STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365575	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherine's C C of Fostoria	25 Christopher Dr Fostoria, OH 44830

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review the facility failed to ensure prescribed medications were with the resident on discharge. This affected one Former Resident (#52) of three former residents (#52, #53, #54) reviewed for discharge. The facility census was 42. Summary of findings: Review of Former Resident (FR) #52's medical record revealed an admission date of 02/24/25 and discharged on 03/03/25. Diagnosis included acute kidney failure, acute respiratory distress syndrome, bacteremia, sacral pressure ulcer, congestive heart failure, and atrial fibrillation. Review of FR #52's discharge Minimum Data Set (MDS) dated [DATE] revealed the resident had an intact cognition. She was dependent for all activities of daily living. Review of FR #52's care plan revealed she wished to return home with family after respite stay. Review of FR #52's medical record revealed she required Acetaminophen (pain), Albuterol nebulizer solution (shortness of breath), Colace (constipation), Eliquis (blood thinner), Famotidine (indigestion), Gabapentin (nerve pain), Guaifenesin (chest congestion), Lactobacillus (probiotic), Levothyroxine (hypothyroidism), Losartan (hypertension), Magnesium Oxide (supplement), Methocarbamol (muscle relaxant), Midodrine (hypotension), Occuvite vitamins, Potassium Chloride (supplement), Pulmicort inhaler (shortness of breath), Sennosides (laxative), Sertraline (antidepressant), and a Ventolin inhaler (bronchospasms) as prescribed by the physician. Review of the Interdisciplinary Discharge Summary and Plan of Care revealed the FR #52 was admitted [DATE] and discharged [DATE]. The reason for admission was respite care. There was a hand written list of medications and the area titled Sent With Resident and Prescriptions Called To Pick Up were left blank. The form failed to be signed or dated. Interview with the Director of Nursing on 05/19/25 at 1:10 P.M. verified that the nursing staff failed to complete a complete discharge assessment and verified medications were not sent home with the resident. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Discharge Summary revised 11/2016 revealed when the manor anticipates discharge a resident must have a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status at the time of the discharge that is available for release to authorized persons, agencies, with the consent of the resident representative, reconciliation of all pre-discharged medications with the resident's post-discharge medications, and a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This deficiency represents non-compliance investigated under Complaint Number OH00165070.

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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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, staff interview, and facility policy review, the facility failed to adequately monitor a resident's (Former Resident #52) wound on admission the throughout her stay. The facility census was 42. Findings included: Review of Former Resident (FR) #52's medical record revealed an admission date of 02/24/25 and discharged on 03/03/25. Diagnosis included Stage IV sacral pressure ulcer (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.), acute kidney failure, acute respiratory distress syndrome, bacteremia, congestive heart failure, and atrial fibrillation. Review of FR #52's discharge Minimum Data Set (MDS) dated [DATE] revealed the resident had an intact cognition. She was dependent for all activities of daily living. Review of FR #52's medical record revealed the record was absent of wound evaluations or measurements. Interview with Corporate Nurse #170 on 05/19/25 at 2:43 P.M. verified the facility failed to measure or assess FR #52's Stage IV sacral pressure ulcer during her respite stay. Interview with FR #52's home health nurse on 05/15/25 revealed the wound worsened during the resident's stay and required a wound vac. The nurse stated the wound was within one month of healing, but the condition of the wound declined during her admission to the facility. The nurse failed to provide the requested documentation for surveyor review. Review of the facility policy titled Pressure Ulcer Policy revised 04/16 revealed should a pressure area present either upon admission or in house, the wound will be monitored at least weekly and should have documentation including location and staging, size (perpendicular measurements of the greatest extend of length and width of the ulceration), depth; and the presence, location and extent of any undermining or tunneling/sinus tract, drainage; the amount and characteristics, pain if present and characteristics, and wound bed and surrounding tissue. As a result of the incident, the facility took the following actions to correct the deficient practice by 05/16/25: • On 04/24/25 the DON/Designee completed skin sweeps of all residents. • (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/25 education was provided to nurse leadership team to ensure that a skin check was completed for all new admission within 72 hours of admission by the DON/Designee. • By 04/25/25 all nurses were educated by the DON/Designee on the pressure ulcer policy. • On 04/25/25 all nurse aides were educated by the DON/Designee on how frequently skin checks were to be completed. They were also educated on notifying the nurse if/when a dressing comes off of the wound. • By 04/25/25 all nurses were educated on following physician orders and policy by DON/Designee. They were educated on not signing an order of application or administration until after completion. • Audits will be completed five times per week for four weeks by the DON/Designee on all new admission to have a thorough skin evaluation and that documentation supported the evaluation including identifying any skin issues, type, description and measurements if applicable through 05/24/25. • Audits were completed three times a week by interviewing nurse aides on knowledge of the frequency of skin checks and what to do if a dressing is off or comes off a wound by the DON/Designee through 05/19/25. • On 05/12/25 three aseptic dressing technique competencies per week were completed with all nurses by the DON/Designee. • On 05/12/25 three catheter irrigation competencies per week were completed with all nurses by the DON/Designee. • On 05/16/25 special QAPI meeting was held and on 05/28/25 a regular QAPI meeting is scheduled. This deficiency represents non-compliance investigated under Complaint Number OH00165070.

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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** Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident was supervised for eating. Resident #19 obtained and ate whole food when ordered a pureed diet, choked, received the Heimlich maneuver, and was admitted to the hospital. This deficient practice affected one resident (#19) of three reviewed (#11 and #24) for choking. In addition, two residents (#19, #53) of four reviewed (#11 and #24) failed to have fall precautions in place which resulted in falls. The facility census was 42. Findings included: 1 - Review of Resident #19's medical record revealed an admission date of 01/18/15. Diagnosis included cerebral vascular accident, schizoaffective disorder, epilepsy, mild intellectual disabilities, and congestive heart failure. Review of Resident #19's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a moderately intact cognition. The resident had coughing or choking during meals or when swallowing medications along with complaints of difficulty or pain with swallowing. Review of Resident #19's care plan revealed the resident had a history of cerebral vascular accident, dysphasia, and teeth in disrepair when affected his chewing ability. Notify the physician for signs of dysphasia, pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or concerns noted during meals. Review of Resident #19's medical record revealed a physician's order dated 04/08/25 through 05/10/25 for a consistent carbohydrate diet, pureed texture, and regular consistency. Review of Resident #19's medical record revealed on 04/08/25 the resident had a choking episode in the dining room during lunch. The resident choked on hamburger. The Heimlich maneuver was performed without success. The resident was lowered to the floor and placed on his side and the airway was able to be cleared. The physician and family were notified. Further orders were received for a chest x-ray due to shortness of breath and to rule out aspiration. Review of Resident #19's speech therapy note dated 04/10/25 revealed the patient was educated on compensatory strategies to use during meals to increase safety. The therapist trained the Certified Nursing Assistants (CNA) to use compensatory strategies with the resident during meals to decrease the risk of aspiration. The diet assessment was completed in order to determine the resident's ability to tolerate diet textures and liquid viscosity at meals. Review of Resident #19's speech therapy note dated 04/23/25 revealed the speech therapist implemented a plan for necessary environmental modifications and cueing to maintain attention to meal task for intake. Speech therapy educated the resident on compensatory strategies to use during meals to increase safety. Speech therapy instructed the resident to utilize lingual sweep and/or alternate bite/sip to clear residue from the oral cavity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #19's progress note dated 05/08/25 revealed the nurse was called to the dining room by a CNA and found the resident having respiratory difficulty with cyanosis. A faint cough was noted. The resident had a history of seizures and dysphasia, and his airway was found to be occluded. Upon reaching Resident #19 the nurse performed the Heimlich maneuver which was unsuccessful. Emergency Medical Services (EMS) had been called. The resident was lowered to the ground and abdominal thrust was initiated. The resident coughed with copious amounts of sputum released. Cyanosis persisted after respirations became regular. Pulses were strong to the extremities. Oxygen was placed on the resident at 8 liters per minute via a nonrebreather mask. The resident was placed on his side to maximize breathing. Resident #19 was transported to the hospital. Review of the hospital emergency room note dated 05/08/25 revealed according to the bedside report taken for EMS upon arrival Resident #19 was eating in the common area non-solid foods, when he was thought to have been choking. There was also a description that he might have had a seizure although staff members are not certain what his seizures look like. EMS reported that when they arrived on scene the patient had spontaneous pulses and respiration. He was not following commands. They checked a blood sugar in route that was greater than 100. They attempted IV access in transport. Upon arrival to the emergency department setting the patient would acknowledge his name. His eyes opened spontaneously. He was not speaking or answering questions. He would follow simple commands such as holding his right or left arm up. Based upon this evaluation he had a Glasgow Coma Score (GCS) score of 11. The physician did not hear any course breath sounds bilaterally. The physician proceeded with an altered mental status workup also evaluated for the possibility of aspiration. Diagnosis included alerted mental status, aspiration, seizure, postictal state, arrhythmia, electrolyte abnormality, liver failure, urinary tract infection, and encephalopathy. Interview with the Administrator on 05/15/25 at 12:10 P.M. revealed Resident #19 choked on fruit during dinner on 05/08/25. The resident had been served the proper pureed meal and CNA's were at the table observed the resident eating. The aides left the table to assist with cleaning the dining room when another resident placed his regular texture fruit cup in front of Resident #19. This resulted in Resident #19 eating the fruit and choking. Telephone interview with Speech Therapist #175 on 05/20/25 at 11:02 A.M. revealed Resident #19 should not eat in his room alone. He should eat in the dining room with staff present due to his high risk of choking. The resident should be in an upright position and eating utensils should be within reach. Review of the facility policy titled Regular Pureed Diet revised 05/2020 revealed the diet is designed for the resident who has some difficulty in chewing or swallowing or who has poor coordination of the lips or tongue. Foods should be of little or no chewing and be easy to swallow. 2. Review of Resident #19's medical record revealed an admission date of 01/18/15. Diagnosis included cerebral vascular accident, schizoaffective disorder, epilepsy, mild intellectual disabilities, and congestive heart failure. Review of Resident #19's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a moderately intact cognition. The resident was independent with ambulation and used a walker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #19's care plan revealed the resident was at risk for falls related to seizure disorder, history of a cerebral vascular accident with a mild right foot drop, mild developmental disability and history of falls. Interventions included Dycem to the recliner. Review of the post fall evaluation dated 04/21/25 revealed on 04/20/25 Resident #19 suffered an unwitnessed fall which occurred in the resident's room. The resident was getting out of bed and into his recliner. The root cause was determined to be that Dycem was not in his recliner per his care plan. No injuries were noted. Interview with the Director of Nursing (DON) on 05/19/25 at 9:10 A.M. verified Resident #19's Dycem pad failed to placed in his recliner causing him to slide out of the recliner. Review of the facility policy titled Fall Reduction Policy revised 04/29/16 revealed it was the policy of the Manor to identify residents at risk for falls and to implement a fall reduction program to reduce the risk of falls and possible injury. 3. Review of Former Resident (FR) #53's medical record revealed an admission date of 02/26/25 with a discharge date of 03/05/25. Diagnosis included rhabdomyolysis, acute kidney failure, dementia, epilepsy, and femur fracture. Review of FR #53's discharge Minimum Data Set (MDS) dated [DATE] revealed the resident had a moderately intact cognition. Bed to chair transfer required supervision or touching assistance. Review of FR #53's care plan revealed he was at risk for falls related to his current diagnosis, recent change in environment, and admission to a care community. Interventions included a safe environment and staff to anticipate his needs and keeping items within reach, and assisting with toileting. Review of FR #53's Fall Risk Evaluation dated 02/26/25 revealed he was a high risk for falls. Review of FR #53's progress note dated 03/04/25 revealed a CNA was walking down the hall when she noticed the resident was sitting on the floor with his back up against the lower end of the bed. His legs were stretched out in front of him. The resident was wearing grippy socks but the bed was not in a locked position and was moving about freely. FR #53 was unable to fully explain what happened. No injuries were noted. Staff were educated regarding the fact the need for the bed to be in the lowest locked position. Interview with the Director of Nursing (DON) on 05/19/25 at 9:10 A.M. verified FR #53's bed failed to be locked causing the bed to move while the resident was attempting to get out of bed. Review of the interdisciplinary team progress note dated 03/04/25 revealed the cause of the fall was that the bed was in the lowest position causing wheels to unlock. The new intervention was to put bed in lowest position that can be with wheels locked. The care plan was updated, and the family, physician and Director of Nursing were updated. Review of the facility policy titled Fall Reduction Policy revised 04/29/16 revealed it was the policy of the Manor to identify residents at risk for falls and to implement a fall reduction program to reduce the risk of falls and possible injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00165646.