

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2024
NAME OF PROVIDER OR SUPPLIER  Pickaway Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  391 Clark Drive Circleville, OH 43113	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28923</p> <p>Based on record review, review of a video recording from an in-room camera, family interview, staff interview, and policy review, the facility failed to honor a resident's known preference on not having a male caregiver assist her with personal care. This affected one (#73) of three residents reviewed for choices/personal preference. The facility census was 71.</p> <p>Findings include:</p> <p>Review of Resident #73's medical record revealed the resident was admitted to the facility on [DATE]. She remained in the facility until 08/27/24, when she was transferred to another nursing facility at the request of the resident and her family. Her diagnoses included schizophrenia, depression, obesity, congestive heart failure, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, and repeated falls.</p> <p>Review of Resident #73's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had clear speech and adequate hearing. She was usually able to make herself understood and was usually able to understand others. She was not indicated to have any behaviors or was known to reject care during the seven days of the assessment period. She had a functional limitation in her range of motion on one side of her lower extremities. She was always continent of her bowel and occasionally incontinent of her bladder.</p> <p>Review of Resident #73's care plans revealed she had a care plan in place for having an alteration in elimination related to debility and generalized weakness. She had a history of being occasionally to frequently incontinent of her bladder. Interventions included the need to assist with toileting and hygiene needs as needed (PRN) and to perform incontinence care per facility protocol. It did not specify any preferences the resident had on who assisted her with personal care.</p> <p>Further review of Resident #73's care plans revealed she had a care plan in place for having an activities of daily living (ADL) self-care performance deficit related to decreased mobility, use of assistive devices, assist of staff, obesity, epilepsy, schizophrenia, depression, and incontinence. Interventions included the resident having video monitoring in her room, providing assistance with ADLs (toileting, personal hygiene, and bathing) every shift and pm, transfer with a two person assist for toilet use, scheduled toileting program before meals, after meals, at bedtime, and PRN. The ADL care plan did not specify the resident's preference on who was to assist her with ADL care.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #53's kardex (care information provided to the aides on each resident to guide the provision of care) revealed the resident was known to have video monitoring in her room. She required a one person assist with bathing and a two person assist with toileting transfers. They were to assist the resident with toileting and hygiene needs PRN. The kardex did not communicate to the staff the resident's preference to only have female caregivers assist her with personal care.</p> <p>Review of a video recording (Video #4) that was not dated or timed when recorded, and was obtained from Resident #73's in room camera, which lasted 16 seconds, revealed a male State tested Nursing Assistant (STNA) entering the resident's room in response to the resident using her call light for assistance. The STNA in the video was identified by the Director of Nursing (DON) as being STNA #300. The clock that was on the wall in the resident's room indicated the recording took place at 12:55 P.M., as it was daylight outside the window shown in the video. The video showed the resident asking for a nurse to take her to the bathroom upon STNA #300 entering her room. He was noted on the video to respond to the resident's request with what and the resident replied I want a nurse to take me to the bathroom. STNA #300 was heard telling the resident that he was a nurse, as he began to push the resident in her wheelchair towards the doorway. The resident was heard saying oh no. The video recording ended when they were heading in the direction out of her room.</p> <p>On 09/09/24 at 9:54 A.M., an interview with Resident #73's Power of Attorney (POA) for healthcare revealed she did make it known to the facility that it was Resident #73's preference not to receive personal care services from male caregivers. She had spoken with the facility's Social Services Coordinator #120 and a nurse supervisor, LPN #200 about it, but it continued to occur. She confirmed video recordings from the resident's in room camera did show male caregivers assisting with the resident's personal care.</p> <p>On 09/09/24 at 1:15 P.M., an interview with STNA #99 revealed Resident #73 may have possibly said something about not wanting male caregivers to provide care to her. She did not hear it personally from the resident or her family, but did hear from other staff members that was what the resident's preference was. She reported the did have some residents that did not want male caregivers to provide care to them. In that event, they would switch out and have a female caregiver do it. She stated the residents had the right to make choices on who assisted them with personal care. She was not aware of any situations in which a male caregiver (aide) provided care to any female residents, if the female resident did not want them to. There may be times when there was only one aide on the hall and it may be a male. The resident would either have to wait or go ahead and have the male aide provide the care to them, if they couldn't or did not want to wait.</p> <p>On 09/09/24 at 2:16 P.M., an interview with LPN #250 revealed Resident #53 was known to want female caregivers only when assisting with personal care. If a male aide answered her call light, the resident would say she wanted a female to assist her.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/09/24 at 4:45 A.M., an interview with STNA #300 revealed he started working at the facility for about a month now. He was there during the end of Resident #53's stay in the facility and was assigned to work her unit/ hall on day shift. The resident was an extensive assist with her care. She was continent for the most part, but was known to have accidents at times. She would let the staff know when she was needing to go to the bathroom. He was aware the resident preferred female staff to render personal care to her, but indicated he has had to assist her with personal care. He has done everything for her, but give her a shower. He indicated it just depended on the day, if she wanted female staff or not. He re-confirmed the resident did make it known that she preferred female employees to provide her with personal care. He was then asked, if it was known the resident preferred personal care by female staff only, why would it be that there were times he assisted in her personal care. He replied female staff were not always readily available. Sometimes he would have to help her, which included taking her to the bathroom. He would do that, if the other female employees were busy helping other residents at the time. He was asked if he could not notify the other female staff, when Resident #53 was needing assistance with personal care, and take over the care of the other resident the female staff were assisting, as long as that other resident was okay with receiving care from a male aide. He stated he supposed he could have done that, but it did not occur to him to do so. He was asked to review Video #4 during the interview and confirmed that was him in the video. He acknowledged the resident was heard telling him she wanted a nurse to take her to the bathroom on two separate occasions during the video. He further acknowledged the resident stated oh no when he informed her he was going to take her to the bathroom as he was a nurse. He confirmed he did assist the resident with going to the bathroom, after the video recording ended. He was informed the residents had the right to choose who provided care to them and there were some female residents that may not be comfortable with a male aide assisting them with personal care. He was also informed that the resident's had the right to indicate personal preferences when it came to accepting care from male caregivers and their preferences and right to make choices about the care they received should be honored.</p> <p>On 09/10/24 at 9:30 A.M., Video #4 was reviewed with the facility's DON. She acknowledged Resident #53 was heard telling STNA #300 a couple of times that she wanted the nurse to take her to the bathroom, when STNA #300 told her that he would take her. She further acknowledged the resident was heard saying oh no when the STNA #300 said he would take her. She confirmed it was known by the facility's staff that the resident preferred female caregivers to assist her with her personal care. She agreed the residents had the right to choose if they did not want a male caregiver to assist them with personal care. She also agreed the male aide should have gotten the assistance from another female aide to help the resident to the bathroom. He could have relieved the female aide, with whatever care she was doing, so Resident #53's preference for a female caregiver to assist her with personal care could be honored.</p> <p>On 09/10/24 at 3:15 P.M., an interview with Social Services Coordinator #120 revealed she had been the facility's acting social worker for the past three years. She was aware of Resident #53's POA voicing concerns with several issues about her care. It was discussed in a care conference held on 08/13/24, that the resident did not want male caregivers to assist with her personal care.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/10/24 at 4:54 P.M., an interview with LPN #200 revealed she was the unit manager for the hall Resident #53 resided on when she was in the facility. She started in that role August 2023, so she was there for the duration of the resident's stay. She claimed the resident would go back and forth on allowing male caregivers to provide care to her. She then went to a point where she did not want male caregivers to provide personal care to her before she went to not wanting them in her room at all. She could not recall exactly when the resident made it known that she did not want male caregivers to assist her with her personal care. She stated it was made known shortly before the resident had an in room camera installed.</p> <p>Review of the facility's policy on Accommodations of Needs issued 08/21/23 revealed the facility would treat each resident with respect and dignity and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences would be accommodated to the extent possible. The resident's needs and preferences should be evaluated upon admission and reviewed on an ongoing basis. In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the resident's wishes.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157409.</p>		