STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to provide a dignified meal experience. This affected one resident (#24) of four residents observed during meal service in the dining room. The census was 72. Findings include: Medical record review revealed Resident #24 was admitted on [DATE] with diagnoses including cerebral infarction, hypertension, dysphagia and cognitive communication disorder. On 09/03/24 at 11:55 A.M., observation of the dining room revealed Resident ##24, #25, #27 and #81 were seated at a table in the dining room. Resident #25, #27 and #81 were served their lunch meals and observed being verbally cued and/or physically assisted with their meal by State tested Nurse Aide (STNA) #374. Resident #24 was observed sitting at the table watching Resident #25, #27 and #81 eat their food, and would randomly look at the other residents' eating their meals and then looking around the dining room. On 09/03/24 at 12:05 P.M., STNA #330 was observed bringing Resident #24's meal tray into the dining room. The lunch meal was placed it in front of Resident #24 and the resident stated good, I am hungry. On 09/03/24 at 12:13 P.M., interview with STNA #621 verified Resident #24 was not served her meal at the same time as the other residents at her table in the dining room stating Resident #24 normally eats in her room and her meal had not been delivered as it comes out on the hall trays to be served to bring her meal to her. On 09/05/24 at 4:05 P.M., interview with the Director of Nursing verified all residents at a table should be served meals at the same time and residents were to be treated with respect and dignity. Review of the undated policy: Your Rights and Protections as a Nursing Home Resident revealed residents have the right to be treated with respect and dignity. Review of the policy: Dignity (revised February 2021) revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with like and feelings of self-worth and self-esteem. Residents were to be treated with dignity and respect at all times. When assisting with care, residents are supported in exercising their right including a dignified dining experience. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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	This deficiency represents non-compliance during the investigation of Complaint Number OH00156069.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, policy review and interview, the facility failed to provide written notice before a resident's room was changed. This affected one resident (#99) of three residents reviewed for room changes. The facility census was 72. Findings include: Medical record review revealed Resident #99 was admitted on [DATE] with diagnoses including charcot's joint left ankle and foot and diabetes mellitus. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #99 was cognitively intact for daily decision-making. Review of Resident #99's Census revealed the following room moves: a. On 02/06/24, admitted to room [ROOM NUMBER]-A. b. On 02/07/24, moved to room [ROOM NUMBER]-A. c. On 02/23/24, moved to room [ROOM NUMBER]-B. d. On 09/05/24, moved to room [ROOM NUMBER]-B. Review of the medical record revealed no documented evidence that Resident #99 was provided written notification including the reason for the change on 02/07/24 or 02/23/24. On 09/11/24 at 11:01 A.M., interview with the Director of Nursing verified there was no evidence of a written notice for Resident #99's room changes. On 09/11/24 at 4:15 P.M., interview with Resident #99 stated she had only received written notice of her room changes on 09/05/24 but not the previous room moves. Review of the policy: Room Change/Roommate Assignment (dated 03/28/23) revealed residents were to receive written or verbal notice at least 24 hours advance notice of the change. Documentation of a room change was to be recorded in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number OH00156069.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365485	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation and interview, the facility failed to ensure the facility map accounted for all resident rooms and resident rooms provided a safe environment for residents. This affected five residents (#67, #68, #73, #97 and #99) of 25 residents residing on the Serenity Hall. The facility census was 72. Findings include: On 09/03/24 between 2:26 P.M. and 2:50 P.M., observation with Maintenance Director (MD) #326 revealed the following: a. Observation of the posted floor plans revealed Resident #97 and #99's room was labeled as a storage room. There was no evidence of room [ROOM NUMBER] on the floor plan. Interview with MD #326 at the time of the observation verified the facility had been approved in January 2024 for the storage room to be designated as a resident room; however the name plate outside room [ROOM NUMBER] stated Storage Room with masking tape listing the resident names and there was no room [ROOM NUMBER] labeled on the facility maps. b. Observation of Resident #67 and Resident #68's room and revealed two black speckled areas along the lower aspect of the drywall near the floor where the baseboard had been removed. The black speckled areas were in a circular shape measuring approximately 5.5 inches. MD #326 verified the residents room remained in the room during renovations stated the areas had not been tested for black mold MD #326 stated the baseboard and baseboard heating system had been removed on 08/30/24 and the room had been in this condition since that time. c. Observation of Resident #73 in room [ROOM NUMBER] revealed electrical wires extending out four inches from a hole in the wall and room [ROOM NUMBER] (Resident #67 and #68) revealed electrical wires 12 inches from a hole in the drywall near the floor. Interview with MD #326 stated the electrical wires were pulled out from behind the drywall when the baseboard heating unit was removed. MD #326 stated the baseboard and baseboard heating system had been removed on 08/30/24 and the room had been in this condition since that time. MD #326 verified both room [ROOM NUMBER] and room [ROOM NUMBER] were occupied resident rooms. d. Observation of room [ROOM NUMBER] revealed the electric outlet faceplate covers were loose, the bathroom tile was cracked/broken around the door frame, no shower curtain in the large walk-in shower and no toilet paper holder was observed. A roll of toilet paper was observed sitting on the bathroom counter that was not within Resident #97 or #99's reach without leaning to their right side. MD #326 verified the observation and stated this room was scheduled for renovation the following week. MD #326 stated there was not a toilet paper holder within reach due to it used to be a storage room but residents had been in the room since around March 2024. The facility stated there was not a policy regarding maintaining a safe environment available for review at the time of the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	This deficiency represents incidental non-compliance investigated under Master Complaint Number OH00156965.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

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Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, observation and interview, the facility failed to provide assistance with meals as needed. This affected one resident (#37) of four residents sampled. The census was 72. Findings include: Medical record review revealed Resident #37 was admitted on [DATE] with diagnoses including moderate intellectual disability, acute respiratory failure, pressure ulcers and schizoaffective disorder. Review of the Nursing Admission/Re-admission Assessment - V 4 dated 08/31/24 revealed Resident #37 required limited assistance with eating. Review of the Skin and Wound Note dated 09/05/24 revealed Nurse Practitioner (NP) #908 assessed Resident #37 to have a Stage IV pressure ulcer to the coccyx, deep tissue injury to the left heel, right heel and left lateral foot. NP #908 indicated the resident had multiple factors that may impair wound healing including the risk of dehydration and malnutrition. Review of the dietitian Progress Notes dated 09/05/24 revealed Resident #37 was ordered a regular, puree texture, nectar thick liquids diet with 25-50% acceptance with refusals noted, and she was dependent for meals and received assistance with meals as needed. On 09/05/24 at 9:53 A.M., observation of Resident #37 revealed she was in bed with the head of the bed up. The resident's breakfast tray was pushed away from the bed out of reach and the food items of the tray were all sealed, covered and unopened. The eggs and bread were pureed and observed on the plate in a measuring scoop form. The juice and milk were unopened. On 09/05/24 at 9:55 A.M., observation with the Director of Nursing (DON) verified the above observation and that the food and drink items had not been set up for the breakfast meal. The drinks were room temperature, the food was not steaming and not within reach. On 09/05/24 at 9:58 A.M., observation revealed State tested Nurse Aide (STNA) #621 entered and exited the room with Resident #37's breakfast tray with the thin consistency juice and milk opened. STNA #621 stated she opened the items and gave the resident a sip of the juice but the resident pushed her away, and refused her breakfast meal at this time. Observation of the juice on the tray at the time of the interview revealed the juice was in the original container and was a thin consistency. On 09/05/24 at 10:26 A.M., interview with STNA #621 revealed Resident #37 needs assistance with meals including set-up but was able to eat independently after set-up. On 09/09/24 at 12:21 P.M., electronic interview with the DON revealed meal delivery times for the main hall was 8:15 A.M. to 8:30 A.M (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents incidental non-compliance investigated under Master Complaint Number OH00156965.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 28704

Based on observation, medical record review, policy review and interview, the facility failed to timely develop and implement comprehensive, individualized and effective pressure ulcer care and treatment to promote the healing of pressure ulcers for Resident #37, who was admitted to the facility with multiple pressure ulcers present. This affected one resident (#37) reviewed for pressure ulcers. The facility identified eight residents with pressure ulcers. The census was 72.

Findings include:

Medical record review revealed Resident #37 was admitted on [DATE] with diagnoses including moderate intellectual disability, schizoaffective disorder, multiple pressure ulcers and anxiety. The resident also had a history of osteomyelitis, peripheral venous insufficiency, and chronic embolism/thrombosis of left popliteal vein.

Review of the hospital Discharge Summary (hospital stay prior to Resident #37's admission to the facility) dated 08/31/24 revealed a specialty hospital Wound Progress Note dated 08/27/24 indicating Resident #37 had a left heel/calcaneus deep tissue pressure injury (DTPI). The wound measured 0.2 centimeters (cm) in length (l) by 1.8 (cm) in width (w). There was no depth documented. The summary also reflected the presence of pressure ulcers to the resident's sacrum, left lateral foot and right heel.

Review of Resident #37's admission Braden Scale for Predicting Pressure Sore Risk Original dated 08/31/24 revealed Resident #37 was at very high risk for pressure ulcer development.

Review of the Resident #37's Nursing Admission/Re-admission Assessment - V4 dated 08/31/24 identified the following skin impairments:

a. A Stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) sacrum pressure ulcer measuring 5.2 centimeters (cm) in length (l) by 4.7 (cm) in width (w) by 0.6 (cm) in (d).

b. Left inner ankle pressure ulcer measuring 1.0 (cm) in (l) by 0.3 (cm) in (w) by zero (d).

c. Right heel pressure ulcer measuring 2.0 (cm) in (l) by 1.5 (cm) in (w) by zero (d).

Review of the facility medical record revealed no documented evidence Resident #37's left heel DTPI was documented during the facility admission assessment.

Record review revealed no baseline plan of care for skin integrity/pressure ulcers had been initiated.

Review of the Physician Orders and Treatment Administration Records dated August 2024 and September 2024 revealed the following:

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. No treatments were ordered for Resident #37's sacrum pressure ulcer until 09/02/24 at 6:30 A.M. when a wet-to-dry dressing was ordered until evaluated by the wound team. b. No treatments were ordered for the left lateral foot, left heel or right heel pressure ulcers until 09/03/24. c. No preventative measures to prevent the further decline or development of new pressure ulcers were ordered between admission (08/31/24) and 09/03/24. Review of the Skin/Wound Note dated 09/03/24 revealed treatments and a low air loss mattress were ordered on this date. The note on 09/03/24 reflected the following wounds and measurements on this date: a. Sacrum Stage IV pressure ulcer (defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) measuring 4.5 (cm) in (l) by 4.0 (cm) in (w) by 1.0 (cm) in (d) with 20% slough. b. Left heel deep tissue injury (DTI) (defined as persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) measuring 0.6 (cm) in (l) by 1.5 (cm) in (w) by zero (cm) in (d). c. Right heel DTI measuring 0.5 (cm) in (l) by (0.5) cm in (w) by zero (cm) in (d). d. Left lateral foot DTI measuring 0.5 (cm) in (l) by 1.0 (cm) in (w) by zero (cm) in (d). Review of Nurse Practitioner (NP) #908's Skin and Wound Note dated 09/05/24 revealed Resident #37 becomes agitated when attempting to reposition her or when providing care, and was assessed with the following: a. Stage IV sacrum pressure ulcer with exposed dermis, subcutaneous, muscle/fascia and bone measuring 4.7 cm in (l) by 5.0 cm in (w) by 1.0 cm in (d) with moderate serosanguineous drainage and malodorous post treatment. No antibiotics were ordered by NP #908. b. Left heel deep tissue injury (DTI) measured 0.40 (cm) in (l) by 1.5 (cm) in (w) by 0.1 cm in (d) with 100% epithelial tissue. c. Right heel pressure DTI measured 0.4 (cm) in (l) by 1.7 (cm) in (w) by 0.1 (cm) in (d) with 100% epithelial tissue and maroon periwound. d. Left lateral foot pressure DTI measured 0.5 (cm) in (l) by 1.0 (cm) in (w) by 0.1 (cm) in (d) width with exposed epithelium tissue and maroon periwound. An admission History and Physical dated 09/07/24 at 7:31 P.M. revealed off-loading of the pressure ulcers was recommended and the resident was to be followed by the wound team. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 9:43 A.M., interview with the DON verified no interventions or treatments were implemented upon admission (08/31/24) until 09/02/24 and 09/03/24 for Resident #37's pressure ulcers. On 09/11/24 between 10:09 A.M. and 10:31 A.M., observation of Resident #37's sacrum pressure ulcer treatment revealed Licensed Practical Nurse (LPN) #412, Registered Nurse (RN) #401 and State tested Nursing Assistant (STNA) #306 positioned the resident and removed the incontinence product. The incontinence product was saturated with dark yellow urine and pasty, dried stool was observed on the buttocks and around the wound edges. There was no dressing covering the Stage IV sacrum pressure ulcer. STNA #306 provided incontinence care and assisted with repositioning the resident without changing her gloves. LPN #412 cleansed the wound with wound cleaner resulting in a brown substance observed on the four by four gauze. The wound was packed as ordered, cream applied to periwound and covered with an ABD without the use of tape. STNA #306 secured the incontinence product and repositioned the resident's clothing and bed sheet with the same soiled gloves. STNA #306 then gathered the linens, removed her gloves and left the room without washing her hands. On 09/11/24 at 10:35 A.M., interview with LPN #412 and RN #401 verified the above observation. No information was provided as to why there was not a dressing in place as ordered at this time and both LPN #412 and RN #401 verified a dressing should have been in place. Review of the policy: Pressure Ulcers/Skin Breakdown - Clinical Protocol (revised March 2014) revealed the nursing staff and attending physician would assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). In addition, the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue; Pain assessment; Resident's mobility status; Current treatments, including support surfaces; and all active diagnoses. This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00156965.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365485	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure oxygen tanks were safely transported. This affected two residents (#57 and #89) observed with oxygen. The facility identified 13 residents utilized oxygen. Findings include: 1. Medical record review revealed Resident #57 was admitted on [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease and dependence on supplemental oxygen. Review of the electronic Physician Orders dated September 2024 revealed continuous oxygen 2 liters via nasal cannula (L/NC). On 09/03/24 at 11:52 A.M., observation revealed State tested Nurse Aide (STNA) #416 was in the lobby area across from the nurses' station and was assisting Resident #57. STNA #416 was observed removing the oxygen regulator from an empty oxygen tank, applied the regulator to a new oxygen tank, applied the nasal cannula set on Resident #57, placed the full oxygen tank into a wheeled oxygen carrier, wedged the carrier between the push handle and the lower metal frame. STNA #416 was then observed transporting Resident #57 to the dining room. On 09/03/24 at 11:57 A.M., interview with Licensed Practical Nurse (LPN) #612 verified the resident's oxygen was not transported safely. 2. Medical record review revealed Resident #89 was admitted on with diagnoses including end stage renal disease, anxiety and chronic obstructive pulmonary disease. Review of the monthly Physician Orders dated September 2024 revealed Resident #89 was ordered continuous oxygen at 4 liters via nasal cannula. On 09/03/24 at 1:05 P.M., observation revealed Resident #89 was being transported from the lobby to her room with an oxygen tank in a rolling two wheel oxygen tank cylinder cart carrier was wedged between the geri-chair push handle and the lower metal frame of the reclining geri-chair. The oxygen tank was not secured during the transport. On 09/03/24 at 1:09 P.M., interview with LPN #612 verified the above observation. Review of the policy: Oxygen Administration (revised 04/30/24) revealed guidelines for safe oxygen administration included ensuring the oxygen tank was securely fastened. This deficiency represents incidental non-compliance during the investigation of Master Complaint Number OH00156965.

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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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on closed medical record review, policy review and interview, the facility failed to prevent a severe weight loss for Resident #2, a resident who received all nutrition via enteral feedings. This affected one resident (#2) of three residents reviewed for nutrition. The census was 72. Actual Harm occurred on 08/03/24 when Resident #2 was assessed to sustain a 10.55% weight loss (with the weight loss occurring between 07/30/24 and 08/03/24). The dietician was not notified and no new nutritional interventions were implemented. The resident continued to lose weight resulting in a 13.8% severe weight loss within 30 days of admission. Findings include: Closed medical record review revealed Resident #2 was admitted on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, atrial fibrillation, total colectomy, gastrostomy, acute kidney failure, hemodialysis and protein-calorie malnutrition. Review of the care plan titled At Nutritional Risk secondary to nothing by mouth (NPO)-tube feeding, hemodialysis treatment, body mass index (BMI) reflects underweight status and use of antibiotics, severe esophageal stricture and ascites (revised 07/19/24) revealed goals including the resident would maintain weight near dry weight and maintain fluid balance and skin integrity through next review on 11/06/24. Interventions included monitor/record/report to physician as needed (PRN) signs/symptoms of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Monitor intake, weight, skin, labs, medication, diet tolerance and hydration status. Weigh at same time of day and record: pre/post hemodialysis weights. Review of the record revealed no evidence the care plan was revised to reflect changes in dialysis and weight loss. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact for daily decision-making, received nutrition 51% or more from a feeding tube, weighed 123 pounds and was 71 inches tall. Review of Resident #2's electronic Physician Orders, Medication Administration Records, Progress Notes and Weights revealed the following: Between 07/17/24 and 07/24/24, the resident received the enteral feeding product, Nepro (therapeutic nutrition designed to help meet the specific nutrition needs of people on dialysis) 55 milliliters per hour (mL/hr) continuous via enteral feeding and his weights ranged between 115.8 pounds (lbs) and 119.9 (lbs). Between 07/24/24 and 07/30/24, the resident received Nepro 60 mL/hr for 18 hours a day via enteral feeding to provide a rest during dialysis treatments and his weights ranged between 119.9 (lbs) and 126.1 (lbs) on 07/30/24. Prostat (nutritional supplement) 30 mL three times a day was started on 07/29/24. Physician #922 ordered Resident #2's dialysis to be held between 07/30/24 through 08/02/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER: Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 1450 West Main Street Newark, OH 43055	

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/03/24, the resident weight was 112.8 (lbs) and he continued to receive Nepro 60 mL/hr for 18 hours a day via enteral feeding with no new interventions implemented. This was noted to be a 13.3 pound/10.55% weight loss between 07/29/24 and 08/03/24. There was no evidence a re-weight was obtained for accuracy or that the physician or dietician were notified at this time. On 08/05/24, Physician #922 ordered Resident #2's dialysis to be discontinued due to improved kidney function. Review of the care plan: Requires Tube Feeding related to Dysphagia (dated 08/09/24) revealed the resident was dependent with tube feeding and water flushes. The registered dietitian was to evaluate quarterly and PRN. Monitor caloric intake, estimate needs, and make recommendations for changes to tube feeding as needed. The next documented weight was obtained on 08/13/24 and Resident #2 weighed 102.4 (lbs). This reflected an additional 10.4 pound weight loss for the resident from 08/03/24. The resident continued to receive Nepro 60 mL/hr for 18 hours a day via enteral feeding. Review of Assistant Director of Nursing (ADON) #350's progress note dated 08/13/24 revealed fluctuations in weight and weight loss noted when initiated weighing with different scale. The note indicated to check weights daily for three consecutive days. No new nutritional interventions were implemented at this time. On 08/14/24, the resident's weight was 99.8 (lbs). A significant weight loss of 13 (lbs) /11.5% in 11 days which constituted a severe weight loss of 13.8% over 30 days/admission weight was identified. Registered Dietitian #924 recommended to increase Nepro 60 mL/hr to 20 hours for a total volume of 1200 mL to infuse and provide 2160 kcal, 97.2 grams of protein and 872 mL of water. Recommendation was also made to increase flush to 100 mL every six hours and monitor weights daily. On 08/15/24, the resident's weight was 101.6 (lbs) and on 08/16/24 his weight was 100.0 (lbs). Resident #2 continued to receive Nepro 60 mL/hr for 18 hours a day via enteral feeding until the morning of 08/16/24. There was no evidence Registered Dietitian #924's recommendations were implemented between 08/14/24 until the morning of 08/16/24. Review of the discharge MDS 3.0 assessment dated [DATE] revealed the resident weighed 100 pounds and received nutrition 51% or more from a feeding tube. Review of a progress note dated 08/16/24 at 5:58 P.M. revealed NP #912 ordered Resident #2 to be sent to the emergency room for evaluation due to lab results and weight loss. The resident was admitted to the hospital and remained in the hospital at the time of the current survey. On 09/05/24 between 2:04 P.M. and 2:45 P.M., interview with the Director of Nursing (DON) verified Resident #2 had a severe weight loss while residing in the facility and receiving nutrition via enteral tube feedings. The DON verified the facility had not implemented interventions to address the weight loss identified on 08/03/24 until 08/16/24 as the dietitian's recommendation to increase the enteral feeding an additional two hours a day was not implemented as recommended on 08/14/24. The DON stated the dietitian was in the facility twice a week and reviewed all weights at that time; therefore, staff does not call or provide written notification to the dietitian with weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 09/10/24, the DON provided, via electronic interview, a statement from Nurse Practitioner #912 dated 08/14/24 stating Resident #2 has experienced a significant weight loss of greater than 20 (lbs) in the last two to three weeks, despite being on an enteral feedings and his daily caloric intake being followed by RD (registered dietitian). Patient with documented severe esophageal stricture. Patient then underwent colectomy and diverting ileostomy on 05/14/24 and was started on enteral feedings. Prior to those procedures, the patient had a documented weight loss of greater than 100 (lbs). Due to apparent malabsorption issues, chronic adult failure to thrive/protein-calorie malnutrition, and other co-morbidities, including end stage renal disease on hemodialysis, and chronic leukocytosis the nurse practitioner indicated weight loss may be unavoidable. On 09/11/24 between 3:05 P.M. and 3:15 P.M., interview with Registered Dietitian (RD) #924 revealed she reviews all high risk residents including dialysis residents. RD #924 revealed Diet Tech #928 was actually in the facility twice a week and notifies her of weight changes, but she still expected the facility to notify her and not wait until Diet Tech #928 was in the building. RD #924 stated she worked remotely and it was her expectation that weights and documentation was put in the electronic medical record timely so she had the most-up-to date information when completing her assessments to make appropriate recommendations. RD #924 stated the facility did not notify her of any weight loss involving Resident #2 until 08/14/24 due to weights not being entered (electronically). RD #924 also revealed no one had informed her Resident #2's dialysis had been discontinued on 08/05/24 stating she had called the resident's son on 08/14/24 to inform him of possible weight fluctuations with dialysis and he (the son) informed her Resident #2 was no longer receiving dialysis. RD #924 verified Resident #2 had GI malabsorption nutrition problems and having the tube feeding continuous at the lower rate could have resulted in a better tolerance, as his weights were stable during the first part of his stay but the facility failed to notify her of this and if the facility would have notified her of his weight changes, even when they thought it was possibly equipment error, she could have implemented additional interventions. RD #924 stated it was her expectation that staff implement her orders timely especially as she notifies three managers in writing when recommendations were made. RD #924 verified the facility failed to timely implement her recommendations and notify her of significant changes in treatment and weights. Review of the policy: Weight Assessment and Intervention (revised 10/06/22) revealed resident weights were monitored for undesirable or unintended weight loss or gain. Any weight change of 5% or more since the last weight assessment was retaken the next day for confirmation. If the weight was verified, nursing would immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian would review the unit weight record monthly to follow individual weight trends over time. This deficiency represents non-compliance investigated under Complaint Number OH00156965.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on closed medical record review, policy review, and interview, the facility failed to implement enteral feeding recommendations timely. This affected one resident (#2) of three residents reviewed for enteral feedings. The facility identified 13 residents who received nothing by mouth. The census was 72. Findings include: Closed medical record review revealed Resident #2 was admitted on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, atrial fibrillation, total colectomy, gastrostomy, acute kidney failure with tubular, hemodialysis and protein-calorie malnutrition. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact for daily decision-making, received nutrition 51% or more from a feeding tube, weighed 123 pounds and was 71 inches tall. Review of the discharge MDS 3.0 assessment dated [DATE] revealed the resident weighed 100 pounds and received nutrition 51% or more from a feeding tube. On 08/14/24, the resident weight was 99.8 (lbs). A significant weight loss of 13 (lb) /11.5% in 11 days and significant weight loss of 13.8% over 30 days/admission weight was identified. Registered Dietitian #924 recommended to increase Nepro 60 mL/hr to 20 hours for a total volume of 1200 mL to infuse and provide 2160 kcal, 97.2 grams of protein and 872 mL of water. Recommendation was also make to increase flush to 100 mL every six hours and monitor weights daily. On 08/15/24, the resident weight was 101.6 (lbs) and on 08/16/24 his weight was 100.0 (lbs). Resident #37 continued to receive Nepro 60 mL/hr for 18 hours a day via enteral feeding until the morning of 08/16/24. There was no evidence Registered Dietitian #924's recommendations were implemented between 08/14/24 until the morning of 08/16/24. Review of the care plan: At Nutritional Risk secondary to NPO-tube feeding, hemodialysis treatment, BMI reflects underweight status and use of antibiotics, severe esophageal stricture and ascites (revised 07/19/24) revealed goals including the resident will maintain weight near dry weight and maintain fluid balance and skin integrity through next review on 11/06/24. Interventions included monitor/record/report to physician PRN signs/symptoms of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Monitor intake, weight, skin, labs, medication, diet tolerance and hydration status. Weigh at same time of day and record: pre/post hemodialysis weights. Review of the record revealed no evidence the care plan was revised to reflect changes in dialysis and weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER: Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan: Requires Tube Feeding related to Dysphagia (dated 08/09/24) revealed the resident was dependent with tube feeding and water flushes. The registered dietitian was to evaluate quarterly and PRN (as needed). Monitor caloric intake, estimate needs, and make recommendations for changes to tube feeding as needed. On 09/05/24 between 2:04 P.M. and 2:45 P.M., interview with the director of nursing (DON) verified the resident had a severe weight loss while received nutrition via enteral tube feedings, there were no new interventions implemented after 07/30/24 until 08/16/24 as the dietitian's recommendation to increase the enteral feeding an additional two hours a day was not implemented as recommended on 08/14/24. The DON stated the dietitian was in the facility twice a week and reviewed all weights at that time; therefore, staff does not call or provide written notification to the dietitian with weight loss. On 09/10/24, the DON provided, via electronic interview, a statement from Nurse Practitioner (NP) #912 dated 08/14/24 stating Resident #2 has experienced a significant weight loss of greater than 20 (lbs) in the last two to three weeks, despite being on an enteral feedings and his daily caloric intake being followed by registered dietitian (RD). Patient (Pt) with documented severe esophageal stricture. Patient then underwent colectomy and diverting ileostomy on 5/14/24 and was started on enteral feedings. Prior to those procedures, the patient had a documented weight loss of greater than 100 (lbs). Due to apparent malabsorption issues, chronic adult failure to thrive/protein-calorie malnutrition, and other co-morbidities, including end stage renal disease on hemodialysis, and chronic leukocytosis; Weight loss may be unavoidable. On 09/11/24 between 3:05 P.M. and 3:15 P.M., interview with Registered Dietitian (RD) #924 revealed she reviews all high risk residents including dialysis residents. Diet Tech #928 was actually in the facility twice a week and notifies her of weight changes, but she still expects the facility to notify her and not wait until Diet Tech #928 was in the building. RD #924 stated she works remotely and it is her expectation that weights and documentation was put in the electronic medical record timely so she has the most-up-to date information when completing her assessments to make appropriate recommendations. RD #924 stated the facility did not notify her of any weight loss involving Resident #2 until 08/14/24 due to weights had not been entered. Also, no one had informed her that Resident #2's dialysis had been discontinued on 08/05/24 stating she had called the resident's son on 08/14/24 to inform him of possible weight fluctuations with dialysis when he informed her that Resident #2 was no longer receiving dialysis. RD #924 verified Resident #2 had GI malabsorption nutrition problems and having the tube feeding continuous at the lower rate could have resulted in a better tolerance, as his weights were stable during the first part of his stay but the facility failed to notify her of this and if the facility would have notified her of his weight changes, even when they thought it was possibly equipment error, she could have implemented additional interventions. RD #924 stated it was her expectation that staff implement her orders timely especially as she notifies three managers in writing when recommendations were made. RD #924 verified the facility failed to timely implement her recommendations and notify her of significant changes in treatment and weights. Review of the policy: Weight Assessment and Intervention (revised 10/06/22) revealed resident weights are monitored for undesirable or unintended weight loss or gain. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00156965.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure residents received oxygen per physician orders. This affected one resident (#57). The facility identified 13 residents that were ordered to receive oxygen. The census was 72. Findings include: Medical record review revealed Resident #57 was admitted on [DATE] with diagnoses including unspecified dementia, chronic obstructive pulmonary disease and dependence on supplemental oxygen. Review of the electronic Physician Orders dated September 2024 revealed continuous oxygen 2 liters via nasal cannula (L/NC). a. On 09/03/24 at 11:52 A.M., observation revealed State tested Nurse Aide (STNA) #416 was in the lobby area across from the nurses' station and was assisting Resident #57. STNA #416 was observed removing the oxygen regulator from an empty oxygen tank, applied the regulator to a new oxygen tank, applied the nasal cannula set on Resident #57 and set the oxygen level to be administered to the resident. On 09/03/24 at 11:57 A.M., observation revealed Resident #57's oxygen was set to 3 L/NC. On 09/03/24 at 11:58 A.M., interview with Licensed Practical Nurse (LPN) #612 verified STNA #416 had set the flow rate of oxygen to 3 L/NC and Resident #57 was ordered to receive 2 L/NC. On 09/04/24 at 1:57 P.M., interview with the Director of Nursing verified a nurse should change oxygen tanks and set oxygen flow rate. b. On 09/11/24 at approximately 10:00 A.M., Resident #57 was observed sitting in a specialty wheelchair in the lobby watching television. No oxygen was observed on or near the resident. On 09/11/24 at 10:39 A.M., observation revealed Resident #57 continued sitting in the lobby watching television and was not wearing oxygen. Surveyor asked Medical Records #345 if Resident #57 was still ordered to receive oxygen. Medical Records #345 looked at the electronic orders and verified the resident should be wearing oxygen at 2L/NC, the resident was not wearing oxygen and she would notify the nurse. On 09/11/24 at 10:47 A.M., Registered Nurse (RN) #401 was observed pushing an oxygen concentrator down the hallway to the lobby area, RN #401 attempted to obtain an oxygenation level for approximately one minute and could not get a reading. RN #401 verified the pulse ox machine was functioning when she applied it to herself; however, when applied to the resident, an oxygenation level could not be obtained. Resident #57 was alert and conversing with RN#401 during the observation and RN #401 applied supplemental oxygen at 2L/NC to Resident #57. At 10:52 A.M., RN #401 was provided a different pulse ox machine and the resident's oxygenation level was 100% while receiving oxygen at a flow rate of 2L/NC. Review of the policy: Oxygen Administration (dated 04/30/24) revealed the physician's orders were to be reviewed for oxygen administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents incidental non-compliance during the investigation of Master Complaint Number OH00156965.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure Resident #37 was comprehensively assessed for pain and failed to develop an individualized pain management program to timely identify and prevent pain associated with the resident's pressure ulcers. This affected one resident (#37) of one resident reviewed for pain management. The census was 72. Actual Harm occurred on 09/05/24 when Resident #37 was observed yelling and moaning during pressure ulcer (wound) care. There was no evidence the facility identified the yelling/moaning was related to pain associated with the pressure ulcers and/or wound care and no evidence the facility provided any type of pain medication prior to the dressing change which included treatment of a Stage IV (defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure ulcer. Findings include: Medical record review revealed Resident #37 was admitted on [DATE] with diagnoses including moderate intellectual disability, schizoaffective disorder, multiple pressure ulcers and anxiety. Review of the Nursing Admission/Re-admission Assessment - V 4 dated 08/31/24 revealed Resident #37 was not able to verbalize pain and was assessed for pain or possible pain by assessing negative vocalization, facial expressions, body language and consolability. Record review revealed from 08/31/24 through 09/04/24 there were no additional pain assessments or documentation addressing pain for Resident #37. There was no baseline plan of care developed for Resident #37 related to pain including pain associated with pressure ulcers. On 09/05/24 at 9:45 A.M., a resident could be heard yelling and moaning. As the surveyor approached Resident #37's room, the moaning and yelling was louder. There was a treatment cart observed outside of the resident's room and State tested Nursing Assistant (STNA) #621 stated the nurse and nurse practitioner (NP) were in the resident's room doing a wound treatment. Resident #37 could be heard yelling and moaning as Assistant Director of Nursing (ADON) #350 was observed exiting the room. ADON #350 stated NP #908 was completing an initial assessment and treatment of the resident's Stage IV sacrum pressure ulcer and heels. ADON #350 was asked if Resident #37 had been pre-medicated (prior to the pressure ulcer wound assessment and treatment) and stated she would have to check because that would have been given by a different nurse. NP #908 exited the room at that time and ADON #350 asked if the resident had been pre-medicated. NP #908 stated I don't know, that was the facility responsibility and returned to the resident's bedside and finished the treatment. ADON #350 reviewed the electronic medication administration record and verified there was no pain assessment prior to the treatment, no pain medication was administered prior to the treatment, and when the resident was screaming and moaning ADON #350 and NP #908 did not intervene to address the resident's pain and finished the treatment. An attempt to interview the resident following the observation was unsuccessful as the resident was not interviewable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the electronic record revealed Resident #37 was ordered as needed (PRN) Tylenol 650 milligrams every four hours for mild pain. There was no evidence the resident had received any PRN Tylenol or non-pharmacological pain interventions on 09/05/24. There was no other scheduled or PRN pain medication ordered for Resident #37. Review of ADON #350's progress note dated 09/05/24 at 2:30 P.M. revealed Resident #37 was assessed due to being a new admission with wounds (pressure ulcers) including a sacrum Stage IV, left and right heels deep tissue injury (DTI) and left lateral foot DTI. The note included, Resident #37 was without complaints or signs of pain when initiated assessment. Resident began yelling with wound care, states I want to go to bed, resident reassured she was in bed, no complaints or signs of pain, continues to yell and strikes out at NP. Resident #37 with frequent yelling out and at times striking out with care. On 09/05/24 at 10:45 A.M., interview with the Director of Nursing (DON) revealed it was not the usual practice of the facility not to medicate prior to doing a pressure ulcer dressing change. The DON stated it was her expectation if a resident complained or exhibited signs of pain, the resident should be assessed and then treated for pain. Review of the physician order dated 09/05/24 revealed a new order for Resident #37 to receive Klonopin one milligram twice a day for anxiety on this date. Review of Resident #37's electronic Medication Administration Record (MAR) dated 09/11/24 revealed Klonopin (anxiolytic) 1 milligrams (mg) was administered at 8:00 A.M. and Tylenol 325 (mg) two tablets was administered at 9:25 A.M. PRN for pain. On 09/11/24 between 10:09 A.M. and 10:31 A.M., following the administration of the pain medication, observation of Resident #37's pressure ulcer dressing changes revealed no signs or symptoms of pain and no yelling and moaning was heard throughout the treatments to the resident's four pressure ulcers. Review of the policy: Pain- Clinical Protocol (dated June 2013) revealed staff and the physician would identify the nature of (characteristics such as location, intensity, frequency, pat tern, etc.) and severity of pain. Staff would assess pain using a consistent approach and a standardized pain assessment instrument ap propriate to the resident's cognitive level. The staff would observe the resident (during rest and movement) for evidence of pain; for example, grimacing while being repositioned or having a wound dressing changed. The nursing staff would identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning. With input from the resident and/or advocate, the physician and staff would establish goals of pain treatment and order appropriate non-pharmacologic and medication interventions to address the individual's pain. This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00156965.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365485	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 28704 Based on observation, dietary meal card review, and interview, the facility failed to provide ordered serving size and ensure whole milk was available for the breakfast meal. This affected seven residents (#19, #28, #41, #54, #71, #73 and #83) who were to receive whole milk and had the potential to affect any resident receiving meals from the kitchen except for seven residents (#17, #23, #67, #74, #78, #84 and #86) who did not receive anything by mouth. The census was 72. Findings include: Review of the Menu Extension dated 09/04/24 revealed breakfast meal included hot or cold cereal, juice, eight ounce glass of whole or 2% milk, six ounces of juice, four ounces of breakfast casserole (scrambled eggs with peppers) and a slice of toast. Review of the breakfast Dietary Meal Cards for Resident #19, #28, #41, #54, #71, #73 and #83 revealed daily items included whole milk. On 09/04/24 at 7:20 A.M., observation of the milk cooler revealed no whole milk was available for the breakfast meal. On 09/04/24 at 7:34 A.M., observation of the breakfast meal trayline service revealed [NAME] #309 was serving breakfast casserole with a spoodle. At the time of the above observation, [NAME] #309 verified she was using a three ounce spoodle to serve the breakfast casserole and stated whole milk was not available for the breakfast meal. Dietary Aide #320 was observed placing a single serving carton of 2% milk on resident breakfast trays. At the time of the above observation, Dietary Aide #320 stated there was currently no whole milk in the facility because they had ran out the previous day due to the observed holiday. Dietary Aide #320 stated the milk was to be delivered to the facility this afternoon and everyone who was ordered whole milk was being provided 2% milk for breakfast. This deficiency represents non-compliance investigated under Complaint Number OH00156069.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Flint Ridge Nrsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 West Main Street Newark, OH 43055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 28704 Based on observation, policy review and interview, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect all residents except seven residents (#17, #23, #67, #74, #78, #84 and #86) who did not receive anything by mouth. The census was 72. Findings include: 1. On 09/04/24 between 7:06 A.M. and 7:20 A.M., observation of the kitchen with [NAME] #309 verified the following: a. The stove hood above the steamer and six burner stove and flat top had large loose, flaking paint with exposed rust extending the length of metal and in the corner/creases of the hood. b. Dust tendrils were observed blowing from the diamond shaped grating on both sides of the stove hood over the steamer and flat top. Heavy dust and grease build up was observed on top of the stove hood, along the electrical outlet boxes and wire guards adjacent to the stove and behind the dishwasher storage racks containing clean dishes ready for meal service. c. Dust and grease build up was observed on the exhaust fans above the trayline service area. 2. On 09/04/24 at 1:13 P.M., observation of the kitchen with Dietary Manager #415 verified the following: a. The face plate covering the gasline was loose and hanging down. b. The lower front panel of the six burner stove was bent creating a one-half gab to the underlying electrical and service wires. c. The knobs on the griddle were installed backwards, the gas flame was unsymmetrical and the left front half of the griddle would not light. A warning sticker was observed on the lower front panel of the six burner stove stating improper installation, adjustment, alteration service or maintenance can cause property damage, injury or death. On 09/04/24 between 3:05 P.M. and 3:14 P.M., interview with Regional Maintenance Assistant #920 verified the kitchen should be clean, the stove hood was in poor condition and requested an estimate for a new hood. On 09/05/24 at 3:54 P.M., interview with Dietary Manager #415 verified the facility did not have a policy regarding cleanliness of the kitchen. This deficiency represents non-compliance investigated under Complaint Number OH00156069.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, policy review and interview, the facility failed to maintain accurate medical records. This affected three residents (#2, #28, and #37) of five sampled residents. The census was 72. Findings include: 1. Medical record review revealed Resident #37 was admitted on [DATE] with diagnoses including moderate intellectual disability, acute respiratory failure and wounds. Review of the specialty hospital Wound Progress Notes dated 08/27/24 revealed Resident #37 had a left heel/calcaneus deep tissue pressure injury (DTPI). The wound measured 0.2 centimeters (cm) in length (l) by 1.8 (cm) in width (w). There was no depth documented. Review of the Nursing Admission/Re-admission Assessment - V 4 dated 08/31/24 revealed Resident #37 had the following skin impairments: a. Left inner ankle pressure ulcer measuring 1.0 (cm) in (l) by 0.3 (cm) in (w) by zero depth(d). No stage was documented. b. Right heel pressure ulcer measuring 2.0 (cm) in (l) by 1.5 (cm) in (w) by zero (d). No stage was documented. c. Vascular sacrum ulcer measuring 5.2 (cm) in (l) by 4.7 (cm) in (w) by 0.6 (cm) in (d). The wound was assessed to be a stage IV vascular ulcer. Review of the record revealed no documented evidence Resident #37's left heel DTPI was documented between admission and 09/03/24. On 09/05/24 at 10:40 A.M., interview with the Director of Nursing (DON) verified the sacrum ulcer was inaccurately assessed upon admission and was a pressure ulcer. The DON also verified there was no staging of the left inner ankle or right heel pressure ulcers upon admission. On 09/11/24 at 11:03 A.M., interview with the DON verified there was no additional information to provide regarding Resident #37's pressure ulcers and the left heel DTPI was not assessed or documented at the time of admission. 2. Medical record review revealed Resident #2 was admitted on [DATE] with diagnoses including severe esophageal stricture, tracheostomy, signoid ostomy, iliostomy, hypertension and acute kidney injury. a. Review of the nutritional review: Progress Notes *NEW* dated 07/19/24 revealed current body weight on 07/17/24 was 115.8 pounds (lb). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutrition/Hydration Status (Dietitian) assessment dated [DATE] revealed Resident #2's diet was nothing by mouth, received enteral tube feeding and had a current body weight of 115.8 pounds (lb) with a body mass index (BMI) of 16.1 indicating underweight. Plan included to monitor weights and continue to coordinate nutritional plan. Review of the Weight Summary dated 07/26/24 revealed a dialysis dry post weight of 126.1 (lb). On 09/05/24 at 4:30 P.M., interview with the DON verified the Nutrition/Hydration Status (Dietitian) assessment dated [DATE] did not reflect Resident #2's current body weight. b. Review of the Progress Note dated 08/13/24 revealed fluctuations in weight was noted and weight loss was noted when initiated weighing with different scale. Nurse practitioner updated and to check daily weight for three consecutive days. On 09/11/24 at 10:05 A.M., interview with the DON verified the difference in weight was an actual weight loss and not the scale and the facility had started education as of 09/09/24 to address the variance in scales. 3. Medical record review revealed Resident #28 was admitted on on 04/13/23 with diagnoses including cerebral infarction, and neuromuscular dysfunction of bladder, urinary retention, and cystostomy. Review of the Physician Standard Written Order (SWO)- Urinary Catheter dated 06/04/24 and signed by the physician on 08/08/24 revealed the resident was to have a standard 22 French (Fr) catheter with a 10 milliliter (mL) balloon. Review of the Order Summary Report dated 09/05/24 included urology to change the suprapubic catheter once a month on the first and ending on the first every month and as needed, suprapubic catheter 22Fr/10 (mL) balloon due to neurogenic bladder, and change suprapubic catheter 22 French 5 (mL) for leakage or blockage as needed. Review of the Treatment Administration Record dated July, August and September 2024 revealed urology changed the suprapubic catheter on the first day of every month including 09/01/24 which was a Sunday. Review of the care plan: Indwelling Suprapubic Catheter: Neurogenic bladder dated 04/24/23 revealed the resident was to use a 22 Fr/10 cc balloon suprapubic catheter due to neurogenic bladder. Review of an intervention dated 08/05/24 revealed the catheter site was to be changed every shift and changed as needed with a 22 Fr/5 cc balloon. On 09/05/24 at 4:10 P.M., interview with the DON verified the urologist was not changing the suprapubic catheter on the first of every month and prior to today the physician order for the catheter was a 22 Fr/10cc balloon. The care plan had two different balloon sizes for the suprapubic catheter and this needed to be clarified with the physician. Review of the undated policy: Charting and Documentation revealed documentation in the medical record will be objective, complete and accurate. (continued on next page)

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	365485	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flint Ridge Nrsg & Rehab Ctr	1450 West Main Street Newark, OH 43055

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00156965.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure infection protocols were implemented when facility staff failed to ensure gloving and hand washing was completed during incontinence care and indwelling catheter supplies were maintained off the floor. This affected two residents (#28, #37). The census was 72. Findings include: 1. Medical record review revealed Resident #37 was admitted on [DATE] with diagnoses including moderate intellectual disability, schizoaffective disorder, multiple pressure ulcers and anxiety. On 09/11/24 between 10:09 A.M. and 10:31 A.M., observation of Resident #37's sacrum pressure ulcer treatment revealed Licensed Practical Nurse (LPN) #412, Registered Nurse (RN) #401 and State tested Nurse Aide (STNA) #306 positioned the resident and removed the incontinence product. The incontinence product was saturated with dark yellow urine and pasty, dried stool was observed on the buttocks and around the wound edges. There was no dressing covering the Stage IV sacrum pressure ulcer. STNA #306 provided incontinence care and assisted with repositioning turning the resident without changing her gloves. LPN #412 cleansed the wound with wound cleaner resulting in a brown substance observed on the 4x4 gauze. The wound was packed with 1/4 strength dakin's soaked gauze and placed in the wound bed, cream applied to periwound and covered with an ABD without the use of tape. STNA #306 secured the incontinence product and repositioned the resident's clothing and bedsheet with the same soiled gloves. STNA #306 then gathered the linens, removed her gloves and left the room without washing her hands. On 09/11/24 at 10:35 A.M., interview with LPN #412 and RN #401 verified the above observations. Review of the policy: Handwashing/Hand Hygiene (revised October 2023) revealed had hygiene was indicated before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene. Review of the policy: Perineal Care (revised October 2010) revealed perineal care will provide comfort and cleanliness and prevent infection. After completion of perineal care, disposable items was to be disposed of, gloves removed and discarded, hands washed thoroughly and then the resident was to be repositioned including bed covers to make comfortable. 2. Medical record review revealed Resident #28 was admitted on on 04/13/23 with diagnoses including cerebral infarction, history of urinary tract infection, neuromuscular dysfunction of bladder, urinary retention, and cystostomy. Review of the Order Summary Report dated 09/05/24 included a suprapubic catheter 22 French/10 mL due to neurogenic bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 1:03 P.M., observation revealed Resident #28 was in her wheelchair in her room speaking with Activity Aide (AA) #624 and a family member. At the time of the observation, Resident #28's urinary catheter bag and tubing were observed dragging across the floor as the resident self-propelled her wheelchair. On 09/11/24 at 1:04 P.M., interview with AA #624 verified the above observation and stated she would find a nurse. STNA #358 entered the room and verified the tubing and catheter bag were dragging across the floor and raised and secured the catheter tubing and bag to prevent it from touching the floor. Review of the policy: Catheter Care, Urinary (revised September 2014) revealed infection control parameters included to be sure the catheter tubing and drainage bag were kept off the floor. This deficiency represents non-compliance investigated under Complaint Number OH00156069.