

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Omni Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3245 Vestal Road Youngstown, OH 44509	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, interview and record review, the facility failed to ensure call lights were within reach. This affected two residents (#45 and #53) of five residents reviewed for call light accessibility and had the potential to affect all residents. The facility census was 121.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #45 revealed an admitted [DATE]. Diagnoses included dementia, depression, chronic obstructive pulmonary disease (COPD) and coronary artery disease.</p> <p>Review of the quarterly minimum data set (MDS) assessment date 06/14/24 revealed the resident was rarely or never understood. She required substantial or maximum assistance for eating and was dependent for oral hygiene of toileting, showering and personal hygiene.</p> <p>Review of the care plan dated 06/14/24 revealed Resident #45 was at risk for falls due to poor safety awareness, history of putting herself on the floor, being combative with care and Alzheimer's. Interventions included therapy referrals as needed, anticipating the residents' needs and ensuring the call light was in reach.</p> <p>Observation on 07/29/24 at 9:31 A.M. revealed Resident #45's call light was wrapped around a plastic guard rail approximately 8 inches from the floor, and not within reach of the resident. Interview at the time of the observation with Housekeeper #146 confirmed Resident #45's call light was not in reach.</p> <p>Review of the medical record for Resident #53 revealed an admitted [DATE]. Diagnoses included Alzheimer's, muscle weakness, anemia, depression and difficulty swallowing.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #53 was severely cognitively impaired. She was required partial to moderate assistance for eating and substantial or maximum assistance for toileting, showering and personal hygiene.</p> <p>Review of the care plan dated 05/09/24 revealed Resident #53 was at a high risk for falls due to weakness and poor safety awareness. Interventions included ensuring the call light was reach, assisting with toileting as needed and having commonly used articles within reach.</p> <p>(continued on next page)</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/29/24 at 9:31 A.M. revealed Resident #53's call light was on the floor next to her bed, and not within reach. Interview at the time of the observation with Housekeeper #146 confirmed Resident #53's call light was not in reach of the resident.</p> <p>Review of the facility policy titled Call Light, Use Of (dated March 2024) revealed call lights would be positioned in a convenient place for the resident.</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565</p> <p>Based on record review, interview, and policy review, the facility failed to refund resident funds within 30 days of discharge. This affected two residents (#373 and #374) of seven residents reviewed for resident funds. The facility census was 121.</p> <p>Findings include:</p> <p>#1. Review of resident records for Resident #373 revealed an admitted [DATE] and a discharge date of [DATE].</p> <p>A review of the Document titled; Choice of Resident Funds Disposition revealed Resident #373 authorized the facility to hold, safeguard and account for personal funds. The document was signed by Resident #373's son on 10/18/19.</p> <p>On 07/31/24 at 12:58 P.M. a review of resident fund balances dated 07/30/24 revealed a balance of \$1485.33 for Resident #373.</p> <p>An interview with Bookkeeper #124 at the time of fund review verified an account balance of \$1485.33 for Resident #373. Bookkeeper #124 also verified the funds were not refunded within 30 days of discharge and the account was still active.</p> <p>#2. Review of resident records for Resident #374 revealed an admitted [DATE] and a discharge date of [DATE].</p> <p>A review of the Document titled; Choice of Resident Funds Disposition revealed Resident #374 authorized the facility to hold, safeguard and account for personal funds. The document was signed by Resident #374's daughter on 05/23/21.</p> <p>On 07/31/24 at 12:58 P.M. a review of resident fund balances dated 07/30/24 revealed a balance of \$1790.93 for Resident #374.</p> <p>An interview with Bookkeeper #124 at the time of fund review verified an account balance of \$1790.93 for Resident #374. Bookkeeper #124 also verified the funds were not refunded within 30 days of discharge and the account was still active.</p> <p>A review of the policy titled; Conveyance of Funds Upon Death (dated January 2024), revealed upon death of a resident with a personal fund deposited with the facility, the facility will convey within 30 days the resident's funds, and a final accounting of those funds.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39968</p> <p>Based on review of Notice of Medicare Non-Coverage letters and staff interview, the facility failed to provide residents forty eight (48) hours' notice of their skilled services were no longer covered. This affected three residents (#97, #107 and #122) of three reviewed for liability notices. The census was 121.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident #97's medical record revealed they were admitted to the facility on [DATE]. A Notice of Medicare Non-Coverage letter revealed services were ended on 03/13/24. The time sensitive, appeal notification letter was signed by Resident #97 but dated by facility staff. Unable to verify accurate date of notification. 2. Review of Resident #107's medical record revealed they were admitted to the facility on [DATE]. A Notice of Medicare Non-Coverage letter revealed services were ended on 07/25/24. The time sensitive, appeal notification letter was signed by Resident #107 on 07/24/24, not allowing 48 hours' notice of non-coverage. 3. Review of Resident #122's medical record revealed they were admitted to the facility on [DATE]. A Notice of Medicare Non-Coverage letter revealed services were ended on 03/28/24. The time sensitive, appeal notification letter was signed by Resident #122 but dated by facility staff. Unable to verify accurate date of notification. <p>Interview on 07/31/24 at 3:53 P.M., Bookkeeper #124 verified the letters to the residents did not provide forty eight hours' notice of non-coverage.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>45441</p> <p>Post nurse staffing information every day.</p> <p>Based on observation and staff interview, the facility failed to ensure posted nursing staff information was updated in a timely manner. This had the potential to affect all residents. The facility census was 121.</p> <p>Findings include:</p> <p>Observation of the posted nursing staff information on 07/29/24 at 7:52 A.M. revealed the posted nursing staff information was dated 07/26/24.</p> <p>Interview on 07/29/24 at 9:34 A.M. with the Director of Nursing (DON) confirmed the posted staffing information had not been updated since 07/26/24.</p> <p>Observation of the posted staffing information on 07/31/24 at 8:20 A.M. revealed the posted staffing information was dated 07/30/24.</p> <p>Interview on 07/31/24 at 9:33 A.M. with the DON confirmed the posted staffing information had not been updated.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 42734</p> <p>Based on record reviews, resident council minute review, interviews and observations the facility failed to follow the menu. This affected 15 of 119 residents (#3, #5, #7, #28, #30, #38, #41, #42, #50, #71, #75, #95, #99, #113 and #118) who received meals from the kitchen. There were two residents (#29 and #37) who received nothing by mouth. The census was 121.</p> <p>Findings include:</p> <p>Review of the dinner menu on 07/30/24 revealed sloppy joes, sweet potato waffle fries and corn were on the menu for dinner. The alternate to the main entree was a hot ham and cheese sandwich and mashed potatoes.</p> <p>Observation on 07/30/24 from 4:10 P.M. to 6:00 P.M. revealed the facility ran out of sloppy joes and sweet potato waffle fries during dinner service for 16 residents. They used the four remaining hot ham and cheese sandwiches and mashed potatoes, the alternate, to replace four of them. They used peanut butter and jelly sandwiches for the remaining 12. At the time of the observation, Food Service Director #168 verified the facility did not calculate the proper amount of food needed. The Registered Dietitian (RD) #222 and Corporate RD (#301) were present and told them to use peanut butter and jelly sandwiches.</p> <ol style="list-style-type: none"> 1. Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnoses included pressure ulcer of sacral region, dementia and chronic obstructive pulmonary disorder. Resident #3 was on a regular, no added salt diet. 2. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic atrial fibrillation and muscle weakness. Resident #5 was on mechanical soft diet. 3. Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, muscle wasting and atrophy and anxiety disorder. Resident #7 was on a regular, no added salt diet. 4. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included type one diabetes mellitus, essential hypertension and epilepsy. Resident #28 was on a regular diet. 5. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, dysphagia and muscle weakness. Resident #30 was on a regular diet. <p>Interview on 07/31/24 at 10:14 A.M. with Resident #30 revealed the did not receive a sloppy joe on 07/30/24. She stated it happened regularly where they do not get what the menu says. She stated They give you what they have. It can be cold too.</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 - Some</p>	<p>6. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included neurocognitive disorder, schizoaffective disorder and contracture of right hand. Resident #38 was on a mechanical soft with pureed meats. The resident did not receive the sweet potato waffle fries.</p> <p>7. Review of the medical record for Resident #41 revealed an admitted [DATE]. Diagnoses included rhabdomyolysis, type two diabetes mellitus and hyperlipidemia. Resident #41 was on a regular diet.</p> <p>8. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included encephalopathy, mild cognitive impairment and type two diabetes mellitus. Resident #42 was on a regular, no added salt diet.</p> <p>9. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included hypertension, congestive heart failure and major depressive disorder. Resident #50 was on a regular diet. He did not receive the sweet potato waffle fries.</p> <p>10. Review of the medical record for Resident #71 revealed an admitted [DATE]. Diagnoses included atherosclerosis of native artery, other pulmonary embolism and paranoid schizophrenia. Resident #71 was on a regular, no added salt, no concentrated sweets diet.</p> <p>Interview on 07/31/24 at 9:50 A.M. with Resident #71 revealed he received rice and mixed vegetables. He stated they do not always get what was on the menu.</p> <p>11. Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included major depressive disorder, essential tremor and anxiety disorder. Resident #75 was on a regular diet.</p> <p>12. Review of the medical record for Resident #95 revealed an admitted [DATE]. Diagnoses included anemia, gastro-esophageal reflux disease and chronic kidney disease. Resident #95 was on a regular diet with mechanical soft texture.</p> <p>13. Review of the medical record for Resident #99 revealed an admitted [DATE]. Diagnoses included Alzheimer's Disease, muscle wasting and atrophy and dysphagia. Resident #99 was on a regular diet.</p> <p>14. Review of the medical record for Resident #113 revealed an admitted [DATE]. Diagnoses included hypertensive chronic kidney disease, irritable bowel syndrome and mild cognitive impairment. Resident #113 was on a mechanical soft diet.</p> <p>15. Review of the medical record for Resident #118 revealed an admitted [DATE]. Diagnoses included cellulitis, hyperlipidemia and adult failure to thrive. Resident #118 was on a regular diet.</p> <p>Interview on 07/31/24 at 12:20 P.M. with CRD #301 revealed the manager orders and calculates food needs.</p> <p>Review of the Resident Council notes from August 2023 through July 2024 revealed comments about food not matching what the menus states.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>42734</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on record reviews, interviews and observations the facility failed to provide food that was served at a palatable temperature. This had the potential to affect 119 residents as two residents (#29 and #37) received nothing by mouth. The census was 121.</p> <p>Findings include:</p> <p>Interviews on 07/29/24 during the screening process of the annual survey with Resident #45, Resident #48, Resident #55, Resident #71, Resident #74 and Resident # 422 revealed concerns with temperature of the food stating it was often cold.</p> <p>Observation of trayline on 07/30/24 from 4:10 P.M. through 6:00 P.M. revealed staff were not utilizing bases for hot pellets until questioned by surveyor. Interview at 4:12 P.M. with Food Service Manager #168 revealed they did not use those. The staff did use them for tray line at the time however they ran out of bases for the following: North Unit-11 residents, East Unit-12 residents and South Unit-16 residents. The same cart for South Unit also ran out of hot pellets for 16 residents.</p> <p>Observation of the test tray on 07/31/24 revealed it was delivered to the South unit at 12:15 P.M. Registered Dietitian (RD) # 222 and Corporate RD (CRD) #301 were present to test the temperatures. Observation of RD #222 taking the temperatures revealed the sauerkraut was 127 degrees Fahrenheit and the milk was 55 degrees Fahrenheit. Both RD #222 and CRD #301 verified the temperatures.</p> <p>Review of the Resident Council notes from August 2023 through July 2024 revealed comments about food being cold, inconsistent, lacking quality and not matching what the menus states.</p> <p>Review of the facility policy titled Preparing Cold Foods, (dated 03/14/23) revealed safe service cold food must be 41 degrees Fahrenheit or below.</p> <p>Review of the facility policy titled Preparing Hot Foods, (dated 03/14/23) revealed safe service cold food, vegetables must be at least 140 degrees Fahrenheit.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155823.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48565</p> <p>Based on observation, interview and policy review the facility failed to ensure the kitchen area was maintained in a clean and sanitary manner and that all food was labeled, dated and stored properly. This had the potential to affect 119 residents receiving food from the kitchen. There were two residents identified as receiving nothing by mouth (#29 and #37). The facility census was 121.</p> <p>Findings include:</p> <p>During the initial kitchen tour conducted on 07/29/24 at 9:15 A.M. the following was observed and verified with Dietary Supervisor #168.</p> <ol style="list-style-type: none"> 1. Drawer one of the right three drawer utensil cabinet for clean utensils storage had visible dirt and grease in it. 2. Drawer three of the left three drawer cabinet contained an open container of chicken stock. The chicken stock was unlabeled as to when it was opened. There was also an open, one pound bag of country gravy mix. The bag of gravy mix was one quarter full and unlabeled as to when it was opened. 3. In the dry storage area there was a one- and one-half pound bag of crispy onions. The bag was one quarter full, opened and undated. 4. In the standup refrigerator located by the door there was a one liter opened bottle of water identified as belonging to a staff member. 5. Ceiling fan noted with heavy buildup of black debris. DS #168 stated the fan worked and they used it. DS #168 turned the fan on, and debris came flying off the fan as the blades were spinning. <p>A review of the policy titled; Storage: Food, Equipment and Utensils (dated February 2019) revealed food, equipment and utensils must be stored in a clean and dry location. The policy also stated all food will be labeled and dated.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>48565</p> <p>Based on observation and staff interview, the facility failed to ensure its refuse area was maintained in a clean and sanitary condition. This had the potential to affect all residents. The facility census was 121.</p> <p>Findings include:</p> <p>Observation of the outside kitchen area with Dietary Supervisor (DS) #168 on 07/29/24 at 9:15 A.M. revealed numerous items of debris including Styrofoam cups, plastic wear and other numerous refuse items around the door where garbage was taken out of the kitchen. A grey cart with wheels had bagged garbage in it that was uncovered. There were grey lids for the cart located in the area. The large dumpster for garbage was overflowing with bagged garbage. The lid for the large dumpster was unable to be closed. DS #168 verified the aforementioned findings at the time of the observation.</p> <p>Interview on 07/29/24 with DS #168 during the observation, revealed the garbage in the small grey bin was not taken to the large dumpster because it was overflowing and there was no room for current garbage to be placed. DS #168 stated the large dumpster was often full.</p> <p>Interview on 07/29/24 at 11:00 A.M. with Regional Administrator (RA) #300 revealed the large garbage dumpster is emptied five times weekly. RA #300 stated the large dumpster is not emptied on the weekends and is picked up mid-morning on Mondays. RA #300 verified there were lids for the gray garbage carts that should be used to keep the carts covered in the event the large dumpster is full.</p>