

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Cedarview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Oregonia Road Lebanon, OH 45036	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure dependent residents were assisted with repositioning to prevent skin impairment. This affected three (#46, #53, #72) of three residents reviewed for repositioning. The census was 74.</p> <p>Findings included</p> <p>1. Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, obstructive uropathy, diabetes, cerebrovascular attack, tracheostomy, gastrostomy, and ventilator dependent.</p> <p>Review of the care plan for Resident #46 dated 01/02/24 revealed the resident was at risk for skin impairment related to immobility. Interventions included to assist to turn and reposition at frequent intervals to provide pressure relief and to offload the hips and sacrum to promote skin integrity.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 was rarely or never understood. The resident's was assessed as dependent for toileting and for transfers.</p> <p>Observation of Resident #46 on 05/14/24 at 9:40 A.M., 11:45 A.M., 1:05 P.M., and 2:14 P.M. revealed the resident was laying on his back in bed with his position unchanged.</p> <p>2. Review of Resident #53's medical record revealed an admitted [DATE]. Diagnoses included hypoxic ischemic encephalopathy, aphasic, respiratory failure, tracheostomy, gastrostomy, and ventilator dependent.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #53 was rarely or never understood. The resident was dependent for toileting and bed mobility.</p> <p>Review of the care plan dated 03/19/24 for Resident #53 revealed the resident was at risk to develop skin conditions related to fragile skin. Interventions were to encourage and assist to turn every two hours.</p> <p>Observation of Resident #53 on 05/14/24 at 9:38 A.M., 11:47 A.M., 1:04 P.M., and 2:14 P.M. revealed the resident was sitting upright in a geriatric chair with his head leaning over to the left side of the chair. The resident's position was unchanged throughout the observations.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of Resident #72's medical record revealed an admitted [DATE]. Diagnoses included respiratory failure with hypoxia or hypercapnia, obstructive uropathy, pneumonia, diabetes, and seizure disorder.</p> <p>Review of an admission MDS assessment dated [DATE] for Resident #72 revealed the resident was rarely or never understood. The resident was dependent on toileting and bed mobility.</p> <p>Review of the care plan for Resident #72 dated 04/11/24 revealed the resident was at risk for skin impairment related to immobility. Interventions were to encourage and assist to turn and reposition every two hours and as needed.</p> <p>Observation of Resident #72 on 05/14/24 at 9:43 A.M., 11:48 A.M., 1:05 P.M., and 2:15 P.M. revealed the resident was lying on her back in the bed with her position unchanged.</p> <p>Interview with the State tested Nurse Aide (STNA) #75 on 05/14/24 at 2:21 P.M. stated she shared the hall with STNA #76 and they worked together to complete their jobs. STNA #75 verified she had not had a chance to turn and reposition Resident #46, Resident #53, and Resident #72 on 05/14/24. STNA #75 stated Resident #53 was in his chair when she arrived at 7:00 A.M. and normally they did not lay the resident down until after lunch.</p> <p>Review of the policy titled, Repositioning, dated 05/01/13, revealed the purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents, to prevent skin breakdown, promote circulation and provide pressure relief for residents. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153613.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on observation, medical record review, staff interview, the facility failed to complete an accurate skin assessment. This affected one (#72) of three residents reviewed for skin assessments. The census was 74.</p> <p>Findings included:</p> <p>Medical record review for Resident #72 revealed an admitted [DATE]. Diagnoses included respiratory failure with hypoxia or hypercapnia, obstructive uropathy, pneumonia, diabetes, and seizure disorder.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #72 revealed the resident was rarely/never understood. The resident was dependent on toileting and bed mobility, was assessed with an indwelling catheter, was always incontinent for bowel, and was dependent on a tracheostomy and a ventilator.</p> <p>Review of a skin assessment dated [DATE] at 11:40 A.M. for Resident #72 documented by Licensed Practical Nurse (LPN) #77 revealed there was not documentation in the skin assessment grid for any new areas of skin impairment.</p> <p>Review of Resident #72's physician orders and progress notes dated 05/14/24 revealed no reports of new skin issues.</p> <p>Observation of Resident #72's skin with State tested Nurse Aide (STNA) #75 and STNA #76 on 05/14/24 at 2:30 P.M. revealed under the resident's left armpit was and area of bright red excoriation and the resident's feet were dry and scaly from the bottom up half way on each foot.</p> <p>Interview with LPN #77 on 05/14/24 at 3:25 P.M. stated she documented a skin assessment for Resident #72 on 05/14/24 at 11:40 A.M. and documented the assessment as completed. LPN #77 stated there was only some redness on the Resident #72's bottom and under her right armpit and did not find anything else.</p> <p>Observation of Resident #72's skin during the interview on 05/14/24 at 3:25 P.M. with LPN #77 revealed she knew about the excoriation under the resident's left armpit, but did not write a note in the skin assessment or in the progress notes about the findings and stated she did not know about the resident's feet being scaly and dry.</p>