special Treatment revealed the resident was receiving hospice services. All comprehensive MDS 3.0 assessments were coded incorrectly for Section J Health Conditions since the admission MDS 3.0 assessment was completed. 5. Resident #73 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the jejunum, dementia without behavioral disturbance, CHF, atrial fibrillation, and generalized anxiety disorder. Review of the physician's orders for Resident #73 revealed she was admitted to hospice with a diagnosis of malignant neoplasm of the jejunum on 06/14/24. Review of the significant change comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #73 was severely cognitively impaired. Review of Section J Health Conditions revealed the resident did not have a life expectancy of less than six months. Review of Section O Special Treatment revealed the resident was receiving hospice services. Review of the quarterly comprehensive MDS 3.0 assessment dated [DATE] revealed J Health Conditions was marked as not having a life expectancy of less than six months. Review of Section O Special Treatment revealed Resident #71 was receiving hospice services. Review of the comprehensive annual MDS dated [DATE] revealed Section J Health Conditions was marked as not having a life expectancy of less than six months. Section O Special Treatment revealed the resident was receiving hospice services. Interview with MDS Licensed Practical Nurse (LPN) #518 on 08/21/24 at 3:30 P.M. revealed the MDS Coordinator was currently on medical leave. This was her first job at completing MDS 3.0 comprehensive assessments. When she was asked how Residents #5, #11, #51, #71, and #73 were incorrectly coded under Section J Health Conditions for hospice, MDS LPN #518 said Corporate told her to never code the resident has a life expectancy of less than six months. She said she would notify the MDS Coordinator that modifications would be needed for all incorrectly coded assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS 3.0 Resident Assessment Instrument (RAI) manual revealed any resident receiving hospice services should be coded as having a life expectancy of less than six months. This deficiency identified noncompliance as an incidental finding during the investigation of Complaint Number OH00156094.

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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 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** 47570 Based on record review and interview, the facility failed to ensure Resident #37 was provided adequate assistance during ambulation to prevent a fall and that fall risk evaluations/assessments were completed at least quarterly. This affected one resident (#37) of three residents reviewed for falls. The facility census was 80. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including dementia, major depression, history of falling, hypertension and anxiety. Review of physical therapy discharge summary dated 09/20/22 revealed Resident #37 was able to ambulate with a front wheeled walker 100 feet with minimum assistance. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #37 had impaired cognition, and required maximum assistance by staff to walk 10 feet and to walk 50 feet and turn twice. She also required maximum assistance to come to a standing position from sitting and transfer from chair to bed. Review of the plan of care dated 05/15/24 revealed Resident #37 was at risk for falls. Interventions included one person assist with transfers and ambulation, bilateral grab bars for positioning in bed, body pillow while in bed, call light in reach, defined perimeter mattress for positioning, encourage resident to call for assistance. Further review of the medical record revealed the most recent Fall Risk Evaluation was done 05/18/23 revealing Resident #37 was at risk for falls with a score of 16. Review of a nurse progress note dated 06/25/24 at 2:17 P.M. written by Licensed Practical Nurse (LPN) #508 revealed Resident # 37 was observed to have fallen on the floor. The physician was notified and Resident #37 had an order to be sent to the emergency room (ER) for an evaluation. Family was notified. Review of a nurse progress note dated 06/25/24 at 7:01 P.M. written by LPN # 511 revealed Resident #37 returned from the hospital emergency room by ambulance, her neurological checks were normal, there was no pain or acute injury from the fall. Review of the facility fall investigation dated 06/25/24 revealed Resident #37 fell on the memory care unit and was sent out to the ER due to complaint of pain. The nursing description of the incident included staff were helping Resident #37 get up to use the bathroom. The resident stood up, a staff member reached out to move a chair and the resident lost her balance and fell in the dining room. Resident #37 yelled I hurt. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement dated 06/25/24 written by State tested Nursing Assistant (STNA) #557 revealed after lunch at 12:45 P.M. STNA #557 grabbed Resident #37's walker to ambulate her to the bathroom. Resident #37 was stood at the walker. STNA #557 asked Resident #37 if she had her balance, Resident #37 stated yes. After STNA #557 asked if Resident #37 had her balance STNA #557 noticed a chair in the way of the path to the bathroom and let go of Resident #37 to move the chair. Resident #37 lost balance and fell to the floor hitting her right hip. Review of a nurse progress note dated 06/27/24 revealed hospital discharge paperwork was reviewed and the x-rays taken at the hospital showed no evidence of fractures from the fall on 06/25/24. The nurse practitioner and therapy supervisor had reviewed the x-rays. Review of facility document Physical Therapy Evaluation and Plan of Treatment dated 06/27/24 revealed Resident #37 had difficulty walking and goal was decreased risk for falls. Resident #37 was referred to physical therapy due to new onset of decreased functional mobility, reduced ability to safely ambulate, reduced balance and increased need for assistance from others. Prior level was assistance with functional mobility with front wheeled walker. Interview on 08/19/24 at 3:17 P.M. with Therapy Supervisor (TS) #574 revealed Resident #37 sustained no injuries from the fall on 06/25/24 and did have pain related to existing arthritis. TS #574 verified Resident #37 was put on therapy case load to decrease her risk for falls. Interview on 08/19/24 at 3:40 P.M. with the Director of Nursing (DON) verified fall risk assessments were to be done quarterly, and the last fall risk assessment was done 05/18/23 prior to Resident #37's fall on 06/25/24. Interview on 08/19/24 at 4:43 P.M. with STNA #557 revealed when Resident #37 fell on [DATE] it was the first time they had worked with Resident #37. STNA #557 stated there was a chair in the path to the bathroom and STNA #557 had to let go of Resident #37 to move the chair. Resident #37 started walking and lost her balance and fell . There were no other witnesses. Interview on 08/19/24 at 4:50 P.M. with LPN #511 and STNA # 539 revealed Resident #37 had always been a one person assist with mobility, but staff always had to have their hands on Resident #37 for safety reasons. Interview on 08/20/24 at 9:35 A.M. with STNA #520 revealed Resident #37 needed one person assistance for walking and needed hands on the resident with a walker. Some days Resident #37 was strong, but some days Resident #37 was unsteady. Review of the facility policy titled Fall Prevention Program updated July 2024 revealed universal fall precautions were put into place due to all resident were considered a fall risk. The policy was to identify upon admission each resident who was at high risk for falls and to attempt to minimize the frequency of falls and risk of injuries from falls through interventions. A fall risk assessment would be completed upon admission, quarterly and as needed. This included reassessment after falls. A care plan would be put into place. This deficiency represents non-compliance investigated under Complaint Number OH00156094.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47570 Based on record review and staff interview, the facility failed to ensure there was a registered nurse (RN) on duty for at least eight consecutive hours, seven days a week as required. This had the potential to affect all 80 residents. The facility census was 80. Findings include: Review of the staff schedule for 08/04/24 revealed there was no RN scheduled in the building for first, second or third shift. Review of the facility Daily Staffing Sheet dated 08/04/24 revealed no ancillary or licensed registered nurse was scheduled 08/04/24 and review of employee time card punch in and out for 08/04/24 revealed nine licensed practical nurses (LPN) punched in and out on 08/04/24, twenty state tested nurse aids (STNA) punched in and out on 08/04/24 and one registered nurse (RN) punched in at 10:54 P.M. on 08/04/24 and punched out at 7:35 A.M. on 08/05/24. Interview on 08/19/24 at 10:50 A.M. with Staffing Coordinator #560 confirmed the schedule did not have any RN listed at least eight hours a day on 08/04/24. Interview on 08/20/24 at 11:02 A.M. with the Director of Nursing (DON) confirmed there was no RN scheduled for eight hours on 08/04/24 and she was not notified on 08/04/24 there was no RN in the facility on 08/04/24. A RN was scheduled to work 08/04/24 but called off resulting in no RN in the facility. Review of the facility policy titled 'Nurse Staffing Information, undated, revealed staff may be required to work different shifts if necessary to maximize staffing, administrative staff would be used in emergency situations and third party agency staff would be utilized in a staffing emergency. This deficiency represents non-compliance investigated under Complaint Number OH00156094.