STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365592	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Manor Nurs and Rehabilitation Center	820 East Center Street Blanchester, OH 45107

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview, and record review the facility failed to ensure residents were informed of their rights to pay for therapy services or decline to pay for those services when Resident #50 and #106 were not given skilled nurse facility advanced beneficiary notice of non-coverage (SNF ABN) form 10055 upon being cut from services and still staying in the building. This affected two (Resident #50 and #106) of three Residents reviewed for beneficiary notices. The facility census was 48. Findings include: 1. Record review of Resident #50 revealed an admitted [DATE] and he still resides in the building. The resident had pertinent diagnoses of: chronic obstructive pulmonary disease, type two diabetes mellitus, heart failure, atrial fibrillation and hyperlipdemia. Review of the Notice of Medicare Non-coverage form 10123 dated 07/09/24 revealed Resident #50 was being discharged for m services on 07/11/24 and he was still residing in the building. Review of the medical record on 08/13/24 revealed there was no skilled nurse facility advanced beneficiary notice of non-coverage (SNF ABN) form 10055 provided Resident #50 when he was cut from skilled services. Interview with The Administrator on 08/13/24 at 2:59 P.M. verified there was no skilled nurse facility advanced beneficiary notice of non-coverage (SNF ABN) form 10055 provided to Resident #50 when he was cut from skilled services and he stayed in the building. 2. Record review of Resident #106 revealed an admitted [DATE] and a discharge to another facility on 06/11/24. The resident had pertinent diagnoses of: arthropathy, myocardial infarction, hypertension, and atrial fibrillation. Review of the Notice of Medicare Non-coverage form 10123 dated 05/23/24 revealed Resident #106 was being discharged for m services on 05/26/24 and he was still going to be residing in the building. Review of the medical record on 08/13/24 revealed there was no skilled nurse facility advanced beneficiary notice of non-coverage (SNF ABN) form 10055 provided to Resident #106 when he was cut from skilled services. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with The Administrator on 08/13/24 at 2:59 P.M. verified there was no skilled nurse facility advanced beneficiary notice of non-coverage (SNF ABN) form 10055 provided to Resident #106 when he was cut from skilled services and he stayed in the building.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview and record review the facility failed to resubmit a Preadmission Screening and Resident Review (PASARR) or discharge the Resident after 90 days per the level two screening determination. This affected one (Resident #15) of one reviewed for PASARR. The facility census was 48. Findings include: Record review of Resident #15 revealed an admitted [DATE] with pertinent diagnoses of: cerebral infarction, hemiplegia and hemiparesis, toxic effect of other metals, bipolar disorder,acute kidney failure, muscle weakness, cognitive communication deficit, obstructive and reflux uropathy, dysphagia, adult failure to thrive, and schizoaffective disorder. Review of the 06/30/24 quarterly Minimum Data Set (MDS) assessment revealed the resident is severely cognitively impaired, he uses a wheelchair to aid in mobility, and is always incontinent of bladder and frequently incontinent of bowel. Review of the 10/17/23 Notice of PASRR determination and right to a state hearing revealed Resident #15 required the level of services provided by a nursing facility and they may continue to reside in the nursing facility for 90 day from the determination. The nursing facility inconjunction with the local entities shall initiate and continue discharge planning activities throughout the period of time specified on this notice. Interview with Licensed Social Worker (LSW) #66 on 08/15/24 ay 9:50 A.M. verified Resident #15 was only approved to be in the facility 90 days and no one sent in the updated PASARR we assumed the local was doing it and it was suppose to be us doing it. LSW #66 verified Resident #15 is still in the facility.

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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 - 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** 31404 Based on record review, resident and staff interview, hospital records review, facility policy review, and fall investigation review, the facility failed to provide appropriate gait belt assistance and care planned two persons assist during a wheelchair to chair transfer. This resulted in harm when Resident #28 sustained a fall with a laceration, and a dislocated toe that required a hospital visit and 11 stitches. This affected one (Resident #28) of four Residents reviewed for accident hazards. The facility census was 48. Findings include: Record review of Resident #28 revealed an admitted [DATE] with pertinent diagnoses of: amyotrophic lateral sclerosis, spinal stenosis lumbar region, chronic obstructive pulmonary disease, type two diabetes mellitus with diabetic neuropathy, weakness, acute kidney failure, umbilical hernia, major depressive disorder, lack of coordination, unilateral primary osteoarthritis left knee, low back pain, tremor, retention of urine, hypertension, anxiety disorder, and malignant neoplasm of the kidney. Review of the 12/05/21 plan of care revealed Resident #28 is at risk for falls related to decreased mobility, poor balance, poor safety awareness, use of psychoactive medications,refusing the use of alarms with removing alarm from self . The chair alarms were discontinued due to placing resident at higher risk due to his increased restlessness and maneuvering self to remove his own alarms. The goal was for Resident #28 to be free from fall related injury with a target date of 08/31/24. Care planned interventions included two persons assist with all transfers since 09/22/22, and follow facility fall protocol. Record review of the 07/09/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #28 was cognitively intact and used a wheelchair to aid in mobility. Resident #28 required substantial to maximal assist for upper and lower body dressing and transfer from bed/chair to chair transfer. (continued on next page)

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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 - Actual harm Residents Affected - Few	Review of Progress Notes dated 07/22/24 at 7:07 A.M. revealed a late entry for 07/19/24 at 11:45 A.M. this resident was lowered to floor by State tested Nurse Aide (STNA) #74 during transfer. Resident was lowered to floor to sitting position then head lowered to floor not hitting his head. Resident was laying on the floor on his back in front of recliner, bilateral lower extremities extended toward the door, fully dressed in street clothes with non-skid socks on and arms at sides. Room was well lit, no obstacles or clutter on floor. Resident was alert and oriented x 4. Denied hitting his head and pain. STNA #74 was not using gait belt for transfer. Resident stated that his foot got caught under the chair as he was pivoting during transfer from wheelchair to recliner. Vital signs, head to toe assessment, range of motion (ROM), skin, pain assessments completed. His vital signs, pain, ROM assessments found within normal limits. Right great toe noted to be misshapen and large laceration from inside right great toe underneath to outside of right great toe noted. Draining moderate amount of bright red blood. Resident was assisted from floor to recliner with Hoyer lift and four person assist. Physician aware and new order received to send to emergency room (ER) for eval. 911 was notified and Resident #28 was transferred to local hospital emergency room per stretcher accompanied by two attendants. Resident to be a two person assist with transfers, staff education completed on the use of gait belts with transfers, and corrective action for STNA for not using gait belt. Resident's family notified of incident and transfer to ER. Resident later return from ER per stretcher accompanied by two attendants with new orders for ortho boot to right foot for three weeks, non-weight bearing status to right foot, monitor right great toe and sutures for signs and symptoms of infection. Review of hospital records dated 07/19/24 revealed the proximal inter phalangeal is dislocated with medial deviation of the distal phalange. The Physician applied mild traction and reduced it without sedation. Wound repair of three-centimeter subcutaneous laceration to right foot. Skin closed with 11 simple sutures. The diagnosis was laceration without foreign body of right great toe without damage to nail. Review of the 07/19/24 Witness Statement revealed State tested Nurse Aide (STNA) #74 revealed she was transferring Resident #28 from wheelchair to recliner without a gait belt. She held his pant and locked arms with him while he stood, he then pivoted to the right and stopped right before turning completely. She slowly lowered him to a seating position on the floor and then slowly lowered his head to the ground in a lying position. Review of the 07/22/24 post fall investigation report for the fall on 07/19/24 revealed Resident #28 had a fall on 07/19/24 at 11:45 A.M. and the contributing factors was STNA was not using a gait belt. Injuries were a dislocated right great toe, and a laceration. Interview with Resident #28 on 08/12/24 at 10:00 A.M. revealed he had a fall three or four weeks ago and he hurt his toe. He stated he needs two people for transfers, and they only used one person. He got 11 stitches in his right big toe. Interview with Director of Nursing (DON) on 08/15/24 at 8:42 A.M. verified STNA #74 did not use a gait belt and transferred Resident #28 by herself. The floor was dry, room light was on evaluated for injuries no complaints of pain did not hit his head. DON stated they got the Hoyer lift to transfer after the fall then we noticed blood on his sock, and we realized he needed treatment and called 911. Resident has an ALS diagnosis that makes him high risk for falls we try to promote the least number of transfers with him. The facility policy is to use gait belts with all transfers, and she verified the plan of care stated he was a two person assist with transfer. The DON stated the care plan should have been adjusted and he is a one or two person assist for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with STNA #97 on 08/15/24 at 8:51 A.M. Resident #28 has been a two person transfer for longer than six months. She stated have never transferred him with one person in the last six months. Review of the 02/2023 Facility Use of Gait Belt Policy revealed it is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. Failure to use gait belt properly may result in termination.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on observation, staff interview, record review, and policy review, the facility failed to ensure medication error rates were not greater than 5% when they did not prime an insulin pen before administration and gave the wrong amount of tablets for cranberry. This affected two (Resident #1 and #29) of four residents observed for medication administration. There was two errors out of 26 opportunities for a medication error rate of 7.69%. The facility census was 48. Findings include: 1. Record review of Resident #1 revealed an admitted [DATE] with pertinent diagnoses of: type two diabetes mellitus, anemia, hypothyroidism, hyperlipdemia, hypertension, and chronic kidney disease stage three. Review of the 06/16/24 modification of quarterly Minimum Data Set (MDS) revealed the resident was moderately cognitively impaired and used a wheelchair to aid in mobility and was frequently incontinent of bladder and occasionally incontinent of bowel. Review of a Physician Order dated 05/07/24 revealed Cranberry 930 milligrams (mgs) give one capsule by mouth one time a day for urinary tract infection prevention. Observation on 08/14/24 at 9:08 A.M. revealed Licensed Practical Nurse (LPN) #84 administered medications to Resident #1 including one tab of Cranberry 450 mgs. Interview with LPN #84 on 08/14/24 at 9:36 A.M. verified she only gave 450 mgs of cranberry and the order is for 930 mgs. 2. Record review of Resident #29 revealed an admitted [DATE] with pertinent diagnoses of: cerebral infarction, asthma, type two diabetes mellitus with diabetic neuropathy, and congestive heart failure. Review of the 05/10/24 significant change Minimum Data Set (MDS) revealed the resident was cognitively intact and used a wheelchair to aid in mobility and is occasionally incontinent of bowel and bladder. Review of a Physician Order dated 04/24/24 revealed an Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject as per sliding scale: if 140 - 179 = 2U; 180 - 219 = 4U; 220 - 259 = 6U; 260 - 299 = 8U; 300 - 339 = 10U; 340 - 379 = 12U; 380 - 419 = 14U; 420 - 500 = 20U >501 call physician, subcutaneously before meals and at bedtime related to type two diabetes mellitus. Review of a Physician Order dated 04/24/24 revealed to Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml/ML (Insulin Aspart) Inject 15 units subcutaneously three times a day related to type two diabetes mellitus. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/15/24 at 11:25 A.M. revealed Licensed Practical Nurse (LPN) #290 took Resident #29 blood sugar level and it was 319 milligrams per deciliter (mg/dl). This required 15 units scheduled dose of Novolog insulin and 10 additional units for sliding scale coverage. LPN #290 dialed the Novolog pen to 25 units she did not prime the insulin pen prior to administration to the Resident. Interview with LPN #290 on 08/15/24 at 11:35 A.M. verified she did not prime the insulin pen before injecting Resident #29. Review of a undated facility policy title insulin administration with use of insulin pen and needle revealed to prime the pen by removing the air from the needle and cartridge. Select two units when turning the dose knob. Hold the pen with the needle pointing up, then gently tap the cartridge holder to collect the air bubbles at the top. Press the push-button until it stops. You should see a O in the dose window. You should see insulin at the needle tip. If you do not see insulin, repeat the priming steps but not more than 6 times. If there is still no insulin, do not use the pen. Turn the dose selector, be careful not to press the push-button. Insert the needle into the resident's and press the push-button all the way in for at least six seconds. Keep pressing until the needle has been pulled out from the skin. This will make sure that you have received the full dose. Use a new needle each time you give an an injection. Always remove and discard the needle into a sharps container after each injection.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on observation, staff interview, record review, and policy review, the facility failed to ensure residents are free of significant medication errors when they did not prime an insulin pen before administering insulin to a resident. This affected one (Resident #29) of four residents observed for medication administration. The facility census was 48. Findings include: Record review of Resident #29 revealed an admitted [DATE] with pertinent diagnoses of: cerebral infarction, asthma, type two diabetes mellitus with diabetic neuropathy, and congestive heart failure. Review of the 05/10/24 significant change Minimum Data Set (MDS) revealed the resident was cognitively intact, used a wheelchair to aid in mobility, and is occasionally incontinent of bowel and bladder. Review of a Physician Order dated 04/24/24 revealed an Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject as per sliding scale: if 140 - 179 = 2U; 180 - 219 = 4U; 220 - 259 = 6U; 260 - 299 = 8U; 300 - 339 = 10U; 340 - 379 = 12U; 380 - 419 = 14U; 420 - 500 = 20U >501 call physician, subcutaneously before meals and at bedtime related to type two diabetes mellitus. Review of a Physician Order dated 04/24/24 revealed to Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml/ML (Insulin Aspart) Inject 15 units subcutaneously three times a day related to type two diabetes mellitus. Observation on 08/15/24 at 11:25 A.M. revealed Licensed Practical Nurse (LPN) #290 took Resident #29 blood sugar level and it was 319 milligrams per deciliter (mg/dl). This required 15 units scheduled dose of Novolog insulin and 10 additional units for sliding scale coverage. LPN #290 dialed the Novolog pen to 25 units she did not prime the insulin pen prior to administration to the Resident. Interview with LPN #290 on 08/15/24 at 11:35 A.M. verified she did not prime the insulin pen before injecting Resident #29. Review of a undated facility policy title insulin administration with use of insulin pen and needle revealed to prime the pen by removing the air from the needle and cartridge. Select two units when turning the dose knob. Hold the pen with the needle pointing up, then gently tap the cartridge holder to collect the air bubbles at the top. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Press the push-button until it stops. You should see a O in the dose window. You should see insulin at the needle tip. If you do not see insulin, repeat the priming steps but not more than 6 times. If there is still no insulin, do not use the pen. Turn the dose selector, be careful not to press the push-button. Insert the needle into the resident's and press the push-button all the way in for at least six seconds. Keep pressing until the needle has been pulled out from the skin. This will make sure that you have received the full dose. Use a new needle each time you give an an injection. Always remove and discard the needle into a sharps container after each injection.