

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Liberty Nursing Center of Mansfield		STREET ADDRESS, CITY, STATE, ZIP CODE 535 Lexington Avenue Mansfield, OH 44907	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, review of the facility shower log, and facility policy review, the facility failed to honor a resident's preference for showers. This affected one resident (#19) of three residents reviewed for activities of daily living. The facility census was 58.</p> <p>Findings include:</p> <p>Review of Resident #19's medical record revealed an admission date of 03/07/23. Diagnoses include schizoaffective disorder, hemiplegia, asthma, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, dementia, generalized anxiety disorder, bilateral myopia, and altered mental status.</p> <p>Review of Resident #19's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had intact cognition. Resident #19 required supervision for showering.</p> <p>Review of the facility's shower schedule for the memory care unit last updated on 03/25/25 revealed Resident #19 was scheduled for showers on second shift (3:00 P.M. to 11:00 P.M.) on Tuesdays and Fridays. There was a handwritten note at the bottom of the shower sheet that stated Please DO NOT change days for residents on this schedule referencing the shower schedule matched what was listed in each resident's electronic medical record. The form additionally stated it has to stay that way for state.</p> <p>Review of the document titled Care Conference Summary dated 04/16/25 revealed the Social Services Designee (SSD) #765 noted on the document Resident #19 wanted showered four times a week.</p> <p>Review of Resident #19's shower documentation for April 2025 revealed Resident #19 was recorded to have received a shower twice weekly on Tuesdays and Fridays on second shift.</p> <p>Review of Resident #19's shower documentation for May 2025 revealed Resident #19 had received a shower on 05/02/25 and 05/06/25. Resident #19 was scheduled to receive showers the remainder of the month on Tuesdays and Fridays on second shifts, with the dates on the shower sheets pre-dated for 05/09/25, 05/13/25, 05/16/25, 05/20/25, 05/23/25, and 05/27/25.</p> <p>Interview on 05/05/25 at 9:50 A.M. and 05/06/25 at 3:22 P.M. with Resident #19 revealed the resident received showers twice a week and wanted to receive a shower at least three times a week. Resident #19 stated she had reported to SSD #765 that she would like showers at least three times per week.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/25 at 3:25 P.M. with SSD #765 verified Resident #19 had asked for four showers a week at a quarterly care conference on 04/16/25.</p> <p>Interview with Registered Nurse (RN) #701 on 05/06/25 at 3:50 P.M. verified Resident #19 had only received and was only scheduled for and had only received showers twice weekly.</p> <p>Review of the facility policy titled Resident Bathing dated 08/15 revealed Residents have the opportunity to express their preference for bathing type, frequency and time of day.</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5. Review of the medical record for Resident #45 revealed an admission date of 12/21/22 with a diagnoses of Parkinson's disease, peripheral vascular disease, and dementia.</p> <p>Review of the MDS quarterly assessment dated [DATE] revealed Resident #45 was severely cognitively impaired.</p> <p>Review of Resident #45's physician orders dated 06/01/23 revealed an order for Citalopram 20 mg daily for depression and an order dated 02/11/25 for trazodone HCL (an antidepressant) 150 mg, one half tablet by mouth at bedtime related to adjustment disorder with mixed anxiety and depressed mood.</p> <p>Review of Resident #45's care plan revised 05/05/25 revealed the resident used psychotropic medications related to behavior management. Interventions included monitoring side effects and effectiveness every shift. Further review of the care plan revealed the resident used antidepressant medication related to depression. Interventions included to monitor and document side effects and effectiveness every shift.</p> <p>Review of Resident #45's nurse's notes dated 06/01/23 through 05/07/25 revealed no documentation of monitoring of adverse effects or effectiveness of the medication Citalopram or trazodone.</p> <p>Review of Resident #45's MAR dated 04/01/25 through 05/06/25 revealed no documentation the resident received monitoring for effectiveness and adverse effects for the use of the medication Citalopram.</p> <p>Interview on 05/07/25 at 8:30 A.M., the Director of Nursing (DON) verified there was no monitoring in place for adverse effects for Residents #3, #8, #11, #26, and #45 who received antidepressant medications. The DON revealed nursing staff should be monitoring residents receiving antidepressant medications for medication effectiveness and adverse consequences. Further interview with the DON revealed the facility had no policy regarding the use of psychotropic medications. The DON revealed the facility followed the policy for antipsychotic medication for the use of psychotropic medications.</p> <p>Telephone interview on 05/08/25 at 10:45 A.M. with Medical Director (MD) #900 revealed he expected nursing staff should be monitoring residents on antidepressants for medication effectiveness and adverse effects.</p> <p>Review of the facility policy Antipsychotic Medication Use, revised 12/2016, revealed nursing staff would observe, document, and report to the attending physician, information regarding the effectiveness of any interventions, including antipsychotic medications and monitor and report side effects and adverse consequences of antipsychotic medications to the attending physician.</p> <p>4. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included major depressive disorder, recurrent, severe with psychotic symptoms, schizoaffective disorder, cognitive communication deficit, and dysphagia.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #3's active physician orders for May 2025 identified an order dated 10/01/24 for Effexor (an antidepressant) extended release oral capsule, give one capsule one time per day related to major depressive disorder, recurrent, severe with psychotic symptoms.</p> <p>Review of the MAR for 04/01/25 through 05/06/25 revealed Resident #3 received Effexor daily from 04/01/25 through 04/03/25, 04/14/25 through 04/30/25, and 05/01/25 through 05/06/25.</p> <p>Review of nurse's notes dated 03/01/25 through 05/07/25 revealed no evidence Resident #3 was monitored for efficacy and adverse consequences related to antidepressant medication.</p> <p>3. Review of Resident #11's medical record revealed an admission date of 08/26/24. Diagnoses included depression and anxiety.</p> <p>Review of Resident #11's MDS assessment dated [DATE] revealed Resident #11 had intact cognition.</p> <p>Review of the care plan dated 03/10/25 revealed Resident #11 received antidepressant medications. Interventions included to monitor for side effects and effectiveness of antidepressant medication every shift.</p> <p>Review of physician orders for May 2025 revealed Resident #11 was ordered Sertraline (an antidepressant) 100 mg one time a day for depression and Bupropion (an antidepressant) 150 mg one time a day for depression.</p> <p>Review of Resident #11's nurse's notes dated 03/01/25 through 05/07/25 revealed no documentation related to monitoring for side effects or effectiveness for antidepressant medications.</p> <p>Review of Resident #11's MAR dated 04/01/25 through 05/06/25 revealed no documentation the resident was monitored for effectiveness and adverse consequences and effectiveness of the antidepressant medications Sertraline or Bupropion.</p> <p>Based on review of the medical record, staff interview, and policy review, the facility failed to ensure residents on psychotropic medications were monitored for effectiveness and adverse consequences. This affected five residents (#26, #11, #8, #3, #45) of five residents reviewed for unnecessary medications. The facility identified 40 residents receiving psychotropic medications. The facility census was 58.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #26 revealed an admission date of 04/02/24. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, cerebral infarction, dementia, and depressive disorder.</p> <p>Review of Resident #26's Minimum Data Set (MDS) annual assessment dated [DATE] revealed the resident had impaired cognition.</p> <p>Review of Resident #26's physician orders dated 10/10/24 revealed an order for Citalopram (an antidepressant) 20 milligrams (mg) daily for depression related to major depressive disorder.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #26's care plan revised 05/02/25 revealed the resident used psychotropic medications related to behavior management. Interventions included monitoring for side effects and effectiveness every shift. Further review of the care plan revealed the resident used antidepressant medication related to depression. Interventions included to monitor and document side effects and effectiveness every shift.</p> <p>Review of Resident #26's nurse's notes dated 02/01/25 through 05/07/25 revealed no documentation of monitoring of adverse effects or effectiveness of the medication Citalopram.</p> <p>Review of Resident #26's Medication Administration Record (MAR) dated 04/01/25 through 05/06/25 revealed no documentation the resident received monitoring for effectiveness and adverse effects for the use of the medication Citalopram.</p> <p>2. Review of the medical record for Resident #8 revealed an admission date of 05/04/18. Diagnoses included type two diabetes mellitus, schizoaffective disorder, dementia, anxiety, depression, and hypertension.</p> <p>Review of Resident #8's MDS quarterly assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of Resident #8's physician order dated 11/27/22 revealed an order for duloxetine (an antidepressant) 60 mg twice daily for depression related to major depressive disorder.</p> <p>Review of Resident #8's care plan revised 09/30/24 revealed the resident used antidepressant medication related to severe depression. Interventions included to monitor and document side effects and effectiveness every shift.</p> <p>Review of Resident #8's nurses' notes from 03/01/25 through 05/06/25 revealed no documentation the resident was monitored for effectiveness and adverse consequences related to the use of antidepressant medications.</p> <p>Review of Resident #8's MAR dated 04/01/25 through 05/06/25 revealed no documentation the resident was monitored for effectiveness and adverse consequences and effectiveness of the antidepressant medication duloxetine.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facilities Self Reported Incident (SRI) the facility failed to report an allegation of sexual abuse to local law enforcement. This affected one resident (#4) of three residents reviewed for abuse and had the potential to affect all residents residing in the facility. The facility census was 58.</p> <p>Findings include:</p> <p>Review of Resident #4's medical records revealed an admission date of 05/19/29. Diagnoses included Hodgkin's lymphoma and malnutrition.</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had intact cognition. Resident #4 required moderate assistance with toileting and personal hygiene and was recorded to be incontinent of bowel and bladder.</p> <p>Review of the care plan dated 04/17/25 revealed Resident #4 had self care deficits. Interventions included assist with activities of daily living by staff. Resident #4 was incontinent of bowel and bladder. Interventions included to check for incontinence frequently and assist as needed.</p> <p>Review of SRI #258540 dated 03/23/25 revealed Resident #4 had reported an allegation of sexual abuse to Licensed Practical Nurse (LPN) #717 on 03/23/25 at approximately 3:00 P.M. SRI stated Resident #4 had reported Certified Nursing Assistant (CNA) #902 had groped her breast and put his finger in her vaginal area. LPN #717 had reported the allegation to the Administrator, who had then informed the Director of Nursing (DON). Resident #4's family and physician had been notified and Resident #4 had declined to be sent to the hospital. The SRI included Resident #4 had been upset over the incident and had requested no male caregivers to provide her with care. The SRI investigation included Resident #4 had alleged during the evening shift of 03/22/25 (time not specified) CNA #902 had touched her inappropriately after cleaning her up from a bowel movement. Resident #4 had described CNA #902 touched her breast and had touched her lap area and had indicated CNA #902 had put his fingers inside of her. LPN #717 had performed a head to toe assessment of Resident #4 with no concerns noted. Resident #4 stated she was scared to have CNA #902 return and had not immediately reported the incident due to she wanted to ensure CNA #902 was no longer present in the facility. The SRI stated CNA #902 was suspended and was asked to come into the facility to provide a statement. Resident #4, her family, and the physician had declined to send Resident #4 to the hospital or to report the allegation to local law enforcement. The SRI results included CNA #902 was terminated on 03/26/25 and the facility had determined the evidence was inconclusive.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation beginning on 03/23/25 revealed Resident #4 and her family had declined to notify local law enforcement and no other agencies were notified. The Administrator interviewed CNA #902 (date and time not included in the investigation) and a written statement was obtained. CNA #902's handwritten statement he provided indicated he denied Resident #4's allegations. However, during a face-to-face interview, CNA #902 had not come out and denied the accusations and CNA #902 had expressed understanding of the situation. The investigation included all other residents had been interviewed by staff and no further allegations had been brought forward, however some residents expressed a dislike for CNA #902. No specific information or residents were mentioned that had claimed a dislike for CNA #902.</p> <p>Review of a staff statement authored by LPN #717 dated 03/21/25 (two days before the alleged incident occurred) revealed Resident #4 had reported the 3rd shift aide had put his finger in her and had massaged her breast. LPN #717 had contacted the Administrator and was instructed to ask Resident #4 if she would like to go to the hospital, which Resident #4 had declined. LPN #717 had performed a head-to-toe assessment and stated during the assessment Resident #4 had reported the aide had wiped her for a long time.</p> <p>Review of a staff statement authored by CNA #731 dated 03/23/25 revealed she had accompanied the nurse into Resident #4's room and had assisted with undressing Resident #4 and performing incontinence care. CNA #731 stated she had overheard the nurse speaking with Resident #4 who had stated CNA #902 had put his fingers in her and had massaged her right breast.</p> <p>Review of an undated staff statement authored by CNA #902 revealed he had cared for Resident #4 on 03/23/25 and he had changed Resident #4 twice. CNA #902's statement included no inappropriate actions were made and he was sorry Resident #4 had felt that way.</p> <p>Review of a progress note dated 03/25/25 timed 1:31 P.M. authored by Social Service Designee (SSD) #765 revealed she was following up with Resident #4 from the sexual abuse incident, with Resident #4 stating she had no concerns related to the incident.</p> <p>No other progress notes were documented regarding the alleged sexual abuse incident or any follow up actions offered or taken after the alleged incident.</p> <p>Observation and interview on 05/05/25 at 10:12 A.M. with Resident #4 revealed when asked if anyone had ever hurt her, Resident #4 had immediately placed her hands over her face and put her head down. Resident #4 had become tearful and Resident #4 stated they fired him. No further questions were asked to Resident #4.</p> <p>Interview on 05/06/25 at 9:30 A.M. with SSD #765 revealed she had spoken with Resident #4 on 03/25/25 and stated Resident #4 had reported CNA #902 had touched her down there and on her breast. SSD #765 stated Resident #4 had told her she did not want the police called because she was embarrassed and didn't want anyone to know what had happened. SSD #765 stated the Assistant Director of Nursing (ADON) had informed Resident #4 that CNA #902 would not return to work at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/25 at 1:35 P.M. with Director of Nursing (DON) revealed he had been notified of the incident regarding Resident #4 on 03/24/25 and stated the Administrator had already began the investigation. The DON stated Resident #4 had not wanted to call the police and stated Resident #4's daughter was contacted and stated it was Resident #4's decision. The DON stated CNA #902 was asked to come to the facility for an interview and stated during the interview with CNA #902 and the Administrator, CNA #902 had not verbally denied the allegations and only stated he understood the process. The DON stated CNA #902 was suspended during the investigation and stated he was later terminated. However, the DON stated he was unsure of the reason for the termination.</p> <p>Telephone interview on 05/08/25 at 10:18 A.M. with Resident #4's son revealed he had been notified of the incident by another family member. Resident #4's son stated he had been upset as the facility had not contacted the police and stated the facility had only done the bare minimum. Resident #4's son stated she did not want to be taken to the hospital or have the police involved due to being embarrassed and having others see the police in her room. Resident #4's son stated he believed the facility could have made other arrangements for Resident #4 to have spoken with the police. Resident #4's son stated he had concerns due to the lack of police involvement and CNA #902 could be working at another facility and possibly doing this to someone else.</p> <p>Interview on 05/08/25 at 10:40 A.M. with Administrator revealed she had been notified of the incident on 03/23/25 at approximately 3:00 P.M. by LPN #717 via telephone. The Administrator stated she had been told CNA #902 had touched Resident #4's breast and vagina. The Administrator stated she had spoken with Resident #4 on 03/25/25, who appeared to be upset about the incident, and stated Resident #4 had expressed concerns CNA #902 could do the same thing to someone else. The Administrator stated no other residents had made any allegations of abuse against CNA #902. While conducting interviews with other residents, some residents had stated CNA #902 had given off a weird vibe. The Administrator was asked to provide more details about which residents had stated that and she was unable to recall, but stated she thought it may have been Resident #114. The Administrator stated she had contacted CNA #902 on 03/23/25 via telephone and left him a voicemail that stated he was suspended pending the outcome of an investigation. The Administrator stated CNA #902 had returned her call on 03/24/25, and she had made him aware of the accusation. The Administrator stated CNA #902 had only verbalized understanding of the process. The Administrator stated CNA #902 came to the facility on [DATE] and had provided a written statement denying Resident #4's accusation, however, he had not verbally denied the accusations when directly asked. The Administrator stated CNA #902 had been terminated on 03/26/24 as the facility did not feel comfortable keeping CNA #902 employed because of the accusations made. The Administrator stated Resident #4 had declined to have the police involved or be sent to a local hospital for an examination, and Resident #4's daughter had also declined. The Administrator stated they had not offered for Resident #4 to speak with the police in a location different than her room so that others may not see the police interviewing her.</p> <p>Telephone interview on 05/08/25 at 12:59 P.M. with the local Ombudsman revealed Resident #4's son had contacted her as he was upset the facility had not contacted the police and/or the nurse aide registry and stated she felt the facility could have done more. The Ombudsman stated she had spoken with Resident #4 following the incident (couldn't recall exact date) and stated Resident #4 had told her CNA #902 had bounced her right breast like it was a basketball. The Ombudsman stated Resident #4 had also stated Resident #4 reported CNA #902 had taken a long time to clean her up and the resident had stated to her if felt like it was never going to end. The Ombudsman stated Resident #4 had told her she was scared and attempted to pull away, but could not. The Ombudsman stated Resident #4 had said she was was afraid to say anything until after CNA #902 had left the facility.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/08/25 at 2:29 P.M. with CNA #728 revealed she had felt CNA #902 was creepy but had not witnessed any wrongdoing, and stated it was just a feeling.</p> <p>Interview on 05/08/25 at 3:01 P.M. with Resident #114 revealed CNA #902 had cared for her and stated during incontinence care one evening (unable to recall exact date) he had turned his hand to the side and had rubbed her backside with the side of his hand. Resident #114 stated she had immediately become uncomfortable and stated after that incident she had requested CNA #902 not care for her. Resident #114 stated she had not informed anyone as to why she did not want CNA #902 caring for her. Resident #114 stated CNA #902 had crept her out.</p> <p>Review of facility policy titled Abuse, Mistreatment, Neglect, Injuries of Unknown Source, and Misappropriation of Resident Property dated 11/17 revealed sexual abuse included sexual harrassment, sexual coercion, sexual assault, and non-consensual sexual contact of any type with a resident. Documentation in the nurse's notes should include the results of the resident's range of motion (ROM), body assessment, vital signs, the notification to the physician and the responsible party, and treatment provided. If an allegation is suspicious of crime having been committed, in addition to reporting to the Ohio Department of Health (ODH), the facility will also report the suspicion to local police immediately, and will also inform the resident's responsible party/family and physician.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure the Pre-admission Screening and Resident Review evaluation (PASARR) was complete after receiving a new psychiatric diagnosis. This affected one (Resident #45) of two residents reviewed for PASARR. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #45 revealed and admission date of 12/21/22 with a diagnosis of Parkinson's Disease, peripheral vascular disease, and dementia.</p> <p>Further review of Resident #45 medical diagnosis revealed a diagnosis of psychotic disorder with hallucinations due to known psychological condition dated 07/20/23.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #45 was severely cognitively impaired.</p> <p>Review of Resident #45's Preadmission Screening and Resident Review evaluation (PASARR) revealed a PASARR was completed on 10/26/22.</p> <p>Further review of Resident #45's medical record revealed there was no PASARR evaluation completed after the resident had received a new diagnosis of psychotic disorder with hallucinations due to known psychological conditions on 07/20/23.</p> <p>Interview with Social Service Designee (SSD) #764 confirmed there was no level two PASARR evaluation and determination after a new diagnosis of psychotic disorder with hallucinations due to known psychological condition on 07/20/23.</p> <p>Review of the undated facility PASARR Notifications, revealed the facility would notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability, for resident review.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative interview, staff interview, medical record review, hospital record review, and review of facility policy, the facility failed to ensure the facility bowel protocol was implemented timely for residents who have not had bowel movements and failed to ensure residents received timely intervention for constipation. This resulted in Actual Harm when Resident #45 had no recorded bowel movement for five days, experienced abdominal pain, and had episodes of emesis with a fecal odor. Resident #45 was transferred to a local hospital and admitted for treatment for dehydration and constipation. Additionally, the facility failed to timely implement their bowel protocol, placing Resident #18 at risk for the potential for more than minimal harm that was not Actual Harm. This affected two (#45 and #18) of three residents reviewed for bowel and bladder. The facility census was 58.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #45 revealed an admission date of 12/21/22 with diagnoses of Parkinson's Disease, peripheral vascular disease, and dementia.</p> <p>Review of Resident #45's care plan dated 12/30/22 revealed the resident had the potential for bowel incontinence related to impaired mobility, cognitive loss, and functional diarrhea. Listed interventions included checking the resident frequently, assist with toileting as needed, and to provide peri care after each incontinent episode. An additional care plan focus dated 12/30/22 and revised on 07/27/23 revealed Resident #45 had Parkinson's Disease. A listed goal included the resident would remain free from further signs, symptoms, discomfort, or complications related to Parkinson's Disease. Listed interventions included to give medications as ordered by the physician, monitor for constipation, and to implement the bowel regimen if no bowel movement in three days.</p> <p>Review of Resident #45's physicians orders dated 12/21/24 revealed an order for bowel protocol as follows: if no bowel movement in three days, give 30 milliliters (ml) Milk of Magnesia (a saline laxative which draws water into the intestines and softens the stool, making it easier to pass). If no result, give Bisacodyl [rectal] suppository (a stimulant laxative which stimulates the intestinal muscles to encourage stool movement) on the fourth day. If there is no result on the next shift after suppository, administer Fleet enema (a liquid medication administered rectally which works by increasing the water content in the large intestine, softening the stool and helping to stimulate bowel movement). Notify the doctor if there were no results and/or severe abdominal pain, rectal bleeding, or vomiting noted during this regimen.</p> <p>Continued review of Resident #45's physicians orders revealed corresponding medication orders dated 12/21/24 for Milk of Magnesia 400 milligrams (mg) per 5 ml, give 30 ml by mouth every 24 hours as needed for constipation, Bisacodyl suppository 10 mg suppository administered rectally every 24 hours as needed for constipation, and Fleet enema 7-19 grams (gm) per 118 ml, insert one application rectally every 24 hours as needed for constipation.</p> <p>Review of Resident #45's quarterly continence evaluation dated 01/01/25 revealed Resident #45 had bowel movements daily, was incontinent of both bowel and bladder, and occasionally needed laxatives, suppositories, or enemas for bowel regulation.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the January 2025 bowel elimination records for Resident #45, completed by the Certified Nursing Assistants (CNA), revealed Resident #45 had a medium-sized bowel movement with loose/diarrhea consistency on 01/31/25.</p> <p>Review of bowel elimination record for Resident #45 between 02/01/25 and 02/05/25, completed by the CNAs, revealed there was no documentation or evidence Resident #45 had a bowel movement between 02/01/25 through 02/04/25. Resident #45 had a small-sized bowel movement with formed/normal consistency recorded on 02/05/25.</p> <p>Review of the Medication Administration Record (MAR) for 02/01/25 through 02/05/25 revealed no doses of Milk of Magnesia, Bisacodyl suppository, or Fleet enema were administered during this time frame. Furthermore, there was no documentation the bowel protocol had been implemented.</p> <p>Review of Resident #45's medical record from 02/01/25 through 02/05/25 revealed there was no evidence Resident #45 had been assessed for constipation and there was no documentation Resident #45's bowel sounds had been assessed.</p> <p>Review of a progress note dated 02/05/25 and timed 5:49 P.M. revealed Registered Nurse (RN) #709 assessed Resident #45 and noted the resident had an emesis that looked and smelled like a bowel movement. RN #709 noted Resident #45 had been constipated throughout the shift without relief. RN #709 updated Nurse Practitioner (NP) #901 who then ordered a Kidney, Ureter, and Bladder (KUB) x-ray (an abdominal x-ray examination used to visualize the urinary system and surrounding structures) examination, Miralax (an osmotic laxative taken orally that works to increase the water content of the stool), and a suppository. The note referenced if Resident #45 had another emesis, to send to the emergency room (ER) for evaluation for possible small bowel obstruction.</p> <p>Review of the nursing progress notes on 02/05/25 at 6:49 P.M. revealed RN #709 documented while providing Resident #45 with Miralax, Resident #45 had another emesis and was being sent to the ER for evaluation.</p> <p>Review of imaging results dated 02/05/25 completed in the ER revealed a Computed Tomography (CT) scan was completed with results indicating moderate to large amount of retained stool throughout the colon which was consistent with constipation and a possible rectal fecal impaction.</p> <p>Review of the ER record dated 02/05/25 revealed Resident #45 arrived at a local ER to be evaluated for not having a bowel movement for about six to seven days. Additionally, Resident #45 was noted to be having issues with nausea, vomiting, decreased appetite, significant abdominal pain, and abdominal distention. Upon arrival at the ER, Resident #45 was tachycardic with a heart rate of 118 beats per minute (normal range is between 60 to 100 beats per minute). Resident #45's abdomen was assessed to be distended and tender. While in the ER, Resident #45 was given intravenous fluids, ondansetron (an antiemetic) 4 mg to treat nausea and vomiting, and a Fleet enema. Resident #45 was placed on supplemental oxygen due to mild hypoxia, which was noted by the ER provider to have been contributed or worsened by the large amount of stool within the abdominal cavity as well as having limited chest wall excursion secondary to a distended abdomen (indicating a reduced ability of the chest wall to expand during inhalation and contract during exhalation). Resident #45 was admitted to the hospital for treatment of moderate dehydration, constipation, and abnormal labs.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 00 indicating severely impaired cognition. Resident #45 required substantial/maximum assistance for toilet transfers and was dependent on staff for toileting hygiene tasks. Resident #45 was recorded to be always incontinent of bladder and frequently incontinent of bowel.</p> <p>Interview on 05/05/25 at 10:32 A.M. with a family member of Resident #45 revealed Resident #45 was hospitalized three months ago due to constipation.</p> <p>Interview on 05/06/25 at 12:13 P.M. with Licensed Practical Nurse (LPN) #711 revealed the CNA's recorded each resident's bowel movements in the electronic medical record (EMR) and then there was a notebook for communication between the aides and the nurses, where the bowel movements were additionally recorded. LPN #711 stated that the night shift nurse would check the bowel record and then report to the day shift nurse what residents were on the bowel movement list, meaning the resident had not have a bowel movement in over three days.</p> <p>Interview on 05/07/25 at 9:45 A.M. with Registered Nurse (RN) #709 revealed she was on duty and her nurse when Resident #45 had vomited what appeared to be fecal matter on 02/05/25. RN #709 stated she assessed the resident and completed a head-to-toe assessment, including vital signs and listening to Resident #45's bowel sounds, but could not recall what they were. RN #709 verified there was no documentation in the resident's record reflecting that she had completed a head-to-toe assessment, including assessing the resident's bowel sounds. RN #709 confirmed she documented that Resident #45 had unrelieved constipation and was told Resident #45 had not had a bowel movement. RN #709 also confirmed she had not followed the facility bowel protocol. RN #709 stated Resident #45 had a total of three emesis before the emergency medical service (EMS) arrived to transport the resident to a local hospital.</p> <p>Interview on 05/07/25 at 10:29 A.M. with CNA #723 revealed if there is no documentation of a bowel movement in the bowel record, that means the resident did not have one. CNA #723 stated Resident #45 had frequent large and hard bowel movements. On 02/05/25, CNA #723 charted the resident had a small bowel movement with normal consistency, but actually appeared as a small, pebble-like bowel movement. CNA #723 stated the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #702 monitored the residents' bowel movements based off the charting completed by the CNAs.</p> <p>Interview on 05/07/25 at 10:56 A.M. with ADON #702 revealed the DON printed out a list of residents on the bowel list, but there was no one to give the list to on the weekend. ADON #702 stated three days without a bowel movement was when the facility wanted to be proactive and would start to follow the bowel protocol. ADON #702 verified staff had not followed the bowel protocol for Resident #45 and should have administered Milk of Magnesia on 02/03/25, a Bisacodyl suppository on 02/04/25, and Fleet enema on 02/05/25. ADON #702 stated the medications were available on-hand at the facility. ADON #702 stated the nurse should have completed an assessment and charted it in the progress notes. ADON #702 revealed if the intervention on the fourth day had not worked then the doctor should have been notified.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/07/25 with the DON revealed he kept a list of residents who have not had a bowel movement on a piece of paper. The DON revealed he got the information from the electronic medical record (EMR). The DON revealed he called the facility on the weekends to inform the nurses of the residents without a recorded bowel movement. The DON verified the staff should follow the bowel protocol and the facility NP should be made aware if the bowel protocol does not work. The DON confirmed Resident #45 was on his list on 02/03/25 for three plus days of not having a bowel movement. The DON stated he was not aware Resident #45's bowel protocol was not implemented or followed. The DON further revealed a small bowel movement would not be counted as a bowel movement.</p> <p>Interview on 05/07/25 at 1:47 P.M. with NP #901 revealed the nurse should initiate the bowel protocol if the resident had no bowel movement in three days. NP #901 stated on day three, the staff should call her and update her. NP #901 stated she was not aware Resident #45 had five days of undocumented bowel movements. NP #901 was also not aware the facility had not implemented the bowel protocol for Resident #45. NP #901 revealed she was informed the resident had an emesis and ordered the resident Miralax. NP #901 further revealed staff will typically contact her for bowel issues, and she was present at the facility twice a week and would check with the nurses regarding any issues prior to leaving the facility. NP #901 confirmed the facility had not contacted her about Resident #45 prior to Resident #45 having an emesis containing possible fecal matter.</p> <p>Interview on 05/08/25 at 10:45 A.M. with Medical Director (MD) #900 revealed the nurse on duty should have completed focused gastrointestinal assessment, and that he would not have gone the route of giving Miralax orally if the resident was vomiting. MD #900 stated he would have asked the nurse what the bowel sounds were, and that it was necessary to complete an assessment to be sure the resident had active bowel sounds. MD #900 stated if he would have been contacted, he would have ordered to give a suppository due to the vomiting, rather than Miralax.</p> <p>2. Review of Resident #18's medical records revealed an admission date of 10/22/24. Diagnoses included constipation.</p> <p>Review of care plan dated 02/02/25 revealed Resident #18 had constipation related to decreased mobility. Interventions included following the facility bowel protocol and recording bowel movement patterns each day.</p> <p>Review of current physician orders for May 2025 included bowel protocol, if no bowel movement in three days give 30 ml of Milk of Magnesia. If no result, give a Bisacodyl suppository on the fourth day. If there is no result on the shift after the suppository, administer Fleet enema. Notify the doctor if there were no results and/or severe abdominal pain, rectal bleeding, or vomiting noted during this regimen. Resident #18's physician orders also included Miralax 17 grams every 24 hours as needed for constipation and Docusate (a stool softener) 100 mg one time a day.</p> <p>Review of bowel movement tracking for April 2025 revealed Resident #18 had a bowel movement on 04/30/25.</p> <p>Review of bowel movement tracking for May 2025 revealed Resident #18 had no bowel movements recorded on 05/01/25, 05/02/25, or 05/03/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Medication Administration Record (MAR) for May 2025 revealed Milk of Magnesia, Bisacodyl suppository, and Fleet enema had not been recorded as administered. There was no evidence the facility had implemented the standing bowel protocol.</p> <p>Interview on 05/05/25 at 8:39 A.M. with Resident #18 revealed she had not had a bowel movement in four days and stated she had requested prune juice and a laxative and had not received either.</p> <p>Interview on 05/06/25 at 1:49 P.M. with Director of Nursing (DON) confirmed no recorded bowel movement for Resident #18 from 05/01/25-05/03/25 and stated interventions should have been implemented that included administering as needed laxatives as per the facility's bowel protocol. The DON further stated Resident #18 had informed the nurse practitioner that she would like a fiber supplement due to not having bowel movements.</p> <p>Review of the facility policy titled Bowel Protocol dated 01/2017, revealed the CNAs would monitor and record resident's bowel movements. The nurse will monitor the documented results. If the resident has not had a bowel movement in three days, the resident will receive 30cc of Milk of Magnesia. If there are no results, the resident will receive a bisacodyl suppository on the fourth day. If there are no results on the next shift after the suppository, a Fleets enema will be administered. The physician will be notified if the resident complains of severe abdominal pain, has rectal bleeding or vomiting during this regimen or if there are no results after these measures have been taken.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to ensure residents were transferred safely using manual and mechanical Hoyer lifts. This affected three residents (#17, #42, #56) of four residents reviewed for transfers using a manual/mechanical Hoyer lift. The facility census was 58.</p> <p>Findings include:</p> <p>1. Review of Resident #42's medical record revealed an admission date of 07/27/22. Diagnoses include Alzheimer's disease, dementia - severe with agitation, major depressive disorder, hypothyroidism, insomnia, anxiety, altered mental status, and hyperlipidemia.</p> <p>Review of the care plan dated 04/30/25 revealed Resident #42 required assistance with transfers using a Hoyer lift with two staff to assist.</p> <p>Observation on 05/05/25 at 10:04 A.M. revealed Hospice Aide (HA) #903 had been transferring Resident #42 from a wheelchair into a shower chair unassisted by other staff members.</p> <p>Interview with HA #903 at 10:04 A.M. revealed she had transferred Resident #42 via a Hoyer lift independently.</p> <p>Review of the policy titled Lifting Machine, Using a Mechanical dated July 2017 revealed at least two (2) nursing assistants were needed to safely move a resident with a mechanical lift.</p> <p>2. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE]. Diagnoses included severe obesity, shortness of breath, and edema.</p> <p>Review of the Minimum Data Set (MDS) five-day assessment dated [DATE], revealed Resident #56 was cognitively intact. The resident required substantial/maximal assistance from staff for transfers.</p> <p>Review of Resident #56's active physician orders for May 2025 identified an order dated 04/02/25 for Hoyer (mechanical) lift for all transfers with the assistance of two staff.</p> <p>Interview on 05/05/25 at 12:17 P.M. with Resident #56 revealed the resident required use of a mechanical lift for transfers. Resident #56 reported they had gotten stuck in the air while being transferred in the Hoyer lift on several occasions. Resident #58 reported staff had to use the emergency release several times during transfers due to the mechanical lift and/or battery no longer functioning.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/25 at 1:59 P.M. with Certified Nursing Assistant (CNA) #719 revealed they had not had any situations where a mechanical lift had stopped working while a resident was being transferred. CNA #719 reported the mechanical lifts would sometimes start beeping during a transfer and staff would lower the resident back down and go obtain another battery. CNA #719 reported CNAs were responsible for charging the batteries used for mechanical lifts and would normally charge them once they started beeping. CNA #719 verified there was no specific time or protocol for charging the batteries.</p> <p>Observation on 05/06/25 at 2:09 P.M. of CNA #719 and Registered Nurse (RN) #703 transferring Resident #56 from wheelchair to bed via mechanical lift, revealed the lift started beeping during the transfer. The lift began moving slower than before it had begun beeping. Resident #56 was lowered into their bed. Once in the bed, CNA #719 began unhooking the straps of Resident #56's sling used for transfers, which was attached to hooks on the mechanical lift. Once unhooked, the metal piece with hooks swung and nearly hit Resident #56 in the head. CNA #719 caught the attachment and stated sorry. Resident #56 stated it was not uncommon for that to happen.</p> <p>Interview on 05/06/25 at 2:23 P.M. with CNA #719 verified the mechanical lift almost hit Resident #56 in the head. CNA #719 reported Resident #56 had an unusual bed and it sometimes caused the legs of the mechanical lift to get stuck underneath, causing the piece that hung down to jerk.</p> <p>Interview on 05/07/25 at 11:16 A.M. with CNA #723 revealed the staff member was concerned about the mechanical lifts and/or batteries. CNA #723 reported mechanical lifts were constantly dying while residents were in the process of being transferred. CNA #723 reported they were transferring a resident earlier in the day and the mechanical lift began beeping. CNA #723 went to obtain another battery and that one did not work at all. CNA #723 reported they had to use the battery that was dying to finish transferring the resident.</p> <p>Review of the facility policy titled Lifting Machine, Using a Mechanical, dated July 2017, revealed before using a lifting device, staff should make sure the battery is charged.</p> <p>3. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE]. Diagnoses included dementia, type II diabetes mellitus, muscle weakness, and need for assistance with personal care.</p> <p>Review of the MDS quarterly assessment dated [DATE] revealed Resident #17 was cognitively impaired. The resident was dependent on assistance from staff for transfers.</p> <p>Review of the plan of care dated 03/18/24 revealed Resident #17 had an activities of daily living self-care performance deficit related to diagnoses. Interventions included transfers via mechanical lift with the assistance of two staff as needed.</p> <p>Review of Resident #17's active physician orders for May 2025 identified an order dated 04/26/25 indicating staff may use the Hoyer (mechanical) lift as needed for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/06/25 at 1:24 P.M. of CNA #728 and CNA #739 transferring Resident #17 from wheelchair to bed via mechanical lift, revealed once Resident #17's mechanical lift sling was connected to the lift, the resident was raised up and wheeled over to the bed. Resident #17 was then lowered into the bed. The legs located on the bottom of the lift remained in the closed position throughout the entire transfer.</p> <p>Interview on 05/08/25 at 9:01 A.M. with CNA #739 verified the legs of the mechanical lift were supposed to be completely open at all times, aside from when underneath of the bed.</p> <p>Review of the policy Lifting Machine, Using a Mechanical Lift revised 07/2017 revealed at least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. Prior to using the lift, make sure the battery is charged and test the controls. Make sure the lift is stable and locked. The policy additionally stated once the transfer destination is reached, slowly lower the resident to the receiving surface. Once the resident's weight is released, stop the lowering and ensure that the sling bar does not hit the resident.</p> <p>Review of page 34 of the manufacturer's instructions for the mechanical lift, not dated, revealed the legs of the lift must be in the maximum open position for optimum stability and safety. The instructions stated if it is necessary to close the legs of the lift to maneuver the lift under a bed, to close the legs of the lift only as long as it takes to position the lift over the patient and to lift the patient off the surface of the bed. The instructions further stated when the legs of the lift were no longer under the bed, to return the legs of the lift to the maximum open position.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163093.</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>Based on observation and staff interview, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect all 57 residents who received food from the kitchen. The facility identified one resident (#313) as receiving nothing by mouth. The facility census was 58.</p> <p>Findings include:</p> <p>Observation on 05/05/25 beginning at approximately 8:15 A.M. of the dishwashing area located in the kitchen revealed there was a pipe which ran along the lower part of the wall, near the floor. There was a black, white, and grey substance built up along the lower part of the wall and a dark puddle of water in the corner on the floor where the walls met. There was also a rubber mat in the dishwashing area which had circular holes for draining. There was an excessive amount of dirt, buildup, and debris which could be seen through the holes and underneath of the mat.</p> <p>An interview at the time of observation with Dietary [NAME] #752 confirmed the aforementioned concerns.</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident interview, and staff interview, the facility failed to ensure recommended specialized rehabilitative services were implemented. This affected one (Resident #13) of one resident reviewed for rehabilitation services. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included muscle wasting and atrophy, heart disease, heart failure, anxiety, osteoarthritis, unsteadiness on feet, weakness, abnormal posture, and postural kyphosis.</p> <p>Review of the nursing progress notes dated 02/06/25 and timed 4:23 P.M. revealed Resident #13 sustained a fall from their wheelchair.</p> <p>Review of Resident #13's physician orders for February 2025 identified an order dated 02/10/25 for physical therapy to evaluate and treat the resident.</p> <p>Review of the physical therapy evaluation dated 02/10/25 revealed Resident #13 was referred to therapy due to a recent fall from their wheelchair. The resident had reportedly requested a bed pad in their wheelchair, which caused them to slide out of their wheelchair.</p> <p>Review of the physical therapy notes dated 02/14/25 revealed Resident #13 had a noted decline with a recommendation for a possible tilt chair to decrease fall risk.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact. The resident required the assistance of at least two staff for bed mobility and transfers.</p> <p>Interview on 05/05/25 at 10:32 A.M. with Resident #13 revealed the resident's wheelchair was in poor condition and just doesn't work right. Resident #13 reported they had fallen from their wheelchair and believed it was because of the condition of the wheelchair. Resident #13 reported they had been inquiring about a new wheelchair for quite some time. Resident #13 reported therapy staff were supposed to be working on obtaining a new wheelchair for her, but she did not believe they were.</p> <p>Observation on 05/05/25 at 10:34 A.M. of Resident #13's wheelchair revealed it was a standard wheelchair and was not a tiltable wheelchair. There were two armrests on the wheelchair, both of which were cushioned and covered with a black material. There was material missing from both arms of the chair and the left side (resident's left) had numerous pieces of clear tape across it.</p> <p>Interview on 05/05/25 at the time of observation with Resident #13 revealed the resident had applied the tape to the arm of their wheelchair in attempt to make it look better due to the missing material.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/25 at 2:27 P.M. with Therapy Director #790 verified therapy staff noted they were going to trial a different type of wheelchair for Resident #13 on 02/14/24. Therapy Director #790 verified there was no evidence of any further discussion of follow-through regarding the wheelchair for Resident #13. Therapy #790 reported therapy staff were supposed to initiate a physician's order and document if they were trialing a wheelchair. Therapy Director #790 verified there was no evidence this was ever completed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on medical record review, interview, and review of facility policy, the facility failed to ensure appropriate and accurate documentation was recorded in the electronic medical records. This affected one resident (#18) of three residents reviewed for documentation. The facility census was 58.</p> <p>Findings include:</p> <p>Review of Resident #18's medical records revealed an admission date of 10/22/24. Resident #18's medical diagnoses included type two diabetes mellitus and atherosclerotic heart disease.</p> <p>Review of the care plan dated 02/02/25 revealed Resident #18 had diabetes. Interventions included to administer medications as ordered and monitor and document for side effects and effectiveness.</p> <p>Review of physician orders for April 2025 revealed Resident #18 had an order dated 01/23/25 for Lantus (a long-acting insulin used to lower blood sugars) 10 units to be administered subcutaneously once daily at noon for diabetes. The order was discontinued on 04/22/25. Resident #18 additionally had an order dated 04/23/25 for Lantus 16 units subcutaneously once daily at noon for diabetes. Resident #18 was not ordered to have any routine blood sugar checks to be completed by or monitored by nursing.</p> <p>Review of a progress note dated 04/21/25 timed 11:06 A.M. authored by Licensed Practical Nurse (LPN) #717 revealed Resident #18 had a critical blood sugar reading of 435 (normal levels are between 60-100), orders were received from the provider to administer 8 units of Humulin (a fast-acting insulin) and recheck the blood sugar. The note continued, Resident #18's blood sugar was rechecked and the result was 552, an additional orders was received from the provider to administer 8 units of Humulin and recheck. Resident #18's blood sugar was rechecked and was 345, an additional order listed to again administer 8 additional units of Humulin and recheck. Recheck of the blood sugar indicated the result was 417, an additional order was given to administer 10 units of Humulin and recheck the blood sugar. Resident #18's blood sugar was then noted to be 323, and the note indicated the nurse was awaiting further orders and would pass the information along to the ongoing nurse. The progress note did not include times of the provider notification, time were orders received, the time each dose of Humulin insulin was administered, or the time the resident's blood sugars were rechecked.</p> <p>Review of progress note dated 04/22/25 timed 1:04 A.M. authored by LPN #714 revealed Resident #18's blood sugar reading was 63.</p> <p>Review of Resident #18's Medication Administration Record (MAR) for April 2025 revealed no evidence the multiple doses of Humulin that were ordered by the provider, as referenced in the 04/21/25 progress note authored by LPN #717, were entered into the electronic medical record or recorded as administered on the MAR.</p> <p>Interview on 05/05/25 at 8:39 A.M. with Resident #18 revealed her blood sugars had often been high due to her diet had too much sugar in it.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/25 at 1:49 P.M. with Director of Nursing (DON) confirmed Resident #18's MAR had not contained documentation of any of the Humulin doses administered on 04/21/25 as referenced in the 04/21/25 progress note. The DON confirmed Resident #18's progress note authored by LPN #717 had indicated several dose of Humulin were administered, however progress note had not included times of administration and blood sugar rechecks. DON stated the insulin orders should have been placed in the MAR.</p> <p>Telephone interview on 05/07/25 at 11:04 A.M. with LPN #717 revealed she had contacted Nurse Practitioner (NP) #901 on 04/21/25 at approximately 11:07 A.M. to report Resident #18's high blood sugar readings. LPN #717 stated she had received orders to administer 8 units of Humulin and recheck the blood sugar. LPN #717 stated she believed she had rechecked Resident #18's blood sugar approximately every two hours. LPN #717 stated she had hand written the orders and had placed them in Resident #18's paper chart. LPN #717 stated she had written a progress note regarding the orders received by NP #901 and stated she had not placed the orders in Resident #18's electronic medical records and therefore had not documented the times of the insulin administration or the blood sugar rechecks on the MAR.</p> <p>Telephone interview on 05/07/25 at 1:58 P.M. with NP #901 revealed she had been contacted by LPN #717 regarding Resident #18's high blood sugar on 04/21/25 and stated she had given orders to administer Humulin and recheck the blood sugars every hour. LPN #717 stated the DON had contacted her on 05/06/25 and had asked her to provide a timeline of each call received from LPN #717 and what orders had been given. NP #901 stated medication orders should have been placed in the electronic medical records and the doses recorded on the MAR when administered.</p> <p>Review of facility policy titled Blood Glucose Monitoring dated 04/17 revealed results of blood glucose monitoring was to be recorded in the Medication or Treatment Administration Record.</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>Based on review of the medical record, review of resident arbitration agreements, and staff interview, the facility failed to ensure the inclusion of all required components of an arbitration agreement. This affected five (#21, #47, #11, #41, #39) of seven residents reviewed for arbitration agreements. The facility identified 33 residents who had entered into arbitration agreements. The facility census was 58.</p> <p>Findings include</p> <p>1. Review of the medical record for Resident #21 revealed an admission date of 08/06/24.</p> <p>Review of Resident #21's signed arbitration agreement dated 08/06/24 revealed the agreement had not provided for the selection of a venue convenient to both parties.</p> <p>Interview on 05/08/25 at 2:19 P.M., the Administrator verified the selection of a venue convenient to both parties was not contained in the arbitration agreement.</p> <p>2. Review of the medical record for Resident #47 revealed an admission date of 06/12/23.</p> <p>Review of Resident #47's signed arbitration agreement dated 06/12/23 revealed the agreement had not provided for the selection of a venue convenient to both parties.</p> <p>Interview on 05/08/25 at 2:19 P.M., the Administrator verified the selection of a venue convenient to both parties was not contained in the arbitration agreement.</p> <p>3. Review of the medical record for Resident #11 revealed an admission date of 08/26/24.</p> <p>Review of Resident #11's signed arbitration agreement dated 08/27/24 revealed the agreement had not provided for the selection of a venue convenient to both parties.</p> <p>Interview on 05/08/25 at 2:19 P.M., the Administrator verified the selection of a venue convenient to both parties was not contained in the arbitration agreement.</p> <p>4. Review of the medical record for Resident #41 revealed an admission date of 02/24/23.</p> <p>Review of Resident #41's signed arbitration agreement dated 04/24/23 revealed the agreement had not provided for the selection of a venue convenient to both parties.</p> <p>Interview on 05/08/25 at 2:19 P.M., the Administrator verified the selection of a venue convenient to both parties was not contained in the arbitration agreement.</p> <p>5. Review of the medical record for Resident #39 revealed an admission date of 04/24/24.</p> <p>Review of Resident #39's signed arbitration agreement dated 04/24/24 revealed the agreement had not provided for the selection of a venue convenient to both parties.</p> <p>(continued on next page)</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/08/25 at 2:19 P.M., the Administrator verified the selection of a venue convenient to both parties was not contained in the arbitration agreement.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #7 revealed an admission date of 12/23/24 with diagnoses of mechanical complication of internal left knee prosthesis, benign prostatic hyperplasia with lower urinary tract symptoms, and neuromuscular dysfunction of bladder.</p> <p>Review of the MDS quarterly assessment dated [DATE] revealed Resident #7 was cognitively intact.</p> <p>Review of the physician orders dated 12/26/24 for Resident #7 revealed an order for a urinary catheter, change bag and tubing every month and as needed.</p> <p>Review of the care plan dated 12/23/24 revealed Resident #7 have a foley catheter due to obstructive uropathy and benign prostatic hyperplasia. The intervention stated to position and secure the catheter bag and tubing below the level of the bladder.</p> <p>Observation on 05/07/25 at 7:48 A.M. revealed Resident #7 was lying in bed with his indwelling urinary catheter drainage bag lying on the floor.</p> <p>Interview with CNA #739 confirmed Resident #7's indwelling urinary catheter drainage bag was lying on the floor and that it should be off the floor and secured.</p> <p>Review of facility policy titled Indwelling Urinary Catheters dated 11/2017 revealed urinary catheter drainage bags will not have contact with the floor.</p> <p>3. Review of the medical record for Resident #45 revealed an admission date of 12/21/22 with a diagnosis of Parkinson's disease, peripheral vascular disease, and dementia.</p> <p>Review of the MDS quarterly assessment dated [DATE] revealed Resident #45 had severe cognitive impairment.</p> <p>Review of the care plan dated 05/05/25 revealed Resident #45 had an active infection with a highly transmissible or epidemiological significant pathogen that required isolation precautions related to Extended-Spectrum Beta-Lactamase (ESBL) (An enzyme produced by some bacteria that can make certain antibiotics ineffective). Listed interventions included to maintain contact precautions: wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. [NAME] personal protective equipment (PPE) upon room entry and properly discard before exiting the patient room.</p> <p>Observation on 05/07/25 at 10:17 A.M. revealed the Administrator entered Resident #45's room wearing no PPE.</p> <p>Interview on 05/07/25 at 10:20 A.M. with the Administrator confirmed she had not applied PPE before entering the room of Resident #45, who was on contact isolation precautions.</p> <p>Review of the facility policy titled Contact Precautions, dated 11/2017 revealed to prevent transmission to other persons, personal protective equipment should be donned prior to entering the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of the medical record, observation, staff interview, and policy review, the facility failed to ensure personal protective equipment was utilized for residents on contact precautions and enhanced barrier precautions. Additionally, the facility failed to maintain placement of urinary catheter drainage bags per infection control guidelines. This affected three residents (#16, #7, and #45) of 20 residents reviewed for infection control. The facility identified two residents requiring contact precautions, 11 residents requiring enhanced barrier precautions and seven residents with indwelling urinary catheters. The facility census was 58.</p> <p>Findings include</p> <p>1. Review of the medical record for Resident #16 revealed an admission date of 10/31/24. Diagnoses included type two diabetes mellitus, dementia, hypertension, atrial fibrillation, obstructive uropathy (blockage that prevents urine from flowing normally through the urinary system) and need for personal care assistance.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had impaired cognition.</p> <p>Review of the physician orders dated 02/05/25 revealed an order for enhanced barrier precautions due to a suprapubic catheter.</p> <p>Review of the care plan revised 02/05/25 revealed Resident #16 required enhanced barrier precautions related to a suprapubic catheter (tube that drains urine from the bladder through an incision in the abdomen). Interventions included to wear a gown and gloves for all high contact resident care such as dressing, bathing, showering, hygiene, transfers in the room, bed mobility, changing linens, changing briefs, indwelling device care, wound care, and high-contact therapy sessions. Further review of the care plan revealed Resident #16 was dependent for toileting and had a suprapubic catheter. Interventions included position catheter bag below the level of the bladder.</p> <p>Observation on 05/05/25 at 8:50 A.M. revealed Resident #16 was resting in bed and his urinary catheter drainage bag was uncovered and lying on the floor.</p> <p>Interview on 05/05/25 at 9:00 A.M. with Assistant Director of Nursing (ADON) confirmed Resident #16's catheter bag was on the floor. ADON stated urinary catheter bags should not be placed on the floor.</p> <p>Observation on 05/05/25 at 10:23 A.M. revealed an enhanced barrier precautions sign on Resident #16's door stating to wear a gown and gloves during high contact resident care, including transferring a resident. Further observation revealed a bin outside the room containing personal protective equipment (PPE) including gowns and gloves.</p> <p>Observation on 05/05/25 at 10:26 A.M., revealed Certified Nursing Assistant (CNA) #733 and CNA #743 were transferring Resident #16 with the mechanical lift from the bed to the recliner. Further observation revealed CNA #743 was not wearing a protective gown. CNA #733 was not wearing a protective gown or gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/05/25 at 10:31 A.M., CNA #743 verified not wearing a protective gown. CNA #733 verified not wearing a protective gown or gloves. CNA #743 confirmed staff should wear a gown and gloves when transferring a resident on enhanced barrier precautions if that was what the sign on the door said.</p> <p>Review of the facility policy Enhanced Barrier Precautions (EBP), dated 04/01/24, revealed EBP was indicated for residents with wounds, indwelling medical devices, and infection or colonization with a multidrug resistant organism (MDRO). Personal protective equipment should include a gown and gloves for high contact care activities including dressing, bathing, showering, hygiene, transferring in the resident's room, changing linens, toileting/changing briefs, indwelling device care, wound care, and therapy sessions. Face/eye protection should also be used if splash/spray was possible.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of facility policy, the facility failed to ensure pneumococcal vaccines were administered per CDC guidelines. This affected two residents (#11 and #45) of five residents reviewed for pneumococcal vaccinations. The facility census was 58.</p> <p>Findings include</p> <p>1. Review of the medical record for Resident #11 revealed an admission date of 08/26/24. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease (COPD), atrial fibrillation, hypertension, and anxiety.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of the immunization records for Resident #11 revealed the resident last received a pneumococcal polysaccharide vaccine (PPSV23) on 01/08/20.</p> <p>Review of CDC recommendations for pneumococcal vaccine timing for adults, dated 10/2024, revealed based on the resident's age and date of last pneumococcal immunization the resident should have been offered one dose of the pneumococcal 15-valent conjugate vaccine (PCV 15), PCV20, or PCV21 one year after the PPSV23 immunization.</p> <p>Interview on 05/07/25 at 10:24 A.M., Registered Nurse (RN) #701 verified the resident had not been offered the PCV15, PCV20, or PCV21 immunization.</p> <p>2. Review of the medical record for Resident #45 revealed an admission date of 12/21/22. Diagnoses included heart failure, Parkinson's disease, type two diabetes mellitus, and dementia.</p> <p>Review of the MDS quarterly assessment dated [DATE] revealed the resident had a severe cognitive impairment.</p> <p>Review of the immunization records for Resident #45 revealed the resident received the PPSV23 immunization on 08/09/22.</p> <p>Review of CDC recommendations for pneumococcal vaccine timing for adults dated 10/2024 revealed based on the resident's age, underlying medical conditions, and date of last immunization, the resident should have been offered the PCV15, PCV20, or PCV21 immunization one year after the PPSV23 immunization.</p> <p>Interview on 05/07/25 at 10:21 A.M., Registered Nurse (RN) #701 verified Resident #45 had not been offered the PCV15, PCV20, or PCV21 immunization.</p> <p>Review of the facility policy Pneumococcal Vaccine, revised 03/2022, revealed administration of the pneumococcal vaccines were made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on review of an all-staff roster, review of staff COVID-19 declination forms, staff interview, and policy review, the facility failed to ensure all staff received education and vaccine information sheets regarding the COVID-19 vaccine. This affected 54 of 79 staff and had the potential to affect all residents. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the all-staff roster provided by the facility revealed there were 79 staff currently employed by the facility.</p> <p>Review of facility documentation revealed no documentation 54 staff had been offered the annual COVID-19 vaccine and received education regarding the risks and benefits of the annual COVID-19 vaccine. Further review revealed 25 new staff hired since 09/01/24 had received some education regarding the COVID-19 vaccine and had declined the annual vaccine. The facility had no documentation any staff were provided the vaccine information sheet for the COVID-19 vaccine.</p> <p>Interview on 05/06/25 at 11:02 A.M., Registered Nurse (RN) #701 revealed the facility had not provided the annual COVID-19 vaccine for staff. RN #701 revealed staff were instructed to obtain the vaccine from their pharmacy or physician.</p> <p>Interview on 05/06/25 at 11:42 A.M., the Administrator revealed staff were informed the facility would no longer be offering the annual COVID-19 vaccine. The Administrator revealed staff were informed they could get the annual COVID-19 vaccine from their physician or pharmacy. The Administrator revealed staff were not provided a vaccine information sheet about the COVID-19 vaccination and had not received annual education about the vaccine when it was available to the facility.</p> <p>Interview on 05/06/25 at 1:15 P.M., the Administrator revealed she had been mistaken. The Administrator revealed she had told the staff they would need to get the COVID-19 vaccine at a pharmacy because she was not aware they could still get the vaccine in the facility. The Administrator revealed she was unaware the facility staff should have received annual education about the COVID-19 vaccine and offered the COVID-19 vaccine annually.</p> <p>Interview on 05/06/25 at 1:23 P.M. Human Resource Manager (HRM) #767 revealed employees were only asked if they would like the COVID-19 vaccine upon hire. HRM #767 revealed employees were not offered the COVID-19 vaccine annually.</p> <p>Interview on 05/07/25 at 10:34 A.M., Certified Nursing Assistant (CNA) #723 revealed the facility informed staff to go to a pharmacy to get the COVID-19 vaccine.</p> <p>Interview on 05/08/25 at 9:09 A.M., RN #705 revealed she could not remember what the facility had said about the COVID-19 vaccine. Further interview with RN #705 clarified she had spoken with the infection control nurse and was told to get the vaccine from their physician or pharmacy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Liberty Nursing Center of Mansfield		STREET ADDRESS, CITY, STATE, ZIP CODE 535 Lexington Avenue Mansfield, OH 44907	
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy COVID-19 Vaccine Policies and Procedures, dated 05/28/21, revealed the COVID-19 vaccination would be offered to all staff per Centers for Disease Control and Prevention (CDC) guidelines and/or FDA guidelines unless such immunization was medically contraindicated, the individual had already been immunized during this time period or the individual refuses to receive the vaccine. All staff would be educated on the COVID-19 vaccine including benefits and risk consistent with CDC or FDA information. A vaccine information sheet (VIS) would be provided when available. The facility would maintain documentation for all staff on COVID-19 vaccination and education including consents and declination forms.</p>		