STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365690	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarview Care Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, staff interview, and policy review, the facility failed to ensure the physician was notified of a change in condition. This affected one (#22) of five residents reviewed for nutrition. The facility census was 72. Findings include: Review of the medical record of Resident #22 revealed an admitted [DATE]. The resident transferred to the hospital on 01/31/24 and readmitted to the facility on [DATE]. Diagnoses included end-stage renal disease, chronic diastolic heart failure, fluid overload, pulmonary embolism, chronic obstructive pulmonary disease, chronic respiratory failure, and obstructive sleep apnea. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident required setup assistance with eating, partial/moderate assistance with personal hygiene, sitting to lying, and rolling from side to side in bed, substantial/maximal assistance for lying to sitting on side of bed, and was dependent on staff for toileting, sit to stand, Review of physician orders revealed an order dated 02/08/24 for the resident to be weighed daily and to report an increase or decrease of three pounds. Review of the medication administration record revealed on 02/08/24, the resident weighed 245.3 pounds and on 02/09/24, the resident weighed 266.8 pounds. Review of a Dietary/Nutrition Progress note dated 02/11/24, revealed a reweigh would be requested. Further of the medical record revealed no progress notes addressing the change in Resident #22's weight. Interview on 04/18/24 at 1:04 P.M., the Director of Nursing (DON) verified there was no documentation in Resident #22's medical record regarding the 21 pound change in weight or the physician being notified. Review of the policy titled, Change in a Resident's Condition or Status, dated May 2017, revealed the nurse will notify the resident's attending physician or physician on-call when there is specific instruction to notify the physician of changes in the resident's condition.

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
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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, review of the Resident Assessment Instrument (RAI) User Manual, review of the facility's Minimum Data Set (MDS) Completion and Submission Timeframe's policy and procedure, and staff interview, the facility failed to ensure MDS discharge assessment was completed within 14 days of discharge. This affected one (#60) of one resident reviewed for MDS discharge assessments. The facility census was 72. Findings include: Review of the medical record for Resident #60 revealed an admitted [DATE], with diagnoses of schizoaffective disorder, anxiety disorder, polysubstance abuse, and nicotine addiction. Resident #60 was discharged on [DATE]. Review of the MDS assessment dated [DATE] revealed Resident #60 is cognitively intact. The resident is independent for ambulation, transfers, dressing, and toileting, requires set up assistance for eating, oral and personal hygiene, and supervision with bathing. Review of the MDS discharge assessment for Resident #60 revealed a completion date of 04/17/24. Resident #60 was discharged on [DATE]. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual revealed the discharge assessment is to be completed no later than 14 days after discharge. Review of the facility's undated MDS Completion and Submission Timeframe's policy and procedure revealed the discharge assessment, return not anticipated, is to be completed no later than 14 calendar days after discharge date . Interview on 04/18/24 at 9:37 A.M., with MDS Coordinator #324 confirmed Resident #60 discharged on [DATE] and MDS discharge assessment was not completed until 04/17/24. MDS Coordinator #324 confirmed the timeline for completion of the MDS discharge assessment is 14 days from date of discharge.

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, review of the Resident Assessment Instrument (RAI) User Manual, review of the facility's Minimum Data Set (MDS) Completion and Submission Timeframe's policy and procedure, and staff interviews, the facility failed to ensure MDS assessments were transmitted within 14 days of completion date. This affected three (#25, # 50, and #59) of three residents reviewed for MDS assessment submissions. The facility census was 72. Findings include: 1. Review of the medical record for Resident #25 revealed an admitted [DATE], with diagnoses of Alzheimer's disease, bi-polar disorder, schizoaffective disorder, anxiety disorder, and alcohol abuse. Review of the MDS assessment dated [DATE] revealed Resident #25 is cognitively intact. Resident #25 is independent for mobility with no devices, transfers, toileting, dressing, requires set up assistance for eating and oral hygiene, and supervision for showering and personal hygiene. Review of MDS assessments for Resident #25 revealed a MDS quarterly assessment dated [DATE] was completed on 03/28/24 and transmitted on 04/14/24. 2. Review of the medical record for Resident #50 revealed an admitted [DATE], with diagnoses of cerebrovascular accident with right sided hemiplegia, alcohol abuse, chronic pain syndrome, seizure disorder, coronary artery disease, congestive obstructive pulmonary disease, and diabetes mellitus type II with neuropathy. Review of the MDS assessment dated [DATE] revealed Resident #50 is cognitively intact. The resident is not ambulatory and uses a wheelchair for mobility, requires partial assistance for toileting, bathing, personal hygiene, dressing, and moderate assistance for transfers. Review of MDS assessments for Resident #50 revealed a MDS quarterly assessment dated [DATE] was completed on 03/26/24 and transmitted on 04/14/24. 3. Review of the medical record for Resident #59 revealed an admitted [DATE], with diagnoses of Wernicke's encephalopathy, depression, post-traumatic stress disorder (PTSD), anxiety disorder, and alcohol abuse. Review of the MDS assessment dated [DATE] revealed Resident #59 is cognitively intact. The resident is independent for mobility with no devices, transfers, dressing, requires supervision for bathing and personal hygiene, and set up assistance for eating, oral hygiene, and toileting. Review of MDS assessments for Resident #59 revealed a MDS quarterly assessment dated [DATE] was completed on 01/26/24 and transmitted on 02/12/24. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual revealed the MDS quarterly assessment is to be transmitted within 14 days after completion. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility's MDS Completion and Submission Timeframe's policy and procedure revealed the MDS quarterly assessment is to be transmitted within 14 calendar days after completion. Interview on 04/16/24 at 2:52 P.M., with the Administrator and MDS Coordinator #324 confirmed the MDS quarterly assessment for Resident #25 dated 03/14/24 was completed 03/28/24 and transmitted 04/14/24; confirmed the MDS quarterly assessment for Resident #50 dated 03/12/24 was completed 03/26/24 and transmitted 04/14/24; and confirmed the MDS quarterly assessment for Resident #59 dated 01/12/24 was completed on 01/26/24 and transmitted 02/12/24. The Administrator and MDS Coordinator #324 confirmed the transmission date to submit these MDS quarterly assessments for Residents #25, #50, and #59 exceeded the 14-day timeline.

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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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on medical record review and staff interviews, the facility failed to notify the state mental health authority of a significant change in condition for residents with mental disorders. This affected two (#9 and #49) of five residents reviewed for Pre-Admission Screening and Resident Review, (PASARR) admission process. The total facility census was 72. Findings include: 1. Review of Resident #49's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #49 include dementia, encephalopathy, major depressive disorder and anxiety disorder. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had severely impaired cognition and was dependent on staff for self-care and mobility. Review of Resident #49's physician orders revealed the resident had orders for hospice service beginning on 07/27/23. Record review of Resident #49 revealed no Pre-admission Screening and Resident Review, (PASARR) within 14 days of a significant change in condition on 07/27/23. 2. Review of Resident #9's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #9 include dementia, major depressive disorder, edema, bipolar disorder, schizoaffective disorder, hypertension, tachycardia, pacemaker, and heart failure. Review of the MDS comprehensive assessment dated [DATE] revealed the Resident #9 had moderately impaired cognition and required supervision with self-care, was dependent on care for toileting and bathing, and total dependent for care with mobility. Review of Resident #9's physician orders revealed the resident had orders for hospice services beginning on 12/29/23 and beginning on 03/23/24. Review of Resident #9's medical record revealed no Pre-admission Screening and Resident Review, (PASARR) within 14 days of a significant change in condition on 12/29/23 and on 03/23/24. Interview on 04/18/24 at 1:26 P.M., with Business Office Manager (BOM) #371 and Social Service Designee (SD) #375 verified Resident #49 and Resident #9 had a significant change in condition when accepting hospice services. BOM #371 stated the facility should have completed a revised PASARR and reported the significant change to the state mental health board within 14 days of the change to hospice services.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observation, staff interview, medical record review,and policy review, the facility failed to ensure the plan of care reflected the fluid restriction as ordered by the physician. The affected one (#61) of one resident reviewed for fluid restriction. The total facility census was 72. Findings include: Review of Resident #61's medical record revealed the resident was admitted to the facility on [DATE] . Diagnoses for Resident #61 include acute respiratory failure with hypoxia, dementia, chronic gastric ulcer, malnutrition, dependence on oxygen, and heart failure. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed the resident had impaired cognition and required moderate assistance with mobility and supervision assistance with feeding self. Review of physician orders dated 01/30/24 revealed orders for No Added Salt diet, nutritional supplement two times a day. Orders also included a fluid restriction 2000 cubic centimeters (cc) per day and document every shift. Review of Resident #61's Plan of Care on 04/16/24 revealed no fluid restriction or division of the fluid between department throughout a 24-hour period. Review of Resident #61's Plan of Care revealed a fluid restriction of 2000 cc with 360 cc breakfast, 360 cc at lunch, 360 cc at dinner and 920 cc for nursing was added to the Plan of Care on 04/17/24 by MDS Coordinator #324. Observation on 04/16/24 of the lunch meal and 04/17/24 breakfast meal, revealed Resident #61's meal ticket at breakfast and at lunch revealed no fluid restriction documented on the meal ticket. Observation of the breakfast meal of 04/17/24, revealed the resident had large containers of fluid greater than 480 cc and 240 cc of dark fluid at bedside, 480 cc fluid on the meal tray and 240 cc of supplement. Interview on 04/17/24 at 8:57 A.M., with State tested Nurse Assistant (STNA) #340 stated Resident #61 had no fluid restrictions and consumed a lot of soda and water. There was no knowledge Resident #61 had an order for fluid restrictions or the amount permitted for the nursing department. Interview on 04/17/24 at 9:12 A.M., with STNA #339 verified Resident #61 had no fluid restriction on her meal ticket and no fluid restriction listed in the plan of care for fluid restriction. STNA #339 verified there was no plan of care to indicate Resident #61 was on a fluid restriction. Interview on 04/17/24 at 12:45 P.M., with Dietary Manger (DM) #311 verified there had been no notification to the dietary department Resident #61 was on a fluid restriction. DM #311 verified the Dietary Department should have been notified of the fluid restriction and the fluid amounts allotted to the dietary and nursing departments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/24 at 12:55 P.M., with the MDS Coordinator #324 verified the STNAs and the dietary staff did not know of Resident #6's a fluid restriction order because the Plan of Care had not included the fluid restriction order and intervention. The MDS Coordinator #324 verified the fluid restriction, and the division of the fluids should have been included in the Plan of Care and on the dietary meal ticket to coordinate the fluid division between departments. Interview on 04/18/24 at 6:41 A.M., with night shift STNA #384 verified a fluid restriction intervention was added to Plan of Care for STNAs on 04/17/24. Prior to 04/17/24, STNA #384 was unaware Resident #61 had an order for a fluid restriction and the amount allotted for the nursing department. Review of the policy, titled, Encouraging and Restricting Fluids, dated October 2010, revealed when a resident is on restricted fluid remove fluids from the room. Review the resident care plan and the daily assignment sheet to assess for any special needs of the resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on observations, medical record review, resident interview, and staff interview, the facility failed to ensure physician orders were followed for assistive devices to prevent further contracture. This affected one (#52) of two residents reviewed for limited range of motion. The facility census was 72. Findings include: Review of the medical record of Resident #52 revealed an admitted [DATE]. The resident transferred to the hospital on 03/15/24 and returned to the facility on [DATE]. Diagnoses included encephalopathy, anxiety, hypothyroidism, depression, chronic obstructive pulmonary disease, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had moderately impaired cognition. The resident was assessed as having impaired range of motion to all extremities. The resident was dependent on staff for all activities of daily living. Observation and interview on 04/15/24 at 10:05 A.M., revealed both of Resident #52's hands were contracted. Resident #52 stated she was supposed to have wash cloths put in her hands but staff were not doing it consistently. Review of physician orders revealed an order dated 04/02/24 to apply bilateral towel rolls in palm for seven hours daily, on at 11:00 A.M. and off at 6:00 P.M. Observation on 04/16/24 at 1:20 P.M., revealed Resident #52 did not have wash cloths in either hand. Observation on 04/16/24 at 3:50 P.M., revealed Resident #52 did not have wash cloths in either hand. Interview on 04/16/24 at 3:51 P.M., with, Registered Nurse (RN) #304 verified Resident #52 did not have wash cloths in her hands as per the order. RN #304 stated he was not aware they were not in her hands and thought the aids had put them in. RN #304 verified the wash cloths should be worn daily between 11:00 A.M. and 6:00 P.M.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, staff interview, review of the Resident Assessment Instrument (RAI), and policy review, the facility failed to ensure a resident's significant weight loss was addressed in an accurate and timely manner. This affected one (#42) of three residents reviewed for weight loss. The facility also failed to ensure weights were completed per the physician's order. This affected two (#09 and #22) of five residents reviewed for nutrition. The facility census was 72. Findings include: 1. Review of the medical record of Resident #42 revealed an admitted [DATE]. Diagnoses included huntington's disease, mood disorder due to known physiological condition with depressive features, schizophrenia, and schizoaffective disorders. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had intact cognition. The resident exhibited delusions during the assessment period. Review of the medical record revealed, on 10/08/23, Resident #42 weighed 160.2 pounds. On 11/21/23, the resident weighed 157 pounds. On 01/02/24, the resident weighed 155.2 pounds. On 02/14/24, the resident weighed 152.8 pounds. On 03/04/24, the resident weighed 148.2 pounds. On 04/01/24, the resident weighed 144.2 pounds. Review of the care plan dated 03/02/24 revealed Resident #42 had a nutritional problem due to diagnoses of Huntington's Disease, schizophrenia, mood disorder. The resident received boost twice per day and remeron. On 03/02/24, the Resident #42's weight was described as stable. Review of current physician orders revealed an order dated 11/22/23 for Boost (oral supplement) twice daily with breakfast and supper. Review of meal intakes for the past 30 days revealed the resident consumed 75-100% of most meals. Review of a diet progress note dated 03/02/24 revealed Diet Technician Registered (DTR) #501 indicated Resident #42 received a regular diet with meal intakes of 75-100% at most meals and Boost twice a day. The resident weighed 152.8 pounds. The resident received Mirtazapine (remeron), which may promote appetite. No new recommendations were made at that time. Further review of the medical record revealed no indication of Resident #42's 4.6 pound weight loss from 03/04/24 being addressed and an additional four pound loss on 04/01/24 being addressed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/18/24 at 1:56 P.M., Diet Technician Registered (DTR) #501 stated, in a perfect world, weights would be addressed within a week, however, she worked at several buildings and had not been able to review weights obtained 18 days prior to the interview. DTR #501 stated Resident #42's weight loss was technically 9.9%, however the weight loss trend warranted being looked at. Review of DTR's method of calculating percent weight loss was taking the exact weight from 6 months prior (160.2 pounds), subtracting the exact current weight (144.2 pounds), dividing by the exact weight from 6 months prior (160.2 pounds), and multiplying by 100. DTR #501 verified Resident #42 had been on the same diet and supplement order since November 2023 and had lost 13 pounds since the last time any changes to his regimen were made. DTR #501 further verified she had not addressed the 4.6 pound loss from 03/04/24 nor the additional 4 pound loss from 04/01/24. Review of the Resident Assessment Instrument (RAI), section K, revealed the method for determining significant weight loss was to use mathematical rounding (ie if the weight is X.1 to X.4 pounds, round down to the nearest whole pound). For example, a weight of 152.4 pounds would be rounded to 152 pounds. Further review of Resident #42's weight loss, revealed the resident had a 10% weight loss (160 minus 144, divided by 160, multiply by 100) during the last 6 months. Interview on 04/18/24 at 2:19 P.M., the Director of Nursing (DON) stated the expectation would be for weights to be reviewed and addressed by the Registered Dietitian or DTR within seven days. The DON stated DTR #501 typically came to the facility on ce a week. Review of the policy titled, Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, dated September 2012, revealed a 10% weight loss in a six month period is severe and the physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Monitoring is also required for residents whose nutritional status is stable, including observing for and reporting significant weight loss. 2. Review of the medical record of Resident #22 revealed an admitted [DATE]. Diagnoses included end-stage renal disease, chronic diastolic heart failure, fluid overload, pulmonary embolism, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of physician orders revealed a current order, dated 03/04/24 for weekly weights and to notify the physician if greater than 5 pound weight gain and additional orders dated 02/08/24 to 02/26/24 for daily weights-report an increase or decrease of three pounds. Review of the medical record revealed the following weights: 04/06/24-235 pounds, 03/04/24- 247.5 pounds, 02/09/24- 266.8 pounds, 02/08/24- 245.3 pounds, and 02/07/24- 245.3 pounds. Review of progress notes and the medication administration record revealed the resident refused to be weighed on 02/10/24, 02/11/24, 02/13/24, 02/14/24, 02/15/24, 02/20/24, 02/21/24 02/22/24. Review of the medical record revealed no documentation of any weight or refusal to be weighed on 02/12/24, 02/16/24, 02/17/24, 02/18/24, 02/19/24, 02/23/24, 02/24/24, 02/25/24, 02/26/24, 03/11/24, 03/18/24, 03/25/24, 04/01/24, 04/08/24, and 04/15/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/18/24 at 10:30 A.M., Registered Dietitian (RD) #503 verified Resident #22's daily weights were not documented in February 2024 and weekly weights were not documented in March 2024 and April 2024. RD #503 stated weights completed are entered into the electronic medical record. Review of the policy titled, Weight Assessment and Intervention, dated March 2022, revealed weights are obtained at intervals established by the interdisciplinary team and recorded in the individual's medical record 44083 3. Review of Resident #9's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #9 include dementia, edema, hypertension, tachycardia, pacemaker, and heart failure. Review of the MDS comprehensive assessment dated [DATE] revealed the Resident #9 had moderately impaired cognition and required supervision with self-care, was dependent on care for toileting and bathing, and total dependent for care with mobility. Review of Resident #9 Plan of Care, dated 09/09/22, revealed the resident had edema to bilateral extremities with expected weight fluctuations. Review of physician orders revealed Resident #9 had orders for hospice service for two hospice periods, beginning on 12/29/23 and then again on 03/23/24. Resident #9 had a physician order, dated 02/25/24, to weigh the resident every morning related to congestive heart failure. The resident received Furosemide tablet 40 milligrams (mg) one time a day related to heart failure and Digoxin tablet 125 micro grams (mcg) one time a day related to atrial fibrillation. Review of Resident #9's weight record from 02/25/24 through 04/15/24 revealed missing weights on dates of 04/01/24, 04/02/24, 04/03/24, 04/04/24, 04/07/24, 04/08/24, 04/09/24, 04/10/24, 4/14/24, 04/15/24, 03/02/24, 03/03/24, 03/05/24, 3/07/24, 03/08/24, 03/09/24, 03/10/24, 03/11/24, 03/12/24, 03/13/24, 03/14/24, 03/15/24, 03/16/24,03/17/24, 03/08/24, 03/18/24, 03/19/24, 03/20/24, 03/21/24, 03/22/24,03/23/24, 03/24/24, 03/25/24, 03/26/24, 03/28/24, 03/29/24,03/30/24, 03/31/24, 02/26/24 and 02/29/24. Interview on 04/18/24 at 10:34 A.M., with RD #503 verified Resident #9 had a physician order for daily weight every morning to monitor congestive heart failure. RD #503 verified Resident #9's daily weights were not documented in the weight record log. RD #503 stated she had not been informed if Resident #9 had refused to be weighed daily and daily weights should be documented in the electronic medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365690	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarview Care Center	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)
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** 44083 Based on observation, record review, and staff interview, the facility failed to ensure the oxygen tubing was changed and dated as ordered by the physician. This affected for two (#19 and #61) of two residents reviewed for oxygen administration orders. The total facility census was 72. Findings include: 1. Review of Resident #19's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #19 include dementia, Down syndrome, chronic respiratory failure, and pseudobulbar affect. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed the resident had severely impaired cognition and required supervision of self-care and maximal assistance for mobility. Review of physician orders revealed Resident #19 was to receive oxygen two to four liters to keep oxygen saturation above 88 percent and oxygen tubing changed, label and date every Wednesday. Observation on 04/15/24 at 8:30 A.M., revealed Resident #19 oxygen tubing was not dated. Interview on 04/15/24 at 8:32 A.M., with Licensed Practical Nurse (LPN) #356 and State tested Nurse Aide(STNA) #330 verified Resident #19 oxygen tubing was not dated. 2. Review of Resident #61's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #61 include acute respiratory failure with hypoxia, dementia, chronic gastric ulcer, malnutrition, dependence on oxygen, and heart failure. Review of Resident #61's MDS comprehensive assessment dated [DATE], revealed the resident had impaired cognition and required moderate assistance with mobility and supervision assistance with feeding self. The resident was assessed to be short of breath with exertion, sitting at rest and when lying flat. The resident required continuous oxygen therapy. Review of physician orders dated 01/30/24 revealed Resident #61 was to receive continuous oxygen at three liters to keep saturation above 92 percent and to change oxygen tubing every Tuesday. Observation on 04/15/24 at 8:31 A.M., revealed Resident #61 oxygen tubing was not dated. Interview on 04/15/24 at 8:32 A.M., with LPN #356 and STNA #330 verified Resident #61 oxygen tubing was not dated. Interview on 04/17/24 at 2:17 P.M., with the Director of Nursing, (DON), verified Resident #19 and Resident #61 had physician orders for oxygen tubing to be changed weekly. The DON stated a contract company is to change and date to the oxygen tubing weekly and may have forgotten to date the tubing.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 31404 Based on record review and staff interview, the facility failed to post nurse staffing information that included the total number worked daily of Registered Nurses, Licensed Practical Nurses, and State tested Nurse Aides. This had the potential to affect all 72 residents in the building. The census was 72. Findings include: Observation on 04/17/24, revealed the Nursing Staffing posting did not include the number of Registered Nurses (RN), Licensed Practical Nurses (LPN), and State tested Nurse Aides (STNA) that were working. Review of the daily staffing posting from 03/01/24 to 04/17/24 revealed all the nursing staff postings sheets were missing the number of Registered Nurses (RN), Licensed Practical Nurses (LPN), and State tested Nurse Aides (STNA) that worked. Interview on 04/18/24 at 12:43 P.M., with the Administrator verified the staffing posting did not show the number of working RN, LPN, or STNA.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42731 Based on observation, staff interview, and policy review, the facility failed to ensure foods were stored in a manner to protect against the potential spread of food-borne illness. This had the potential to affect all 59 residents who received food from the kitchen. The facility identified 13 residents who were NPO (nothing by mouth) and did not receive food from the kitchen. The facility census was 72. Findings include: Observation on 04/18/24 at 1:16 P.M., revealed the refrigerator on the facility's C-hall contained 10 unlabeled containers, each containing unidentified substances. None of the containers were labeled nor dated. Additionally, there was a sandwich, which was loosely wrapped in a plastic sandwich bag, unsealed, unlabeled, and undated. Further observation revealed the refrigerator did not contain a thermometer, nor was any type of temperature log. Interview at the same time of the observation, with Registered Nurse (RN) #375 verified the 10 containers were unlabeled and undated and all foods in the refrigerator should be labeled and dated. RN #375 stated she thought five of the containers were ambrosia, however, she was unsure of the contents of the other containers. RN #375 verified the sandwich was not sealed, labeled, nor dated and stated the sandwiches are normally all kept in a large Ziploc back together which would be labeled and dated. RN #375 further verified the refrigerator did not have a thermometer and there was no temperature log. RN #375 stated refrigerator temperatures should be checked and recorded on each shift. Review of the policy titled, Food Receiving and Storage, dated October 2017, revealed all foods stored in the refrigerator will be covered, labeled, and dated with a use by date. Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines.

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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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observation and staff interview, the facility failed to provide full visual privacy for resident. This affected for two (#48 and #61) of three residents reviewed for physical environment. The total facility census was 72. Findings include: 1. Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #48 include acute respiratory failure, schizoaffective disorder, bipolar disorder, anxiety disorder, and depressive disorder. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed the resident had intact cognition and was dependent on staff for self-care and mobility. Observation on 04/15/24 at 8:32 A.M., revealed Resident #48 had no privacy curtain which prohibited full privacy around the entire bed. Resident #48 had a roommate. Interview on 04/15/24 at 8:32 A.M., with Licensed Practical Nurse (LPN) #356 and State tested Nurse Assistant(STNA) #330 verified Resident #48 had no privacy curtain and full privacy could not maintained while providing care. 2. Review of Resident #61's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #61 include acute respiratory failure with hypoxia, dementia, chronic gastric ulcer, malnutrition, dependence on oxygen, and heart failure. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed the resident had impaired cognition and required moderate assistance with mobility and supervision assistance with feeding self. Observation on 04/15/24 at 8:32 A.M., revealed Resident #61 had an privacy curtain ceiling track railing which was coming lose from the ceiling and had no privacy curtain. This prevented full visual privacy around Resident #61's bed. Resident #61 had a roommate. Interview on 04/15/24 at 8:32 A.M., with Licensed Practical Nurse (LPN) #356 and State tested Nurse Aide (STNA) #330 verified Resident #61's privacy curtain track was coming lose from the ceiling and had no privacy curtain. Full privacy could not maintain while providing care. Interview on 04/18/24 at 7:18 A.M., Housekeeping Director #401 verified double occupied resident rooms of Residents #48 and #61 had no privacy curtains on 04/15/24, which could not provide privacy for Residents #48 and #61.