

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365695	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Doylestown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 95 Black Drive Doylestown, OH 44230	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on observation, interview, record review, and facility policy review the facility failed to ensure Resident #20 was knowledgeable of the facility smoking policies and safe vaping procedures and care planned interventions were implemented. This affected one resident (#20) of one resident reviewed for smoking hazards.</p> <p>Findings include:</p> <p>Review of Resident #20's medical record revealed an admitted [DATE] with diagnoses including heart failure, mixed conductive and sensorineural hearing loss, cognitive communication deficit, and type 2 diabetes mellitus.</p> <p>Review of facility provided policy titled, No Smoking Policy dated March 2016, revealed the facility was smoke-free facility. Residents were not permitted to smoke in the residence or on the grounds. (Unless previously arranged on admission. Smoking will be done outside in designates area. No new admissions will be permitted to smoke). Effective March 1, 2016, new admissions were not permitted to use e-cigarettes or vapor cigarettes. Residents admitted prior to March 1, 2016, may use these devices if previously agreed upon. E-Cigarette or vapor cigarette material must be kept at the nurse station and smoking must be done in the designated area. The policy noted I have read the above policy and have had it explained to me. I fully understand and agree to the terms of the above policy. There was a place on the form for the resident and witness to sign.</p> <p>Review of Resident #20's medical record and information provided by the facility revealed no evidence Resident #20 signed the 2016 No Smoking Policy.</p> <p>Review of the quarterly minimum data system (MDS) dated [DATE] revealed Resident #20 had intact cognition.</p> <p>Review of the physician order dated 09/23/23 revealed Resident #20 may use electronic cigarette and may keep at bedside.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan initiated on 08/02/24 and revised on 05/13/24 revealed Resident #20 used an e-cigarette daily, he had an order for a nicotine patch, there were times resident went go outside and smoked his E-cigarette, and he was allowed to smoke in his room. Interventions included resident can smoke unsupervised, instruct resident about facility policy on smoking: locations, times, safety concerns.</p> <p>Observation and interview on 09/09/24 at 9:53 A.M. with Resident #20 revealed he was vaping in his room during interview with his vaping supplies on the over bed tray. Resident #20 reported he is permitted to vape in his room and keep his vaping supplies in his room.</p> <p>Observation and interview on 09/11/24 at 9:25 A.M. with Resident #20 revealed his vaping supplies were on the over bed tray in his room. Resident #20 denied signing anything regarding vaping. Resident #20 reported he lived her [AGE] years and has been vaping here for [AGE] years.</p> <p>Interview on 09/11/24 at 9:40 A.M. with the Director of Nursing (DON) #201 confirmed Resident #20 had been permitted to vape in his room and keep his vape supplies with him. DON #210 reported it has been that way since way before they were hired. DON #201 not aware if Resident #20 signed a smoking form and unable to provide signed smoking form for Resident #20.</p> <p>Interview on 09/11/24 at 2:00 P.M. with Assistant Director of Nursing (ADON) #207 revealed she and Licensed Social Worker (LSW) #207 spoke with Resident #20 (on this day 09/11/24) regarding he must vape outside in designated area and his vape supplies must be kept at nurses' station. ADON #207 reported no documentation regarding Resident #20 signed smoking policy prior to 09/11/24.</p> <p>Interview on 09/12/24 at 11:45 A.M. with LSW #246 reported she didn't know if Resident #20 signed a smoking form prior to this day. LSW #246 reported the facility was looking for the signed smoking form and was unable to locate it.</p> <p>Review of the updated policy provided by the facility tilted, Smoking Policy dated 01/2023, revealed the facility was a smoke free facility. There was no smoking in the residence. This policy applies to all families, visitors, staff, and residents. Residents who request to smoke will be assessed for safety upon admission and smoking will be done in designated outdoor smoking areas. Smoking includes cigarettes, cigars, pipes, e-cigarettes, vape pens/devices. All smoking materials including lighters/matches/e-cigarettes/vape charging devices must be kept in a secured area at nurses' stations. These items cannot be kept in resident rooms. The policy noted I have read the above policy and have had it explained to me. I fully understand and agree to the terms of the above policy. There was a place on the form for the resident and a witness to sign.</p> <p>Review of Resident #20's medical record and information provided by the facility revealed no evidence Resident #20 signed the 2023 No Smoking Policy.</p> <p>After surveyor intervention, the facility provided evidence Resident #20 signed and dated the No Smoking Policy, revised March 2016 on 09/11/24 rather than the updated policy dated 01/2023.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>39333</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, interview, and the facility submitted Payroll Based Journal (PBJ) tracking information, the facility failed to ensure service of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 68 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the PBJ Staffing Data Report form submitted from 01/01/24 through 03/31/24 revealed the following dates submitted for the second quarter, the facility was low on registered nurse (RN) hours in the building on the following dates: 01/01/24 Monday (MO); 01/06/24 Saturday (SA); 01/14/24 Sunday (SU); 01/21/24 (SU); 01/28/24 (SU); 02/10/24 (SA); 02/11/24 (SU); 02/17/24 (SA); 02/18/24 (SU); 03/02/24 (SA); 03/10/24 (SU); 03/16/24 (SA); 03/17/24 (SU); 03/30/24 (SA); and 03/31/24 (SU).</p> <p>Review of schedules and assignment sheets from 01/01/24 through 08/11/24 with the DON on 09/11/24 at 8:44 A.M. revealed a RN was present in the building for at least eight consecutive hours a day, seven days a week as required except for the following dates: 01/01/24 Monday (MO); 01/06/24 Saturday (SA); 01/14/24 Sunday (SU); 01/21/24 (SU); 01/28/24 (SU); 02/10/24 (SA); 02/11/24 (SU); 02/17/24 (SA); 02/18/24 (SU); 03/02/24 (SA); 03/10/24 (SU); 03/16/24 (SA); 03/17/24 (SU); 03/30/24 (SA); 03/31/24 (SU); 04/13/24 (SA) and 04/14/24 (SU). This was verified by the DON on 09/11/24 at 8:43 A.M.</p> <p>Interview on 09/11/24 at 8:44 A.M. with the Director of Nursing (DON) stated that there was a hard time getting registered nurses. The DON stated that at the end of April 2024 corporate established an intercompany agency that has RNs, they hired four new RNs and offered a sign on bonus.</p> <p>The deficient practice was corrected on 04/15/24 when the facility implemented the following corrective actions:</p> <p>Beginning in March 2024, the facility corporation started an intercompany agency sending RN's to facilities that need staff.</p> <p>At the end of April (04/30/24), the facility started staff sign on bonuses.</p> <p>The facility hired four registered nurses: RN #207, RN# 223, RN #239, RN #271, and RN #500.</p> <p>Review of schedules and assignment sheets from 04/15/24 through 08/31/24 with the DON, Human Resource Director (HR) #501 and Nursing Assistant Coordinator/State tested Nursing Assistant (STNA) #203 on 09/11/24 at 8:15 A.M. through 8:40 A.M. revealed a (RN) was present in the building for at least eight consecutive hours a day, seven days a week as required.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>Based on observation, interview and record review, the facility failed to follow the menu and give residents the alternate menu items of choice. This affected three residents (Residents #10, #20, and #37) of three residents who had their meals and tickets reviewed. The facility census was 68.</p> <p>Findings include:</p> <p>1. Review of Resident #10's medical record revealed an admitted [DATE] and a readmitted [DATE] with diagnoses included but not limited to atrial fibrillation, adjustment disorder, and peripheral vascular disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 was moderately cognitively impaired and required supervision for eating.</p> <p>Review of the physician's order for September 2024 revealed Resident #10 was ordered a regular diet, with regular texture and thin consistency liquids on 04/12/24.</p> <p>Observation and interview on 09/11/24 at 1:13 P.M. revealed Resident #10 ordered a sloppy joe melt on a bun, French fries, macaroni salad and [NAME] slaw. Resident #10's lunch tray had cheesy potato casserole instead of French fries and a chicken breast instead of a sloppy joe melt. Interview with Resident #10 revealed that she was upset because her daughter orders her meals based on her likes and she doesn't eat chicken breast. State tested Nursing Assistant (STNA) #237 verified at time of observation.</p> <p>2. Review of Resident #20's medical record revealed an admitted [DATE] with diagnoses included but not limited to heart failure, major depressive disorder, and peripheral vascular disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact and required set up for eating.</p> <p>Review of the physician's order for September 2024 revealed Resident #20 was ordered a regular diet, with regular texture and thin consistency liquids on 08/13/24.</p> <p>Observation and interview on 09/11/24 at 1:00 P.M. revealed that Resident #20 ordered a sausage on a bun, French fries, macaroni salad and [NAME] slaw. Resident #20's lunch tray had cheesy potato casserole instead of French fries and macaroni salad. Interview with Resident #20 revealed he was upset and stated he was not hungry. State tested Nursing Assistant (STNA) #237 verified at time of observation.</p> <p>3. Review of Resident #37's medical record revealed an admitted [DATE] with diagnoses included but not limited to diabetes, left femur fracture, and hypothyroidism.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact and required set up for eating.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician's order for September 2024 revealed Resident #37 was ordered a regular diet, with regular texture and thin consistency liquids on 06/22/24.</p> <p>Observation and interview on 09/11/24 at 1:00 P.M. revealed Resident #37 ordered a sloppy joe and French fries. Resident #37's lunch tray had cheesy potato casserole instead of French fries and a chicken breast. Interview with Resident #37 revealed she was upset and stated that she does not eat chicken breast and it looked dry. State tested Nursing Assistant (STNA) #237 verified at time of observation.</p> <p>Interview on 09/11/24 at 2:05 P.M. with A.M. [NAME] #257 revealed there were no French fries, no macaroni salad, and no ground beef for sloppy joes. [NAME] #257 stated the dietary manager did the food order prior to going on vacation. [NAME] #257 stated they do not run out of food often. [NAME] #257 stated in the past, she would tell her supervisor or the administrator but didn't notify any staff or residents this time and verified residents did not get the alternative they selected.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39333</p> <p>Based on observations, interview and policy review, the facility failed to ensure food was stored properly and the kitchen and food service areas were clean and sanitary. This had the potential to affect all 68 residents in the facility receiving meals from the kitchen.</p> <p>Findings include:</p> <p>1. Initial tour of the kitchen on 09/09/24 from 7:37 A.M. through 8:05 A.M. revealed the dry storeroom had food residue and a dried black liquid on the floor, the bottom of the reach-in freezer had frozen liquid on the bottom, and in the walk-in refrigerator there was sliced cheese and sliced turkey that was not labeled or dated. This was verified by [NAME] # 257 on 09/09/24 at 8:06 A.M.</p> <p>2. Observation of memory care unit's serving area on 09/09/24 at 12:06 P.M. revealed the microwave was dirty and the top inside of the microwave had rust spots. This was verified by Licensed Practical Nurse (LPN) #210 at time of observation.</p> <p>Interview on 09/11/24 10:53 A.M. with Registered Dietitian (RD) #508 revealed she inspects the kitchen monthly. RD revealed was shocked to see the microwave on memory care unit in that condition.</p> <p>Review of the facility policy dated 05/22 with a revision date of 02/23 titled, Corporate Nutrition Services, revealed that the following guidelines in this policy will help ensure food safety and sanitation in a commercial kitchen. Equipment should be cleaned after use. There was no mention of labeling or dating in the policy.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on observation, record review, and interview the facility failed to maintain acceptable infection control practices during medication administration. This affected two residents (#16 and #120) of two residents reviewed for medication administration.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #120 revealed an admitted [DATE] with diagnosis including but not limited to heart failure and type 2 diabetes mellitus with diabetic neuropathy.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.</p> <p>On 09/10/24 at 7:51 A.M. Licensed Practical Nurse (LPN) #400 was observed administering medications to Resident #120. Resident #120 was taking medications from medicine cup and dropped 6 pills from the medicine cup on the bed sheets. LPN #400 picked up the six pills with her bare hands and placed them in the medicine cup and proceeded to administer the six pills to the resident.</p> <p>Interview on 09/10/24 at 7:56 A.M. with LPN #400 verified she should have used gloves to pick up his medication and not her bare hands.</p> <p>Interview on 09/10/24 at 8:47 A.M. with Director of Nursing (DON) confirmed LPN #400 should have used gloves to pick up Resident #120's medication from his bed sheets and not her bare hands.</p> <p>2. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnosis included but not limited to cognitive communication deficit and dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.</p> <p>On 09/10/24 at 9:00 A.M. LPN #210 was observed picking up the medication cup from the medication cart. One pill fell out of the medicine cup and fell on to the medication cart. LPN #210 used a spoon to push the pill back into the medicine cup and proceeded to Resident #16's room and administered the medications.</p> <p>Interview on 09/10/24 at 9:09 A.M. with LPN #210 verified she should have thrown the pill out that fell on to the medication cart and got a new pill.</p> <p>Interview on 09/10/24 at 9:53 A.M. with DON verified if a nurse dropped medication on the medication cart they are to dispose of it and get a new pill.</p>		