

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Batavia Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 Golden Age Drive Batavia, OH 45103	
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. 51642 Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure dignity was maintained for one (#73) of four residents observed during care. The census was 96. Findings included: Review of an admission record indicated the facility admitted Resident #73 on 01/25/23. The resident had a medical history that included diagnoses of traumatic brain injury, chronic respiratory failure with hypoxia, and a tracheostomy. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 08/02/24, revealed Resident #73 had severe impairment in cognitive skills for daily decision-making per a staff assessment of mental status (SAMS). The MDS assessment indicated the resident was dependent on staff with all activities of daily living (ADLs) and required tracheostomy care. Review of Resident #73's care plan, included a focus area initiated 05/28/21, that indicated the resident had altered health maintenance related to a progressive physical and mental status due to a motor vehicle accident resulting in a traumatic brain injury. Interventions directed staff to provide tracheostomy care as ordered. During an observation of tracheostomy care in Resident #73's room on 09/24/24 at 8:40 A.M., Respiratory Therapist (RT) #9 removed Resident #73's inner cannula, placed another inner cannula inside the tracheostomy tube's outer cannula, suctioned a small amount of phlegm, cleansed around the tracheostomy site with a mixture of peroxide and sterile normal saline, and placed split sponges under the flange of the outer cannula. The door to Resident #73's room remained open during the tracheostomy care. During an interview on 09/24/24 at 2:37 P.M., RT #9 stated the staff member forgot to close the door while providing tracheostomy care that morning for Resident #73. RT #9 stated the door should have been closed while providing tracheostomy care for Resident #73. The Director of Nursing (DON) was interviewed on 09/24/24 at 3:03 P.M. and stated Resident #73's door should have been closed during personal care which included tracheostomy care. (continued on next page)		

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 09/25/24 at 11:11 A.M. and stated Resident #73's door should have been closed during tracheostomy care for dignity. Review of an undated facility policy titled, Resident's [NAME] of Rights, indicated the resident has a right to a dignified existence. Nursing home residents have the right to be free from physical, verbal, mental, and emotional abuse, to be treated with the courtesy and respect in full recognition of dignity and individuality, and privacy during medical examinations and personal care. This deficiency represents non-compliance investigated under Complaint Number OH00157584.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46659 Based on observation, medical record review, staff interview, review of a job description, and facility policy review, the facility failed to maintain infection control practices when handling dirty linens for one (Hall K) of seven halls observed and failed to use proper hand hygiene during incontinence care. This had the potential to affected 16 (#2, #5, #6, #8, #10, #17, #25, #29, #42, #44, #47, #57, #65, #68, #70, and #85) residents who resided on Hall K and one (#83) of two residents observed during incontinence care. The census was 96. Findings included: 1. On 09/23/24 at 10:15 A.M., an observation on Hall K revealed an open resident's door with dirty linens on the floor. State tested Nurse Aide (STNA) #1 was observed throwing linens on the floor and then was observed picking up the linens without wearing gloves and placing them into a bag. During an interview on 09/23/24 at 10:20 A.M., STNA #1 stated she should not have thrown anything on the floor and should have worn gloves when she put the dirty linens in the bag. STNA #1 stated she had infection control education during orientation. On 09/23/24 at 11:13 A.M., STNA #1 was observed carrying unbagged dirty linens down the hallway to the dirty linen room and the dirty linens were observed to be touching the STNA #1's clothing. During an interview on 09/23/24 at 11:16 A.M., STNA #1 stated she should have bagged the dirty linens prior to leaving the resident's room and should not have allowed the linens to touch her clothing. During an interview on 09/25/24 at 10:40 A.M., Registered Nurse Clinical Manager (RN CM) #2 stated linens should go into a bag and should never be placed on the floor. RN CM #2 stated staff should wear gloves when placing dirty linens into a bag, linens should never be carried down the hall unbagged, and should not touch their clothes. RN CM #2 stated it was an infection control issue. During an interview on 09/25/24 at 11:10 A.M., Licensed Practical Nurse Clinical Manager (LPN CM) #3 stated dirty linens should go into a bag and should never be thrown on the floor. LPN CM #3 stated staff should always wear gloves when picking up dirty linens, should bag the linens, and place them into the barrel in the utility room. LPN CM #3 stated dirty linens should never touch the staff's clothing and should always be bagged. She stated she expected staff to bag linens wearing gloves, tie the bag, and not allow the bag to touch their clothing. LPN CM #3 stated she expected dirty linens to never be placed on the floor and stated it was an infection control issue. During an interview on 09/25/24 at 11:47 A.M., the Director of Nursing (DON) stated she expected staff to place dirty linens in a bag. The DON stated that dirty linens should never be on the floor and should never be picked up without gloves or be allowed to touch staff's clothing. She stated infection control was mentioned every month during in-services. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/25/24 at 9:21 A.M., the Administrator stated they did not have a policy about the proper disposal of linens, but she expected staff to put dirty linens in bags and put them into the dirty linen closet. During a follow-up interview on 09/25/24 at 12:19 P.M., the Administrator stated staff should wear gloves and should place the dirty linens in a bag and the bag or linens should not touch the staff's clothing. Review of a facility policy titled, Infection Prevention and Control Program (IPCP), revised 11/28/17, revealed laundry services staff handle, store, and transport linens appropriately including but not limited to; using standard precautions (i.e. [id est, that is], gloves) and minimal agitation for contaminated linen and holding contaminated linen and laundry bags away from his/her clothing/body during transport. Review of an undated nursing assistant and STNA job description document revealed responsibilities and major duties included to adhere to all infection control policies within the assigned facility. 51642 2. Review of an admission record indicated the facility admitted Resident #83 on 10/28/22. According to the admission record, the resident had a medical history that included diagnoses of need for assistance with personal care, tracheostomy status, morbid obesity, and diabetes. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/11/24, revealed Resident #83 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS assessment indicated the resident was always incontinent of urine and required substantial/maximal assistance from staff with toileting hygiene. Review of Resident #83's care plan, included a focus area initiated on 10/12/22, that indicated the resident was at risk for infection related to chronic disease and urinary tract infection (UTI). An intervention was directed for staff to monitor for signs/symptoms of UTI, including foul smelling urine, cloudy urine, sediment, and decreased urine output. The care plan also included a focus area initiated on 10/20/22, that indicated the resident required assistance with activities of daily living. An intervention was directed for staff to provide toileting assistance as needed. During an observation of incontinence care in Resident #83's room on 09/24/24 at 11:12 A.M., STNA #10 donned gloves, a gown, and mask for enhanced barrier precautions (EBP). STNA #10 removed Resident #83's incontinence brief that was soiled with pale-yellow urine. STNA #10 cleansed Resident #83's genitals, groin, buttock, and anal areas with disposable wipes. Without removing her contaminated gloves and without sanitizing or washing her hands, STNA #10 then placed a clean incontinence brief under Resident #83 and placed her gloved hands on the resident's back and assisted the resident with rolling onto their back from their side. STNA #10 then attached both sides of the incontinence brief, removed her gloves, and sanitized her hands. STNA #10 then donned clean gloves and scanned the resident's urine alarm device. STNA #10 then removed her gown, gloves, and mask and placed them in a bag. STNA #10 was interviewed on 09/24/24 at 11:30 A.M. STNA #10 stated she had failed to remove her gloves and sanitize or wash her hands after cleansing the resident's genitals, groin, buttock, and anal areas prior to placing the clean incontinence brief under Resident #83. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed on 09/24/24 at 1:54 P.M. T he DON stated staff were to always change gloves going from dirty to clean tasks such as after cleansing the genitals, buttock, and anal areas and prior to putting a clean brief on the resident. The DON stated it was especially true for Resident #83, who was on EBP. The Administrator was interviewed on 09/25/24 at 11:11 A.M. The Administrator stated staff should remove gloves and wash or sanitize hands prior to placing a clean brief on because going from dirty to clean tasks required washing or sanitizing hands after glove removal and prior to placing a clean brief on a resident. Review of a facility policy titled, Hand Hygiene, revised 11/28/17, indicated staff will perform hand hygiene when indicated, using proper technique. Staff perform hand hygiene (even if gloves are used) in the following situations including; before and after contact with the resident, and after contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the resident's environment.		