STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Bethesda Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 N Brush St Fremont, OH 43420	

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, resident interview, staff interview medical record review and review of facility policy, the facility failed to ensure resident preferences of room temperatures were honored. This affected two (#39 and #40) of three residents reviewed for choices. The facility census was 68. Findings Include: 1. Review of Resident #39's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes, emphysema, chronic obstructive pulmonary disease, morbid obesity, and depression. Review of Resident #39's Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #39 was cognitively intact. Resident #39 required limited assistance for transfers and two person physical assistance with toilet use. Resident #39 displayed no behaviors during the review period. Review of Resident #39's care plan, revised 05/09/24, revealed support and interventions for self-care deficit, altered nutrition, discharge plan for a short term stay, risk for falls and risk for altered psychosocial well-being. Interview on 05/28/24 at 9:36 A.M. with Resident #39 found her to be alert and oriented. Resident #39 reported it was too hot in her room and the dial on the wall did not control the temperature. Resident #39 stated the room was too hot and humid and when she asked for her room to be cooler she was told the law required the rooms to be maintained between 71 degrees Fahrenheit (F) and 81 F. Resident #39 stated 71 F was too warm for her and she wanted her room to be cooler, around 68 degrees. Coinciding observation of Resident #39's room found it to feel warmer than the temperature in the hallway. Interview on 05/28/24 at 1:41 P.M. with Maintenance Staff (MS) #573 verified residents were not able to control the temperatures of their room related to cooling. MS #573 reported the thermostats on the walls controlled the heat, but the cooling portion was controlled by an online temperature gauge for the whole building. MS #573 used a portable temperature gun and verified Resident #39's room was 74 F. 49742 (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365510	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Care Center	600 N Brush St Fremont, OH 43420

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included chronic diastolic (congestive) heart failure, type II diabetes mellitus with diabetic neuropathy, morbid (severe) obesity, unspecified osteoarthritis, restless leg syndrome, allergic rhinitis, other seborrheic dermatitis, chronic pain syndrome, hypertensive heart disease with heart failure, anxiety disorder, dependence on supplemental oxygen, encounter for palliative care, major depressive disorder and obstructive sleep apnea. Review of Resident #64's most recent BIMS assessment, dated 04/14/24, revealed Resident #40 was cognitively intact. Interview on 05/28/24 at 1:24 P.M. with Resident #40 found her to be alert and oriented. Resident #40 reported it was too hot for her in her room and she was not able to open her window or control the temperature. Resident #40 reported her oscillating fan was broken and no longer moved side to side, which did not help with the heat. She reported her hospice staff were working on getting her a new fan, but even with the fan, it was too hot in the room. Concurrent observation of the thermostat in the room found it was reading 77 F. Resident #40 reported she would not want it hotter than 68 F in her room. Interview on 05/28/24 at 1:31 P.M. with Hospice Aide (HA) #574 verified it was too hot and uncomfortable in Resident #40's room. HA #574 reported it had been mentioned to facility staff, but nothing had been done. HA #574 stated Resident #40's oxygen concentrator added heat to the room, as did keeping her door closed for privacy. HA #574 stated the fan was not effective in maintaining the room at Resident #40's preferred temperature and the window was not able to be opened. Interview on 05/28/24 at 1:36 P.M. with MS #573 verified residents were not able to control the temperatures of their room related to cooling. MS #573 verified the thermostat reading was 77 F in Resident #40's room. Observation of Resident #40's room temperature with MS #573 utilizing a portable thermometer gun revealed the resident's room was actually 79 degrees. MS #573 verified Resident #40's oxygen concentrator increased the temperature in the room and the window was not able to be opened. Review of the facility policy titled, Resident's [NAME] of Rights and Dignity Policy, revised 10/24/22 revealed the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted and maintained or enhanced their quality of life, recognizing each resident's individuality.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, observation, resident interview, staff interview and review of the facility and review of facility policy the facility failed to ensure appropriate and timely care and services to assist with hearing. This affected one (#53) of three residents reviewed for hearing. The facility census was 68. Findings include: Review of the medical record for Resident #53 revealed an admitted [DATE]. Diagnoses included dementia, type II diabetes mellitus, morbid obesity, depression and hypertension. Review of the annual Minimum Data Set (MDS) assessment, dated 04/11/24, revealed Resident #53 had moderate cognitive impairment, and had highly impaired hearing with no hearing aid use. Resident #53 was usually understood and usually understood others. Review of the care plan, dated 09/07/22, revealed Resident #53 had maximum hearing difficulty. Interventions included to ask yes and no questions, decrease background noise, face resident when speaking, repeat phrases resident misunderstood, allow time for the resident to respond, and to refer for audiology evaluation. An update to the care plan on 04/17/23 included to observe for changes in hearing. Review of the audiology group visit summary dated 04/18/24 revealed Resident #53 required post cerumen (build up of earwax) management with a recommendation for a medical consult due to what appeared to be an occluded right ear canal. Interview on 05/28/24 at 2:56 P.M. with Resident #53 verified he had difficulty hearing, with the resident stating he was hard of hearing while pointing to his right ear. Throughout the interview, Resident #53 leaned forward and turned his left ear in the direction of the surveyor in an attempt to hear what was being said. Observation on 05/29/24 at 8:40 A.M. of Resident #53, while conversing with Licensed Practical Nurse (LPN) #536, revealed the resident asked What? several times and leaned forward with his head turned so the left ear was pointed in the direction of LPN #536. Interview on 05/30/24 at 11:23 A.M. with Activities Director (AD) #501 revealed she scheduled residents to be seen by audiology and followed-up on any recommendations made during the appointment. AD #501 denied knowledge of the medical consult recommendation for an occluded right ear canal made by the audiology group on 04/18/24 for Resident #53. AD #501 verified the recommendation for the medical consult had not yet been carried out. Review of the undated facility policy titled Other Diagnostic Services, revealed the community will provide services to meet the needs of residents and is responsible for the quality and timeliness of the services.

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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** 47057 Based on medical record review, staff interview and review of facility policy, the facility failed to complete neurology checks on a resident with an unwitnessed fall per facility policy. This affected one (#29) of one resident reviewed for falls. The facility census was 68. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included right femur fracture. Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #29 was cognitively intact. Resident #29 had one fall since the last comprehensive assessment, resulting in no injury. Review of a nursing progress note, dated 05/23/24 at 7:15 A.M., revealed Resident #29 had an unwitnessed fall. Review of the current care plan revealed, following Resident #29's fall on 05/23/24, a new intervention was initiated to have the resident in the common area after she gets up for more supervision. Further review of the medical record revealed no evidence neurology checks were completed following Resident #29's unwitnessed fall on 05/23/24. Interview on 05/30/24 at 1:06 P.M. with the Director of Nursing (DON) verified the neurology checks were not completed following Resident #29's fall on 05/23/24. Follow-up interview on 05/30/24 at 2:57 P.M. with the DON revealed the facility policies did not specify when neurology checks should be completed. Review of the facility policy titled Neurologic Assessment, Long-Term Care, revised February 2024, revealed a focused neurological assessment is necessary after a fall if the resident may have sustained a head injury.

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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** 47057 Based on observation, staff interview, and policy review the facility failed to ensure portable oxygen tanks were sufficiently supplied with available oxygen for resident use. This affected one resident (#267) reviewed for oxygen use. The facility identified 12 residents who were on oxygen therapy. The facility census was 68. Findings include: Review of the medical record for Resident #267 revealed an admitted [DATE] with diagnoses of chronic respiratory failure and chronic obstructive pulmonary disease (COPD). Review of the admission Minimum Data Set (MDS) assessment, dated 05/10/24, revealed Resident #267 was cognitively impaired and required the use of oxygen. Review of the current physician orders revealed Resident #267 was ordered oxygen two to four liters per nasal cannula to maintain an oxygen reading of 90% or above. Review of the care plan, dated 05/06/24, revealed Resident #267 was care planned for respiratory disorders with chronic respiratory failure. Interventions included use of oxygen as ordered. Review of the Medication Administration Record (MAR) for May 2024 revealed oxygen saturation (measurement of appropriate oxygenation) ranged from 90% to 97% when receiving oxygen therapy per physician orders. Observation on 05/30/24 at 7:16 A.M. revealed Resident #267 sitting in common area with oxygen tubing applied via nasal cannula and the dial set at two liters of oxygen. Further observation revealed the portable tank gauge was on the red refill line, indicating no oxygen remained in the portable oxygen tank. Concurrent interview with the Director of Nursing (DON) verified the portable oxygen tank gauge was pointed to the red refill line and the portable oxygen tank was empty. Interview on 05/29/24 at 12:08 P.M. with Licensed Practical Nurse (LPN) #532 revealed Resident #267 preferred to be in the common area and all staff were to monitor the portable oxygen tank when they passed by. LPN #532 stated there are no alarms for portable oxygen tanks we all just must check it frequently. Review of the facility policy titled Oxygen Administration, long-term care revised 12/23 revealed oxygen tanks may need frequent replacement.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, observation, resident interview, staff interview and review of facility policy, the facility failed to maintain accurate physician orders and failed to accurately assess a dialysis access site. This affected one (#30) of one resident reviewed for dialysis. The facility identified six residents who received dialysis. The facility census was 68. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included end stage renal disease with a dependence on renal dialysis, type II diabetes mellitus, major depressive disorder, primary glaucoma left and right eyes, legal blindness, hyperparathyroidism and peripheral vascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was cognitively intact and received dialysis. Review of the care plan revealed Resident #30 had an alteration in health maintenance due to dialysis for end stage renal disease. Interventions included hemodialysis on Tuesday, Thursday, and Saturday, no blood draws from left arm, dialysis was responsible for blood draws unless otherwise directed, diet per physician order, fluid restriction 1800 milliliters (ml) in 24 hours, monitor intake and output each shift, weights per order, notify dialysis of all medication changes and observe vascular access for edema, drainage, redness. Review of the current physician orders revealed orders to collect dialysis binder from resident belongings upon return from dialysis and return the binder to the nurses station, check the binder to make sure there were no new orders from dialysis on dialysis days, complete pre and post dialysis data collection with each dialysis treatment, dialysis three times a week on Tuesday, Thursday and Saturday, fluid restriction of 1800 ml per 24 hours, check right upper extremity fistula twice a day for thrill and bruit, if thrill is not heard and bruit not felt the provider or dialysis was to be called, and no blood pressures in left arm for fistula each shift. Review of the Medication Administration Record (MAR) for May 2024 revealed nursing documented pre and post dialysis treatment communication and collection of the dialysis binder after each dialysis treatment for Resident #30. Review of the Treatment Administration Record (TAR) for May 2024 revealed Resident #30's left arm was not used for blood pressures, the thrill and bruit was checked each shift with documentation of both a thrill and bruit being present on 05/01/24 day shift, 05/10/24 on night shift and on both shifts on 05/14/24, 05/15/24, 05/16/24 and 05/17/24. Negative thrill and bruit documentation on all other dates and shifts except for 05/01/24 on nights, 05/08/24 and 05/09/24 where the thrill and bruit was marked non applicable and on 05/08/24 and 05/09/24 when the assessment of the thrill and bruit was not completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Vascular Surgery progress note, dated 08/07/23, revealed Resident #30 had a past history of upper extremity fistula and was currently receiving hemodialysis through a permacatheter (used for dialysis treatment) in the left chest area due to issues with blood flow in the left upper extremity. Further review of the medical record from 08/07/23 through 05/29/24 revealed no evidence of Resident #30 having a left upper chest permacatheter for dialysis. The record was absent of any documentation of care or monitoring of a left upper chest permacatheter. Interview on 05/29/24 at 4:36 P.M. with Resident #30 revealed dialysis was being completed from a catheter in the left upper chest. Resident #30 stated neither the left or right arm fistula worked, adding the right arm fistula got infected and his left arm swelled when the fistula was used and, therefore, was no longer used. Concurrent observation revealed Resident #30 had a catheter to the left upper chest with a clean, dry and undated dressing in place covering the insertion site of the catheter. The left and right extremity fistulas were non functioning and without either a thrill or bruit. Interview on 05/29/24 at 4:59 P.M. with the Director of Nursing (DON) verified Resident #30 had a permacatheter in the left upper chest and had been receiving dialysis through the catheter since at least August 2023. The DON confirmed the medical record for Resident #30 contained no information on the permacatheter and further verified there were no physician orders to address the care and management of the permacatheter. The DON also verified the charting of the right upper extremity fistula being checked each shift for a thrill and bruit with no physician notification completed when a thrill could not be felt and bruit could not be heard as ordered Interview on 05/29/24 at 5:00 P.M. with Licensed Practical Nurse (LPN) #536 verified Resident #30 has a fistula in the left upper extremity, which was checked for thrill and bruit each shift. LPN #536 was unaware Resident #30 had a dialysis catheter in the left upper chest. Review of the undated facility policy titled Dialysis Program Guidelines revealed the purpose included providing quality care and treatment services to residents requiring dialysis including having a care plan to address the care of the access site including monitoring for infection and bleeding. Additionally, nursing was responsible for communication and coordination of care with each dialysis treatment including monitoring for complications post dialysis by assessing access sites, monitoring dressing and assessing for bleeding.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 37451 Based on employee file review, staff interview and review of facility policy, the facility failed to ensure State tested Nursing Assistants (STNAs) had evaluations completed as required. This had the potential to affect all 68 residents residing in the facility. The facility census was 68. Findings Include: Review of the employee file for State tested Nursing Assistant (STNA) #555 revealed a hire date of 11/11/22. No annual performance evaluations were found. Review of the employee file for STNA #557 revealed a hire date of 12/18/23. A 90 day performance evaluation was not found. Interview on 05/30/24 at 8:57 A.M. with the Administrator verified State tested Nursing Assistant (STNA) #555 did not have an annual evaluation completed and STNA #557 did not have her 90 day evaluation completed. He stated he would have the Director of Nursing (DON) follow-up to make sure the evaluations were not somewhere else and not yet put into the file. Interview on 05/30/24 at 1:28 P.M. with the DON verified the evaluations for STNAs #555 and #557 were not completed. Review of the facility policy titled Performance Review Guidelines, revised 07/01/12, revealed employee performance evaluations for all non-exempt staff would be reviewed prior to the 90th day of employment and annually.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, observations, staff interview and review of the facility policy, the facility failed to ensure timely psychiatric follow-up for a resident experiencing an exacerbation of mood symptoms. This affected one (#33) of one residents reviewed for behavioral services. The facility census was 68. Findings include: Review of the medical record for Resident #33 revealed an original admitted [DATE] and a readmitted [DATE]. Diagnoses included Parkinson's disease, dementia, morbid obesity, delusional disorders, heart failure, major depressive disorder, anxiety disorder, visual hallucinations, bipolar affective disorder and bipolar II disorder. Review of the annual Minimum Data Set (MDS) assessment, dated 04/23/24, revealed Resident #33 was cognitively intact with no functional impairment with a walker and wheelchair used for mobility. Resident #33 was independent with eating, oral care, and toilet hygiene, moderate assistance with bathing and personal hygiene, and maximal assistance with dressing. Active diagnosis included non Alzheimer's dementia, Alzheimer's, anxiety disorder, depression, and bipolar disorder. Review of the current physician orders for Resident #33 revealed orders for mental health to evaluate and treat, hydroxyzine pamoate (used to treat anxiety) 50 milligrams (mg) one capsule at bedtime and every six hours as needed, Zyprexa (antipsychotic medication) 5 mg one tablet every Tuesday, Thursday, Saturday and Sunday, Zyprexa 10 mg at bedtime, clonazepam (used to treat anxiety) 0.5 mg two tablets at bedtime, cannabidiol 0.5 ml solution every eight hours as needed and Lexapro (antidepressant) 10 mg one tablet one time a day. Review of the medication administration records for April 2024 and May 2024 revealed medications were administered as ordered with no as needed medications administered. Review of the care plan for Resident #33 revealed a history of socially inappropriate behaviors, feeling isolated and the use of psychotropic medications. Interventions included assessing for isolation, involve resident in meaningful activities, mental health services as per orders, medications to be administered as ordered, monitor for effectiveness and need for titration of psychotropic medications, encourage the resident to talk about situations and to evaluate changes in behavior, mood or anxiety. Review of an application for emergency admission, dated 01/29/24 and timed 1:30 P.M., revealed Resident #33 tried to leave facility to go to the road to kill self. Resident #33 also posed a danger to others by threatening others with increased paranoia. Review of a psychiatric note, dated 01/29/24, revealed Resident #33 had worsening hallucinations, delusions, and was making threatening statements to staff and throwing things. Resident #33 yelled they are trying to kill me, was being poisoned and made statements about blood in hair (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a social services progress note, dated 01/30/24 and timed 2:40 P.M., revealed Resident #33 had a significant change in condition with inability to respond to questions and an inability to complete a cognitive assessment. Review of the acute hospital discharge transition record, dated 02/15/24 and timed 8:22 A.M., revealed Resident #33 was admitted to acute inpatient psychiatry from 01/30/24 to 02/16/24 for stabilization of behaviors. Resident #33 was given a primary diagnosis of bipolar II disorder. Review of the progress notes from 02/16/24 to 04/23/24 revealed no behaviors documented for Resident #33. Further review of the medical record revealed Resident #33 received counseling sessions on 02/20/24 with emotional support provided, on 02/27/24 the session focused on increasing social interactions, on 03/12/24 Resident #33 was noted to have a depressed mood, on 03/19/24, 03/26/25 and 04/16/24 Resident #33 was unwilling to engage in the therapy session and on 04/02/24 and 04/09/24 Resident #33 was in an activity and did not participate in the therapy session. Review of a social services note, dated 04/23/24 and timed 11:52 A.M., revealed Resident #33 mentioned getting his things ready to leave as the resident had been hearing mean things about not being welcome at the facility. Resident #33 stated he would be better off dead and the world would be better off without him. Resident #33 asked to see the counselor. Review of the Threats of Harm assessment, dated 04/24/24 and timed 11:25 A.M., revealed Resident #33 was at low to moderate risk of harming self and had no plan. Further review of the medical record revealed Resident #33 had no evidence of additional assessments, ongoing behavior monitoring or interventions put in place to address Resident #33's feeling of not being welcome at the facility and feeling the world would be better off without him until seen by mental health services on 05/15/24 (22 days after the resident made the statements and requested to see the counselor) for a a mental health visit and medication management. Observation on 05/29/24 at 12:47 P.M. found Resident #33 sitting in doorway of room in wheelchair, with arms crossed and resident looking down the hallway with an emotionless expression. Additional observations of Resident #33 on 05/29/24 at 2:14 P.M., on 05/30/24 at 9:05 A.M. and 11;18 A.M. found Resident #33 physically distant from other residents, non communicative with flat and emotionless affect. Resident #33 had no social interaction with others. Interview on 05/30/24 at 10:49 A.M. with Social Services Assistant (SSA) #571 verified the interview with Resident #33 on 04/23/24 occurred. SSA #571 verified Resident #33 did not have any updated care plan interventions implemented, increased monitoring or assessments completed until the resident was seen by psychiatric services on 05/15/24. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility titled Behavioral Health and Mental Health Services, dated December 2016 revealed based on assessment, the facility must ensure that a resident who displays or is diagnosed with a mental disorder receives the appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Additionally, behavioral and mental health will be care planned and updated as needed with on-going documentation in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observations of medication storage, medical record review, staff interview, review of the manufacturer's recommendations and policy reviews, the facility failed to ensure insulins were dated when opened and failed to ensure expired insulins were discarded. This affected three (#10, #20, and #267) of three residents medications observed for medication storage. The facility census was 68. Findings include: 1. Review of the medical record for Resident #267 revealed an admitted [DATE], with diagnosis of diabetes mellitus type II. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #267 revealed he was cognitively impaired and required the use of insulin. Review of the current physician orders from [DATE] for Resident #267 revealed jardiance 10 milligrams (mg) and blood sugar monitoring before meals and at bedtime with Lispro insulin per sliding scale coverage , d+[DATE]=two units, ,d+[DATE]=four units, ,d+[DATE]=six units, ,d+[DATE]=eight units, ,d+[DATE]=10 units, greater than 400 call physician. Review of the care plan dated [DATE] for Resident #267 revealed he was care planned for diabetes with interventions to monitor blood sugars and physician orders. 2. Review of the medical record for Resident # 10 revealed an admitted [DATE], with diagnoses of renal failure and diabetes screening. Review of the quarterly MDS assessment dated [DATE] for Resident #10 revealed he was cognitively intact and required the use of insulin. Review of the current physician orders date [DATE] for Resident #10 revealed blood sugar monitoring before meals and at bed time with Lispro insulin sliding scale coverage for a blood sugar of ,d+[DATE]=three units, , d+[DATE]=six units, ,d+[DATE]=nine units, ,d+[DATE]=12 units, ,d+[DATE]=15 units, greater than 400 call physician. Review of the care plan dated [DATE] for Resident #10 revealed he was care planned for elevated blood sugar levels, indicating possible diabetes with intervention for blood sugar monitoring according to physician orders. 3. Review of the medical record for Resident # 20 revealed an admitted [DATE], with a diagnosis of diabetes mellitus type II. Review of the quarterly MDS assessment dated [DATE] for Resident #20 revealed he was cognitively intact and required the use of insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Bethesda Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 N Brush St Fremont, OH 43420	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current physician orders dated [DATE] for Resident #20 revealed blood sugar monitoring before meals and at bed time with Lispro insulin sliding scale coverage of ,d+[DATE]-eight units, , d+[DATE]=12 units, ,d+[DATE]=16 units, ,d+[DATE]=20 units, ,d+[DATE]=24 units, and ,d+[DATE]=28 units. Review of the care plan revised [DATE] for Resident #20 revealed he was care planned for diabetes with interventions to monitor blood sugar per physician orders. Observations on [DATE] at 8:07 A.M., during medication storage of the medication cart for the 100 hall revealed one insulin pen of Lispro for labeled for Resident #20 that was opened and undated and one multi-dose vial of Lispro labeled for Resident #267 that was opened and undated. Interview, at the time of observation, on [DATE] at 8:07 A.M., with Licensed Practical Nurse (LPN) #532 verified the insulin pen and the multi-dose insulin vial were both opened and undated. Observation on [DATE] at 9:08 A.M., during medication storage of the medication cart for the 200 hall revealed one Lispro insulin pen labeled for Resident #10 opened and dated [DATE]. Interview, at the time of the observation, LPN #536 verified the Lispro insulin was for Resident #10 and verified it was dated for [DATE] and was beyond the expiration date for the insulin pen. Review of the policy titled Storage and Expiration Dating of Medications, Biologicals dated [DATE] revealed if multi-dose vial of an injectable medication has been opened or accessed the vial should be dated and discarded within 18 days unless the manufacturer specified a different date for that opened vial. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Facility staff may record the calculated expiration date based on the date opened. Review of the policy titled General Dose Preparation and Medication Administration revised [DATE] revealed facility staff should enter the opened on the label of medications with shortened expiration dates such as insulin. Review of the manufacturer's recommendations for Lispro insulin pen, revised [DATE] revealed the Lispro insulin pen should not be used beyond 28 days after opening.

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NAME OF PROVIDER OR SUPPLIER Bethesda Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 N Brush St Fremont, OH 43420	

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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** 47057 Based on observation, resident interview, staff interview, and review of the policy, the facility failed to ensure used soiled bed pans were stored appropriately in a shared bathroom. This affected one (#38) of one resident reviewed for used bed pan storage in a shared bathroom. The facility census was 68. Findings include: Review of the medical record for Resident #38 revealed an admitted [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD), diabetes mellitus type II, high blood pressure, dependence on oxygen, anxiety, and schizoaffective disorder, and bipolar disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #38 revealed she is cognitively intact and is independent with transfers, ambulating, and requires moderate assistance with toileting. Review of the care plan dated 02/26/24 for Resident #38 revealed she is care planned for assistance with toileting. Interview on 05/28/24 at 8:58 A.M., with Resident #38 stated my roommate only uses bedpans, I only use the bathroom and the aides always leave the bed pans either on the floor, sometimes they leave them on the back of the toilet so when I sit down they fall on me, sometimes they are left upside down draining into the toilet, and sometimes they leave them in the sink. Resident #38 also stated she goes to the community bathroom to brush her teeth because the sink is used to clean the bed pan. Observation on 05/28/24 at 8:59 A.M., revealed in the bathroom for Resident #38 there were two bed pans on the floor and stacked on top of each other. Neither of the bed pans were labeled or in a plastic bag. The top bed pan had obvious signs of use of old fecal matter stains that were visible. Interview on 05/28/24 at 9:40 A.M., with State tested Nursing Assistant (STNA) #549 verified used bedpans on the floor in the bathroom, verified the bedpans appeared to have been used, and uncovered. STNA #549 stated the facility policy is to keep the bed pans in a bag after the bed pan has been cleaned after use. Interview on 05/29/24 at 12:15 P.M., with Licensed Practical Nurse (LPN) #532 stated no complaints prior to today regarding bed pans left uncovered in the bathroom from Resident #38 but has seen them in the past when she worked as an STNA. Review of the policy titled Infection Prevention and Control Manual Resident Care, dated 2020, revealed all resident personal items will be appropriately labeled with the resident name and stored in bedside stands or other designated resident storage areas and cleaned and disinfected as indicated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41528 Based on observation, staff interview, census list review, and policy review, the facility failed to ensure the flooring was maintained in a clean and appropriate condition. This affected fifteen (#2, #6, #9, #15, #25, #43, #45, #49, #56, #58, #60, #61, #62, #69, and #70) residents in the memory care unit. The census was 68. Findings include: Observation on 05/28/24 at 8:50 A.M., of flooring the hallway near the nurses station through the dining room revealed irregular areas of sticky yellowish residue on the linoleum floor. The affected area was sticky and covered with dust and debris. Staff, residents, and visitors were observed walking through the affected areas. Interview on 05/28/24 at 10:55 A.M., with Licensed Practical Nurse (LPN) #531 verified the floor was always sticky and does not come up. The dirt from the carpet or shoes gets stuck to the sticky areas of the floor, even with daily mopping. Interview on 05/28/24 at 11:21 A.M., with Housekeeping #524 verified the linoleum flooring had sticky areas that maybe from old wax residue. Housekeeping #524 reported the flooring needs to be treated with the auto-scrubber but they do not bring it down this hallway. Review of the census list identified fifteen (#2, #6, #9, #15, #25, #43, #45, #49, #56, #58, #60, #61, #62, #69, and #70) residents in the memory care unit. Review of policy titled, Safe Physical Environment, revised May 2023, revealed all residents have a right to safe, clean, comfortable, and homelike environment. Housekeeping and maintenance services will be completed to maintain a sanitary, orderly, and comfortable interior.