

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Arbors at Stow		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 L'Ermitage Pl Stow, OH 44224	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>Based on observation, review of the facility policy, and interview with staff the facility failed to ensure the water temperature on the 200 unit was maintained at a comfortable temperature. This affected seven residents (Resident #17, #29, #40, #51, #74, #83, and #110) who resided on the 200 hall and had the potential to affect all 23 residents on the 200 unit (#17, #29, #30, #34, #35, #40, #45, #47, #50, #51, #54, #58, #65, #74, #79, #83, #93, #86 #97, #98, #103, #110, #117). The facility census was 125.</p> <p>Findings include:</p> <p>On 01/07/25 at 9:30 A.M. an interview with Certified Nursing Assistant #520 revealed the 200 unit never had enough hot water for showers and the water never really got hot.</p> <p>Observation on 01/07/25 at 10:00 A.M. revealed the hot water temperature in the central bathing room on the 200 unit was 105 degrees Fahrenheit (F), the hot water in Resident #17 and 51's room was 98 degrees F, and the hot water in Resident 40 and 83's Room was 88 degrees F.</p> <p>Observation of water temperatures with Maintenance Director #472 on the 200 unit on 01/07/25 at 11:40 A. M. revealed the hot water temperature in the central bathing room was 114.1 degrees F, the hot water in Resident #17 and #51's room was 104.1 degrees F, the hot water in Resident #40 and #83's room was 95.4 degrees F, and in Resident #29 and #110's room the water temperate was 99.1 degrees F. Maintenance Director #472 verified the water temperatures were below 105 degrees F.</p> <p>Review of the facility water temperature log from 10/01/24 to 01/01/25 revealed the proper water temperature was 105 degrees Fahrenheit (F) to 120 degrees F. The temperatures documented for the 200 Unit were 111-112 degrees F.</p> <p>On 01/09/25 at 11:40 A.M. an interview with Resident #74 revealed there was never enough hot water for showers. He stated he usually received his shower around 11:00 A.M. and the water was cold.</p> <p>On 01/09/25 at 11:45 A.M. an interview with Resident #110 revealed the hot water was not very hot and he did not like to get a shower because it was too cold. He stated the water in his room never got hot.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Safe Water Temperatures, dated 01/01/22 revealed it was the policy of the facility to maintain appropriate water temperatures in resident care areas.</p> <p>Review of the medical record revealed Resident #17 was admitted to the facility on [DATE]. Diagnoses included severe dementia, hypertension, osteoarthritis, hallucinogen use, anxiety disorder, dysphagia, major depressive disorder, and peripheral vascular disease. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 17 had severely impaired cognition and required maximum assistance with bathing.</p> <p>Review of the medical record revealed Resident #29 was admitted to the facility on [DATE]. Diagnoses included severe dementia, diabetes, heart failure, anxiety disorder, major depressive disorder, chronic pain, dysphagia, osteo arthritis, hypertension, gout, and alcohol abuse. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #29 had severely impaired cognition and required moderate assistant for bathing.</p> <p>Review of the medical record revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, vascular dementia, moderate protein-calorie disturbance, emphysema, adult failure tot thrive, history of adult neglect, sexual disorders, atherosclerotic heart disease, psychosis, transient ischemic attack, anemia, osteoarthritis, insomnia, major depressive disorder, atopic dermatitis, anxiety disorder, hydrocele, dysphagia, and dermatophytosis.</p> <p>Review of the medical record revealed Resident #51 was admitted to the facility on [DATE]. Diagnoses included severe dementia, diabetes, benign prostatic hyperplasia, delusional disorder, aortic aneurysm, emphysema, psychosis, congestive heart failure, anxiety disorder, insomnia. major depressive disorder, and amnesia.</p> <p>Review of the Modification to the Annual MDS assessment dated [DATE] revealed Resident #51 had severely impaired cognition and required supervision for bathing.</p> <p>Review of the medical record revealed Resident #74 was admitted to the facility on [DATE]. Diagnoses included right side hemiplegia, extended-spectrum beta-lactamases, chronic obstructive pulmonary disease, asthma, diabetes, protein-calorie malnutrition, anemia, dysphagia, benign prostate hyperplasia, malignant neoplasm of the prostate, restless leg syndrome, hypertension, obstructive sleep apnea, dementia, anxiety disorder, cerebral infarction, gout, insomnia, major depressive disorder, and osteoarthritis. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #74 had severely impaired cognition.</p> <p>Review of the medical record revealed Resident #83 was admitted to the facility on [DATE]. Diagnoses included dementia, hypertension, celiac disease, polyneuropathy, generalized anxiety disorder, and depression. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #83 had severely impaired cognition and required moderate assistant for bathing.</p> <p>Review of the medical record revealed Resident #110 was admitted to the facility on [DATE], Diagnoses included dementia, chronic obstructive pulmonary disease, diabetes, moderate protein-calorie malnutrition, major depressive disorder, hypertension, traumatic brain injury, anxiety disorder, insomnia, benign prostatic hyperplasia, and chronic kidney disease. Review of the Admission MDS dated [DATE] revealed Resident #110 had intact cognition and he refused bathing.</p> <p>(continued on next page)</p>		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Complaint Number OH00160780, OH00160433, and OH00160414.		

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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>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** 35765</p> <p>Based on observation, review of the medical record, review of the facility policy and interview with staff the facility failed to ensure hair care was provided to Resident #35 and Resident #40. This affected two residents (Resident #35 and #40) out of five reviewed for activities of daily living (ADL). The facility census was 125.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE]. Diagnoses included dementia, diabetes, aphasia, cerebral infarction, atrial fibrillation, intracerebral hemorrhage, psychosis, peripheral vascular disease, congestion heart failure, osteoarthritis, allergic rhinitis, insomnia, hyperlipidemia, major depressive disorder, generalized anxiety disorder, over active bladder, and vitamin D deficiency.</p> <p>Review of the plan of care dated 08/29/23 revealed Resident #35 had an ADL self care performance deficit related to anxiety, cognitive impairment, congestive heart failure, cerebral vascular accident, pain, dementia, depression, and lack of coordination. Interventions indicated Resident #35 required one person assistance for personal hygiene.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #35 had severely impaired cognition and was dependent for personal hygiene.</p> <p>Observations on 01/06/25 at 9:30 A.M., 11:56 A.M. and 2:30 P.M. revealed Resident #35 was sitting out in the lounge area in a chair and his hair was sticking up everywhere.</p> <p>On 01/07/25 at 2:30 P.M. an interview with Certified Nursing Assistant (CNA) #452 verified Resident #35 had not had his hair combed.</p> <p>Observation on 01/07/25 at 10:11 A.M. revealed Resident #35 was being walked out of the central bathing room after his shower with CNA #454. CNA #454 sat him down in a recliner with his hair not combed. CNA #454 went back into the central bathing room, came back out with her jacket and took her jacket into the janitor's closet. CNA #454 never attempted to comb the hair of Resident #35.</p> <p>On 01/07/25 at 10:14 A.M. an interview with CNA #454 confirmed she had not combed/brushed the hair of Resident #35.</p> <p>Observation on 01/09/25 at 8:40 A.M. revealed Resident #35 was sitting out in the lounge and his hair was not combed and was sticking up everywhere. An interview at this time with Licensed Practical Nurse #443 confirmed the hair of Resident #35 had not been combed and she instructed a CNA to comb his hair.</p> <p>(continued on next page)</p>		

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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>Review of the facility policy titled, Activities of Daily Living, dated 12/28/23 revealed the facility took measures to minimize the loss of residents' functional abilities including ADLs. ADLs included the ability to bathe, dress, groom, transfer, ambulate, toilet, and eat. A resident who was unable to carry out ADLs was to receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>2. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), vascular dementia, moderate protein-calorie disturbance, emphysema, adult failure tot thrive, history of adult neglect, sexual disorders, atherosclerotic heart disease, psychosis, transient ischemic attack, anemia, osteoarthritis, insomnia, major depressive disorder, atopic dermatitis, anxiety disorder, hydrocele, dysphagia, and dermatophytosis.</p> <p>Review of the plan of care dated 02/02/24 revealed Resident #40 had an ADL self-care performance deficit related to anxiety, dementia, depression, COPD, fluctuating ADLs, and a history of falls. Interventions indicated Resident #40 required one person assistance for personal hygiene.</p> <p>Review of the Annual MDS assessment dated [DATE] revealed Resident #40 had severely impaired cognition and was dependent on staff for persona hygiene.</p> <p>Observation on 01/06/25 at 11:59 P.M. and 2:33 P.M. revealed Resident #40 was sitting in the lounge area in his wheelchair. His hair was not combed.</p> <p>On 01/06/25 at 2:33 P.M. an interview with CNA #454 confirmed she had not combed the hair of Resident #40.</p> <p>Review of the facility policy titled, Activities of Daily Living, dated 12/28/23 revealed the facility took measures to minimize the loss of residents' functional abilities including ADLs. ADLs included the ability to bathe, dress, groom, transfer, ambulate, toilet, and eat. A resident who was unable to carry out ADLs was to receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160433.</p>		

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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>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** 30809</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 and interview the facility failed to provide adequate supervision to Resident #7 to prevent Resident #7 from obtaining an over-the-counter medication and possible ingestion of the medication. This affected one out of three residents reviewed for accidents.</p> <p>Findings include:</p> <p>Clinical record review revealed Resident #7 was readmitted on [DATE] with diagnoses including dementia, malnutrition, stage three kidney failure, high blood pressure, atherosclerotic heart disease, anxiety, disorientation, heart disease with heart failure, irritable bowel syndrome, auditory hallucinations, hypothyroidism, chronic inflammation of the gallbladder, depression, insomnia, viral hepatitis, bipolar disorder with psychotic features, old heart attack, gastroesophageal reflux disease, obsessive compulsive disorder, borderline personality disorder, dependent personality disorder, post-traumatic stress disorder, vitamin D deficiency, iron deficiency, trouble swallowing, schizoaffective disorder, and schizophrenia.</p> <p>Review of Resident #7's nursing progress note dated 09/10/24 indicated staff had found a container of Tylenol medication under her pillow on her bed. Resident #7 informed the staff she had found the Tylenol container with Tylenol medication on the desk and no staff had seen her take the medication off the desk. The container of Tylenol was inspected and pills were counted. Resident #7's vital signs were obtained and were within normal limits and at baseline for Resident #7. Poison control was notified. Resident #7's vital signs were monitored and no acetaminophen (Tylenol) based products were to be administered for 24 hours.</p> <p>An interview with Regional Director of Clinical Services (RDCS) #606 on 01/09/25 at 12:54 P.M. verified the above finding and stated the facility was unable to determine if Resident #7 had consumed any of the Tylenol medication. The facility had contacted the poison control center and followed the guidance provided by the poison control center. There were eight Tylenol 325 milligram (mg) tablets missing from the container of Tylenol found under Resident #7's pillow. The facility was able to watch Resident #7 obtain the Tylenol from the top of the medication cart located in the common area of the E pod nursing unit on the facility's video camera. RDCS #606 stated the incident was discussed during the quality assurance and performance improvement committee and a plan of correction was developed and implemented. A full house search for medication was conducted of all residents in the facility. All nursing staff and medication technicians were educated regarding medication storage. All nursing staff and technicians completed a quiz twice a week for four weeks to verify their knowledge of medications storage and securing medications. Medication carts were observed weekly to ensure compliance with the storage and security of medications in the facility. Random resident room sweeps were conducted three to four times a week for four weeks to ensure no medications were in resident possession.</p> <p>(continued on next page)</p>		

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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>On 01/09/25 at 2:33 P.M. and interview with Licensed Practical Nurse (LPN) #607 revealed she was assigned to care for Resident #7 at the time of the incident on 09/10/24. LPN #607 stated she had inadvertently left a container of Tylenol 325 mg pills on top of her cart. Resident #7 saw the Tylenol container on top of her cart and took the container and hid the container of Tylenol pills under her pillow in her room. During the early morning hours on 09/10/24 an unnamed certified nursing assistant (cna) found the container of Tylenol under Resident #7's pillow in her room. LPN #607 notified the Administrator, Director of Nursing (DON), poison control center and Resident #7's family of the incident. LPN #607 stated she was in charge of two nursing units and was on the other nursing unit when Resident #7 took the container of Tylenol tablets off her medication cart. LPN #607 indicated the staff did not supervise Resident #7 closely to prevent her from obtaining the container of Tylenol medication.</p> <p>Review of the facility policy Medication Storage implemented on 10/30/20 indicated the policy of the facility was to ensure all medications housed on the premises would be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.</p> <p>The guidelines for storage of medications included:</p> <p>a. All drugs and biologicals would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.</p> <p>b. Only authorized personnel would have access to the keys to locked compartments (see attached listing).</p> <p>c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.</p> <p>The deficient practice was corrected on 10/18/24 when the facility implemented the following corrective actions:</p> <p>On 09/10/24 the poison control center was contacted by LPN #607 for guidance for how to proceed.</p> <p>On 09/10/24 the Quality Assessment and Process Improvement committee met and discussed the plan to correct the deficient practice.</p> <p>On 09/10/24 the DON in-serviced the licensed nurses and medication technicians on the facility medication administration and medication storage policy. This was confirmed by review of sign in sheets.</p> <p>On 09/10/24 all residents' rooms were searched by the Administrator and DON to ensure no medications were stored in their room and residents had no medications in their possession.</p> <p>(continued on next page)</p>		

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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>On 09/10/25 the licensed nursing staff and medication technicians completed a medication storage quiz to determine knowledge of medication administration and storage policy. Licensed nursing staff and medication technicians completed a medication storage quiz twice a week for four weeks ending on 10/18/24.</p> <p>On 09/10/25 resident room sweeps were initiated three to four times a week to be completed by unit managers and the DON to ensure no medications were in the residents' possession. The room sweeps were discontinued on 10/18/25 with no concerns identified.</p> <p>On 09/10/25 bi-weekly random observations of the medication carts by the unit managers and DON were initiated to ensure the carts were locked and secured appropriately. The bi-weekly observations of the medication carts were discontinued on 10/18/25 with no concerns identified.</p> <p>Observations from 01/02/15 through 01/09/25 on all shifts revealed no unsecured medications.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809</p> <p>Based on observation, record review, policy review and interview the facility failed to ensure residents received adequate fluids to prevent dehydration. This affected Resident #73 and had the potential to affect 17 residents (#19, #28, #36, #49, #59, #63, #67, #70, #71, #72, #81, #84, #87, #88, #91, #99, and #109) who resided on the C pod nursing unit and 19 residents (#5, #31, #33, #41, #44, #46, #64, #66, #73, #77, #90, #92, #94, #100, #101, #108, #112, #121 and #224) who resided on the D pod nursing unit. The facility also failed to ensure diets were followed as ordered. This affected one resident (Resident #93) of five reviewed for nutrition. The facility census was 125.</p> <p>Findings include:</p> <p>Actual harm occurred on 11/16/24 when Resident #73, who had severe cognitive impairment was noted to have an acute change in condition/altered mental status with slurring/mumbling words, an inability to perform hand grasps and equal but fixed pupils. The resident was transferred to the hospital and admitted with dehydration with elevated sodium, acute kidney injury which required intravenous fluids to treat. The resident returned to the facility on [DATE].</p> <p>Findings include:</p> <p>1. Clinical record review revealed Resident #73 was admitted on [DATE] with diagnoses including Alzheimer's disease, chronic kidney disease (stage 3), hyperlipidemia, atherosclerotic heart disease, anemia delusional disorders, dementia with behaviors, vitamin D deficiency, osteoarthritis, gastroesophageal reflux disease, depression, paranoid personality disorder, high blood pressure, cardiac murmur, benign prostatic hyperplasia with lower urinary tract symptoms, hyperosmolality, heart attack, mood disorder, irritable bowel syndrome, anxiety, and dysphagia (trouble swallowing).</p> <p>Review of Resident #73's plan of care dated 12/21/23 revealed Resident #73 was at risk for fluid volume deficit related to cognitive impairment. Interventions on the plan of care included to encourage Resident #73 to drink fluids of choice unless contraindicated (i.e., fluid restriction) and assist as needed; offer fluids during activities; offer fluids of choice; ensure all beverages offered complied with diet/fluid restrictions and consistency requirements, and review and report to physician/certified nurse practitioner abnormal laboratory results and any signs of dehydration.</p> <p>Review of the change of condition nursing progress note dated 11/16/24 indicated the nurse was on another nursing unit when an unnamed certified nursing assistant (CNA) notified the nurse that Resident #73 was previously alert at baseline and then was observed sitting at common area table slumped forward and unresponsive for a few seconds. The nurse immediately went to the unit and assessed Resident #73 and obtained his vital signs. The nurse obtained a blood pressure of 176/56, heart rate of 74 beats per minute, respirations 18 per minute, oxygenation level was 97 percent on room air, and temperature was 97.2 degrees Fahrenheit (F). Resident #73 appeared to have a decrease in alertness, was observed slurring/mumbling words, and unable to grasp hands. Resident #73's pupils appeared equal but fixed. The nurse called emergency medical services (911) and waited with Resident #73 until emergency medical personnel arrived. Resident #73 was transported to the hospital for evaluation and treatment.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #73's fluid intake documentation dated 11/01/24 to 11/30/24 revealed Resident #73 had consumed only between 850 milliliters (ml) and 900 ml of fluid on 11/14/24 and 11/15/24 prior to his hospitalization on [DATE] for a diagnosis of dehydration.</p> <p>Review of the nursing progress note dated 11/17/24 revealed the nurse contacted the hospital and was informed Resident #73 was admitted with a diagnosis of altered mental status.</p> <p>Review of the nursing progress note dated 11/19/24 revealed Resident #73 was readmitted to the facility from the hospital.</p> <p>A review of Resident #73's discharge summary from the hospital dated 11/19/24 indicated Resident #73 was discharged from the hospital in fair condition. The reason for Resident #73's admission to the hospital was altered mental status, dehydration, and high blood pressure. The discharge summary indicated Resident #73 who had a history of Alzheimer's disease, and hypertension (high blood pressure) presented with concern of altered mental status, decreased arousability from the (facility) memory care unit. Upon arrival his mentation slowly improved and Resident #73 was found to be dehydrated with elevated sodium, acute kidney injury and was started on intravenous fluids. Neurology was consulted and found Resident #73 was negative for seizure but demonstrated encephalopathy. Neurology did not feel encephalopathy was central neurologic in nature and signed off the case.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73's had severe cognitive impairment.</p> <p>An interview on 01/08/25 at 7:30 A.M. with Licensed Practical Nurse (LPN) #494 revealed when a resident returned from the hospital LPN #494 completed a head to toe assessment and obtained vital signs and reviewed the medication list. LPN #494 verified the medication list and obtained other orders from the physician. LPN #494 stated he readmitted Resident #73 back to the facility on [DATE] and had received report by phone from the nurse at the the hospital prior to Resident #73's arrival to the facility. LPN #494 did not document what the nurse had told him during the report and was unable to remember what the nurse had told him during the phone call. LPN #494 did not remember the hospital's diagnoses during Resident #73's admission to the hospital and could not state what was being done to prevent Resident #73 from being readmitted to the hospital (related to concerns with dehydration). LPN #494 was unable to state where information from the hospital could be located in Resident #73's clinical record. LPN #494 did not know what care planned interventions were in place to prevent Resident #73 from returning to the hospital for the altered mental status symptoms/dehydration. LPN #494 verified most of the residents on the D pod nursing unit were cognitively impaired which made them at risk for dehydration but was unable to state where he would need to look on the residents' plan of care for interventions to implement to ensure the residents had adequate hydration.</p> <p>An interview with CNA #509 on 01/08/25 at 8:31 A.M. revealed CNA #509 was unaware Resident #73 was at risk for dehydration or had been admitted to the hospital recently for a diagnosis of dehydration. CNA #509 stated the residents (including Resident #73) were not provided water unless they asked for water and could request water from the staff.</p> <p>An interview with the Director of Nursing on 01/09/25 at 10:25 A.M. verified Resident #73 was hospitalized with a diagnosis of dehydration as noted on the hospital discharge summary dated 11/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Registered Dietitian (RD) #902 on 01/09/25 at 10:45 A.M. revealed Resident #73's calculated fluid need was 1, 650 ml of fluid per day to prevent dehydration. RD #902 stated residents (including Resident #73) should be offered two cold beverages and one hot beverage of choice with each meal.</p> <p>Review of facility policy Hydration, revised 10/26/23, revealed the facility would offer each resident sufficient needs and preferences to maintain proper hydration and health.</p> <p>2. An observation on 01/07/25 at 9:00 A.M. revealed there was no cup of water present in the residents' rooms on the D pod. An interview with CNA #509 revealed the residents could request water and the staff would provide them water upon request. CNA #509 verified the residents did not have water within their reach at all times and needed to make a request for water which would be provided.</p> <p>There were 19 residents, Resident #5, #31, #33, #41, #44, #46, #64, #66, #73, #77, #90, #92, #94, #100, #101, #108, #112, #121 and #224 who resided on the D pod nursing unit.</p> <p>An observation of the breakfast meal on 01/08/25 between 7:30 A.M. and 9:00 A.M. on the D pod nursing unit revealed the meal cart arrived with a one gallon pitcher of orange juice, one gallon pitcher of water and a carafe of hot coffee. The residents were seated in the dining room and encouraged to get out of bed to eat their breakfast. All the residents were served one cup of orange juice filled 2/3 to 3/4 full. There were three more meal trays to be served when the gallon of orange juice was empty. The staff had to return to the kitchen to obtain additional orange juice to finish serving all the residents a beverage.</p> <p>An interview with CNA #509 on 01/08/25 at 8:31 A.M. revealed one resident (name not provided) out of the 19 residents residing on the D pod nursing unit were at risk for dehydration. CNA #509 stated the activity personnel brought fluids and a snack to the unit daily but was unable to state where the activity staff documented the amount of fluid the residents consumed to ensure they were well hydrated. CNA #509 stated the residents were not provided water unless they asked for water and could request water from the staff.</p> <p>Review of the facility's Week at a Glance for the facility's four week 2024-2025 menus revealed for breakfast eight ounces milk, six ounces of coffee or tea, and four ounces of juice would be offered, for lunch six ounces of coffee or hot tea would be offered, and for dinner eight ounces of milk and six ounces of coffee or hot tea would be offered.</p> <p>Review of facility policy Hydration, revised 10/26/23, revealed the facility would offer each resident sufficient needs and preferences to maintain proper hydration and health.</p> <p>46195</p> <p>3. Observation on 01/08/25 at 8:38 A.M. of the residents in the common area of the C Pod revealed the residents had a half glass full (four ounces or 120 milliliters) of orange juice on their breakfast tray. A gallon pitcher of juice on the beverage cart was empty.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/08/25 at 8:36 A.M. and on 01/09/25 at 10:07 A.M. with Certified Nursing Assistant #444 revealed the residents on C Pod preferred juice over water, but there was not enough juice to provide a full glass for each resident. The CNA stated when they would call down to the kitchen to get more juice, it would take too long for the kitchen to bring the extra juice, and by the time the kitchen brought the extra juice to the pod, the residents no longer wanted the juice.</p> <p>Interview on 01/09/25 at 10:07 A.M. with Registered Nurse #488 revealed residents were receiving 120 milliliters (four ounces) of fluid for each meal.</p> <p>Interview on 01/08/25 at 4:22 P.M. with Dietitian #902 confirmed that residents were not receiving enough fluids with meals per her observations, and the aides had been provided a lot of education on the importance of providing adequate fluids. She went on to state there should be multiple pitchers of each of the cold fluids on the beverage carts, so they didn't run out.</p> <p>There were 17 residents, Resident #19, #28, #36, #49, #59, #63, #67, #70,#71, #72, #81, #84, #87, #88, #91, #99, and #109 who resided on the C pod nursing unit.</p> <p>Review of the facility's Week at a Glance for the facility's four week 2024-2025 menus revealed for breakfast eight ounces milk, six ounces of coffee or tea, and four ounces of juice would be offered, for lunch six ounces of coffee or hot tea would be offered, and for dinner eight ounces of milk and six ounces of coffee or hot tea would be offered.</p> <p>Review of undated facility document C Pod revealed the beverage cart for C Pod, which housed 19 residents, would consist of one hot water carafe, two coffee carafes, one gallon (128 ounces) pitcher of juice, one gallon pitcher of water and one-half gallon of milk. Twelve coffee cups and nineteen regular cups were to be sent on each cart.</p> <p>Review of facility policy Hydration, revised 10/26/23, revealed the facility would offer each resident sufficient needs and preferences to maintain proper hydration and health.</p> <p>35765</p> <p>4. Review of the medical record revealed Resident #93 was admitted to the facility on [DATE]. Diagnoses included diabetes, vascular dementia, traumatic brain injury (TBI). major depression disorder, hypertension, anxiety, sexual dysfunction, osteoarthritis, magnesium deficiency, atherosclerotic heart disease, hyperlipidemia, mild cognitive impairment, insomnia, hypothyroidism, persistent mood disorder, low back pain, and dementia.</p> <p>Review of the Dietary Progress note dated 02/20/24 timed 12:34 P.M. revealed the family of Resident #93 requested he have double portions.</p> <p>Review of the physician's orders revealed Resident #93 had an order for regular diet with double entrees dated 03/15/24.</p> <p>Review of The Dietary Progress note dated 09/13/24 timed 11:13 A.M. revealed the staff informed the dietician Resident #93 was still hungry after meals so double portions were added. However, he already had an order for double portions.</p> <p>(continued on next page)</p>		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	<p>Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #93 had severely impaired cognition and was independent with eating. Resident #93 weighed 261 pounds, had no swallowing concerns and did not have a weight loss or gain.</p> <p>Review of the Dietary Progress note dated 12/10/24 timed 3:58 P.M. revealed Resident #93 triggered for a significant weight loss of 10.9 percent in 180 days. His current body weight was 247.2 pounds and the weight loss was desirable. Resident #93 was on a regular diet with double portions.</p> <p>Review of the plan of care with a revision date of 12/13/24 revealed Resident #93 was at risk for nutrition/hydration related to advanced age, history of significant weight changes, diabetes, dementia, TBI, depression, hypertension, anxiety, vitamin D deficiency, hypothyroidism, low mobility, mood disorder, and magnesium deficiency. Interventions included to provide diet as ordered, regular diet, regular fluids, regular texture, thin consistency with double entrees per his request dated 02/19/24.</p> <p>Observation of dining on the 200 unit on 01/06/25 at 11:55 A.M. revealed the residents were having chicken gravy over biscuits (the facility called the meal chicken pot pie) and fruit salad. Further observation revealed Resident #93 only received one serving of chicken gravy and one biscuit on his plate.</p> <p>On 01/06/25 at 12:11 P.M. an interview with Certified Nursing Assistant #432 verified Resident #93 only received one serving of his entree.</p> <p>Review of the facility policy titled, Resident Food Preferences, dated 01/01/22 revealed the nutritional assessment would include an evaluation of individual's food preferences. When admitted the Dietary Manager or designee would identify a resident's food preferences. The Dietary Manger or designee would visit residents periodically to determine if revisions were needed regarding food preferences. The nursing staff would inform the kitchen about resident's requests.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161030 and OH00160414.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>Based on review of the medical record, review of pharmacy recommendation, and interview the facility failed to address pharmacy recommendation timely for Residents #7, #35, and #90. This affected three residents (#7, #35, and #90) of five reviewed for unnecessary medications. The facility census was 125.</p> <p>Findings include:</p> <p>1. Review of medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included dementia, chronic kidney disease, anxiety disorder, disorientation, altered mental status, hypertensive heart disease, irritable bowel syndrome, auditory hallucinations, hypothyroidism, cholecystitis, major depressive disorder, insomnia, bipolar disorder, obsessive compulsive disorder, borderline personality disorder, post-traumatic stress disorder, and schizophrenia.</p> <p>Review of the physician's orders revealed Resident #7 had an order for aripiprazole 20 milligrams every morning for bipolar disorder dated 11/16/24.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had severely impaired cognition and was on an antipsychotic.</p> <p>Review of the pharmacy recommendation dated 12/02/24 revealed Resident #7 received an atypical antipsychotic aripiprazole which carried a risk to cause adverse metabolic effects. The recommendation indicated to please consider checking a fasting lipid panel (cholesterol levels) and a hemoglobin A1C (average blood sugar level over the past three months) now then annually. The recommendation was not addressed until 01/07/25.</p> <p>Further review of the physician's orders revealed Resident #7 had an order for a lipid panel and Hemoglobin A1C to be obtained for 01/08/25 dated 01/07/25.</p> <p>Review of the laboratory results collected on 01/08/25 and reported 01/09/25 revealed Resident #7's high-density lipoprotein cholesterol level was low at 47 (normal greater than 50) and the Hemoglobin A1C was still pending.</p> <p>On 01/09/25 at 11:04 A.M. an interview with the Director of Nursing (DON) confirmed the pharmacy recommendation for Resident #7 was never addressed. The DON reached out to the nurse practitioner (NP) to address the pharmacy recommendation, the NP agreed, and the lab was drawn yesterday (01/08/25).</p> <p>Review of the facility policy titled, Addressing Medication Regimen Review Irregularities, dated 12/28/23 revealed it was the policy of the facility to provide a Medication Regimen Review (MMR) for each resident to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event. The MMR of each resident must be reviewed by a licensed pharmacist at least once a month.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE]. Diagnoses included dementia, diabetes, aphasia, cerebral infarction, atrial fibrillation, intracerebral hemorrhage, psychosis, peripheral vascular disease, congestion heart failure, osteoarthritis, allergic rhinitis, insomnia, hyperlipidemia, major depressive disorder, generalized anxiety disorder, over active bladder, and vitamin D deficiency.</p> <p>Review of the laboratory results dated [DATE] revealed Resident #35 had a vitamin D level of 80 (normal 30-100).</p> <p>Review of the physician's orders revealed Resident #35 had an order for cholecalciferol (vitamin D3) 50,000 units every Friday morning dated 08/16/24.</p> <p>Review of the pharmacy recommendation dated 09/03/24 revealed Resident #35 was ordered Vitamin D 50,000 units every week and his Vitamin D level was 80 on 08/12/24. The recommendation indicated to please evaluate need for current dosing and consider a dose reduction to every other week.</p> <p>Review of the Quarterly MDS assessment dated [DATE] revealed Resident #35 had severely impaired cognition.</p> <p>On 01/08/25 at 3:42 P.M. an interview with the Director of Nursing confirmed there was no documentation the physician addressed the pharmacy recommendation from 09/03/24 nor could documentation of a rationale for not implementing the recommendation be found.</p> <p>Review of the facility policy titled, Addressing Medication Regimen Review Irregularities, dated 12/28/23 revealed it was the policy of the facility to provide a Medication Regimen Review (MMR) for each resident to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event. The MMR of each resident must be reviewed by a licensed pharmacist at least once a month.</p> <p>30809</p> <p>3. Resident #90 was admitted on [DATE] with diagnoses including neurocognitive disorder, dementia, pancytopenia (a blood disorder that occurs when the body has abnormally low levels of red blood cells, white blood cells, and platelets), depression, psychosis, traumatic brain injury, anemia, anxiety, low magnesium level, post-traumatic stress disorder, vitamin D deficiency, delirium, high cholesterol, urinary retention, metabolic encephalopathy, urea cycle disorder, high blood pressure, and thrombocytopenia (low platelet count).</p> <p>A review of Resident #90's pharmacy review recommendation dated 10/02/24 indicated Resident #90 was recently admitted with an order for an antipsychotic, Quetiapine 50 milligrams (mg) four times a day. The recommendation further indicated Federal guidelines for long-term care facilities required an evaluation of antipsychotic usage within two weeks of admission.</p> <p>Please consider a trial dose reduction to assess continued need for treatment and check one of the following:</p> <p>() Reduce the current order to _____.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>() Medication to be continued as ordered. Discontinuation of therapy likely will be harmful to resident and/or others or it will interfere significantly with the provision of care for others.</p> <p>There was no documentation from the physician on the pharmacy recommendation form or in Resident #90's clinical record to indicate the physician was aware of the pharmacist's recommendation.</p> <p>An interview on 01/08/25 at 3:43 P.M. with the Director of Nursing verified the pharmacy recommendations for Resident #90 were not communicated to the physician/provider and the DON was unable to provide documentation of a follow-up to the recommendation.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809</p> <p>Based on observation, staff interview, and record review, the facility failed to ensure expired medications and supplies were discarded appropriately. This affected one resident (Resident #3) of eight residents reviewed for medication administration. The census was 125.</p> <p>Findings include:</p> <p>Clinical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease, vascular dementia, multiple sclerosis, severe protein calorie malnutrition, hypothyroidism, major depressive disorder, spinal stenosis, mononeuropathy, fibromyalgia, anemia, vitamin D deficiency, obesity, and anxiety disorder.</p> <p>Review of Resident #3's physician order dated 10/23/24 revealed staff were to administer cholecalciferol (vitamin D3) oral capsule 125 milligrams (mg) 5000 unit (UT) orally in the morning related to vitamin D deficiency.</p> <p>Observation on the medication cart on nursing unit D on 01/07/25 at 7:55 A.M. revealed a container of cholecalciferol oral capsule 125 mg 5000 UT tablets with an expiration date of 11/21/24. The container of cholecalciferol contained 100 tablets and there were 37 tablets missing.</p> <p>Interview with Licensed Practical Nurse (LPN) #422 verified the above findings. LPN #422 stated that Resident #3 received 37 doses of the cholecalciferol after the expiration date of 11/21/24.</p> <p>Review of the medication administration record (MAR) dated 11/22/24 to 01/07/25 revealed Resident #3 received the routine ordered cholecalciferol 125 mg in the morning between 7:00 A.M. and 10:00 A.M.</p> <p>Review of the facility policy Medication Storage implemented on 10/30/20 indicated the pharmacy and all medication rooms were to be routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. Those medications were to be destroyed in accordance with the Destruction of Unused Drugs Policy.</p> <p>Review of the facility policy Medication Administration implemented on 10/30/20 indicated medications were to be administered by a licensed nurse, or other staff legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The compliance guidelines included for staff to identify expiration date and if the medication was expired to notify the nurse manager.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on observation, interview, review of completed cleaning schedules, and review of facility policies, the facility failed to ensure the kitchen was clean and sanitary and food items were properly stored, which had the potential to affect all residents who received food from the kitchen. The facility identified no residents as receiving nothing by mouth. The facility census was 125.</p> <p>Findings include:</p> <p>Observation of the kitchen on 01/06/25 from 8:40 A.M. to 9:20 A.M. with Dietary Manager (DM) #900 revealed the following concerns:</p> <ul style="list-style-type: none"> -The wall mounted fan, which was off but pointed toward the tray line, had a visible buildup of black dirt and dust on the blades and on the front and back of the metal guards. -The vents in the commercial hood had an accumulation of black dirt and debris. -The six gas burner cooktop had dried food and debris around the burners. -The left side of the double convection oven, which was next to the six burner cooktop, had dried food splatters on the outside of the unit. -The base of the bottom oven of the double convection oven had six large black areas of burnt on food residue. -The square clear plastic storage container located on the stainless steel work station next to the toaster, which was storing stainless [NAME] lids, had a buildup of food crumbs throughout the bottom of the container, and three of the lids being stored in the container had dried food particles on them. -The white tiled wall next to the plate warmer and a trash can had numerous food splatter marks. -The plate warmer had numerous food spattered marks down the side of the unit. -The proofing pan bun rack, sitting next to the three-compartment sink, had a build up of dried food particles on the tiers. -The dry storage area had debris around the perimeter of the floor which included eight single serve packets of graham crackers, one individual saltine packet, two single serve ketchup packets, one single serve jelly packet, and one single serve sugar packet. -The walk-in freezer had one box with a factory bag of 13 sausage patties open to air, one box with a factory bag of 13 vegetable patties open to air, and one box with a factory bag one fourth full of cinnamon rolls open to air. <p>(continued on next page)</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>-The trash can next to the three-compartment sink had a buildup of food splatter marks down the outside of the trash can.</p> <p>At the time of observation, DM #900 confirmed the areas of concern.</p> <p>Review on 01/07/25 at 9:46 A.M. of the kitchen's completed cleaning schedules from 12/01/24 to 01/06/25 with District Manager (DM) of Healthcare Services Group (HSG) #901 on 01/17/25 revealed there was no completed day shift cleaning schedules, and Sunday 12/08/24 was the only night shift cleaning schedule completed. At the time of observation, DM of HSG #901 confirmed the cleaning schedules were not consistently being filled out.</p> <p>Additional observation on 01/07/25 at 10:41 A.M. of the kitchen revealed a wall mounted fan, which was on and blowing towards the dish machine, had an accumulation of visible black dirt and dust on the front and back guards and the blades. At the time of observation DM #900 confirmed the fan was dirty and was potentially blowing dirt toward the dish machine.</p> <p>Review of facility policy Environment, revised September 2017, revealed all food preparation and service areas would be maintained in a clean and sanitary condition.</p> <p>Review of facility policy Equipment, revised September 2017, revealed all foodservice equipment would be clean and sanitary.</p> <p>Review of facility policy Food Storage: Cold Foods, revised February 2023, revealed all foods would be stored wrapped or in covered containers to prevent cross contamination.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160433.</p>		

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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 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>Based on observation, review of the medical record and interview the facility failed to ensure Resident #34 received speech therapy as ordered. This affected one resident (Resident #34) of one reviewed for therapy services.</p> <p>Finding include:</p> <p>Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, protein calorie malnutrition, iron deficiency anemia, atherosclerotic heart disease, major depressive disorder, benign prostatic hyperplasia, hypokalemia, anemia, hyperlipidemia, anxiety disorder, spinal stenosis, vitamin D deficiency, insomnia, dysphagia, and heart failure.</p> <p>Review of the physician's orders revealed Resident #34 had an order for Speech Therapy to evaluate and treat for dysphagia three to five days a week for 30 days dated 11/20/24.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #34 had no swallowing concern, and was independent with eating.</p> <p>Observation of meal service on 01/06/25 from 11:55 A.M. through 12:30 P.M. revealed meal trays came out to the 200 unit at 11:55 A.M. Speech Therapist (ST) #605 was leaning up against the pillar in the dining area with his head down and his eyes closed. He stood like that for 15 minutes while the residents ate their food . ST #605 was asked who he was seeing and he stated Resident #34. ST #605 never went over to Resident #34's table, he never spoke to him or cued him to eat and he left the unit at 12:30 P.M.</p> <p>On 01/06/25 at 12:15 P.M. an interview with Certified Nursing Assistant #452 confirmed ST #605 had his eye closed while leaning up against the pillar in the dining room during the meal services when he should have been watching Resident #34 eating his meal.</p> <p>Review of the Speech Therapy note dated 01/06/25 revealed Speech Therapist # 605 saw Resident #34 at lunch. ST #605 monitored resident's mastication during meal and the resident had no difficulty. The resident showed no signs or symptoms for aspiration.</p> <p>On 01/08/25 at 11:34 A.M. an interview with Therapy Director #610 revealed ST #605 had been employed with the company since September 2024. Therapy Director #610 stated she had no concerns with his treatments and she had not had any complaints of him being on drugs or sleeping on the units. Therapy Director #610 stated ST #605 had been suspended until further notice however he denied sleeping on the unit.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160780.</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** 32650</p> <p>Based on record review, interview, and policy review, the facility failed to ensure documentation was complete and accurate for two residents (Residents #106 and #123) of 28 residents reviewed for accuracy of documentation. The facility census was 125.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #106 was admitted to the facility on [DATE] with diagnoses including diabetes, chronic obstructive pulmonary disease (COPD), major depressive disorder, high blood pressure, peripheral vascular disease, congestive heart failure, schizophrenia, and multiple areas of arthritis.</p> <p>Review of the admission comprehensive Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed Resident #106 was cognitively intact but had delusions. Resident #106 was able to perform all personal care independently.</p> <p>Review of the nursing progress dated [DATE] timed 5:35 A.M. authored by Licensed Practical Nurse (LPN) #496 revealed LPN #496 found Resident #106 sitting on the floor on her buttocks with her legs extended in front of her. LPN #496 assessed Resident #106 and the resident said she fell while trying to go to the bathroom. Resident #106 complained of right sided rib pain and difficulty breathing. Resident #106's nurse practitioner was notified and gave an order to transfer Resident #106 to the local emergency room (ER) for evaluation. Prior to transfer LPN #519, (the nurse assigned to Resident #106's unit) administered Tylenol 325 milligrams (mg) two tablets at 5:37 A.M. for a complaint of pain.</p> <p>Review of a progress note dated [DATE] timed 6:38 A.M., authored by LPN #519 revealed Resident #106 had right hip pain.</p> <p>Review of a progress note dated [DATE] timed 11:41 A.M. revealed Unit Manager LPN #481 contacted the ER and was informed Resident #106 was being admitted with a right hip fracture.</p> <p>Review of the initial fall assessment for Resident #106 completed on [DATE] by LPN #496 revealed the Resident #106 complained of right rib pain and difficulty breathing. Resident #106 had decreased range of motion in her right arm but there was no change in her gait.</p> <p>Review of the fall investigation for Resident #106 revealed LPN #519 provided a witness statement regarding the resident's fall. There was no witness statement from LPN #496 (the nurse who found Resident #106 on the floor).</p> <p>(continued on next page)</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>Phone interview with LPN #519 on [DATE] at 1:52 P.M. revealed he did remember Resident #106 falling in the common area. The resident fell while he was completing his morning medication administration. When he exited a resident's room he saw Resident #106 on the floor. LPN #519 went over to the resident and he and an aide got the resident up and moved her to a nearby recliner. LPN #519 did not remember which aide helped him. LPN #519 then assessed the resident who was complaining of right leg pain when he tested for range of motion. Resident #106 did not complain of rib pain or difficulty breathing as documented by LPN #496. LPN #519 said he wrote a progress note indicating Resident #106's pain was to her right leg and not the right ribs as previously noted by LPN #496.</p> <p>Interview with the Director of Nursing (DON) on [DATE] at 9:45 A.M. regarding the differing nursing documentation from LPN #496 and LPN #519 revealed she was unsure why the two assessments were different.</p> <p>Review of the facility's Fall Prevention Program policy, last revised [DATE], revealed when a resident falls the facility was to obtain witness statements in the case of injury.</p> <p>44808</p> <p>2. Review of the medical record for Resident #123 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, hypertension, major depressive disorder, and repeated falls. Resident #123 expired on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #123 was rarely/never understood and had severely impaired cognition for daily decision making.</p> <p>Review of the fall investigation, dated [DATE] timed 6:20 P.M., indicated Resident #123 experienced an unwitnessed fall. The assessment indicated Resident #123 had a pain score of two out of 10 based on negative vocalization (occasional moan or groan, low level of speech with a negative quality) and negative body language (tensed, distressed pacing).</p> <p>Review of the progress note, dated [DATE] timed 7:18 P.M., indicated Resident #123 experienced a fall, was assessed for injury which identified a large hematoma to the left forehead which was red in color with a dark purple center, swelling which extended into the resident's hairline, and a pain level of two out of 10.</p> <p>Review of the assessment titled Fall - Initial - V 2, dated [DATE] at 7:23 P.M., indicated Resident #123 experienced a fall with a pain level of zero (which contradicted the pain level reported in the fall investigation and the progress note related to the fall), no suspected head injury, and no other suspected injury.</p> <p>Review of the assessment titled Fall - Follow-up, dated [DATE] at 8:24 A.M. indicated Resident #123 did have a decreased level of consciousness or suspected head injury and there was a noted or suspected injury related to the incident on the resident's head.</p> <p>Review of the assessment titled Fall - Follow-up, dated [DATE] at 5:00 A.M. indicated Resident #123 did not have a suspected head injury or other suspected injury.</p> <p>(continued on next page)</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>Review of the assessment titled Fall - Follow-up, dated [DATE] at 8:35 P.M. indicated Resident #123 did have a decreased level of consciousness or suspected head injury and there was a noted or suspected injury related to the incident described as a hematoma to the face.</p> <p>Review of the assessment titled Fall - Follow-up, dated [DATE] at 9:40 A.M. indicated Resident #123 did have a decreased level of consciousness or suspected head injury and there was a noted or suspected injury related to the incident described as a hematoma to the face.</p> <p>Review of the assessment titled Fall - Follow-up, dated [DATE] at 11:36 P.M. indicated Resident #123 did not have a suspected head injury or other suspected injury.</p> <p>On [DATE] at 9:25 A.M., an interview with the Director of Nursing (DON) verified Resident #123 had a hematoma to the left forehead with swelling and not all of the fall assessments indicated that injury. She further stated that Resident #123's admission to hospice was related to a steady decline and was not a result of the fall on [DATE].</p> <p>On [DATE] at 2:02 P.M., an interview with the DON revealed Resident #123 was having increased behaviors, decreased mental status, decreased participation in activities and care prior to the fall which contributed to the hospice decision. The DON verified there was no documentation in the medical record regarding Resident #123's declining status prior to the fall.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809</p> <p>Based on observation, record review and interview the facility failed to maintain acceptable infection control practices to prevent the spread of infection during wound care for Resident #37 and failed to ensure staff performed hand hygiene to prevent cross contamination of germs during Resident #2's, Resident #9's, Resident #87's and Resident #120's medication administration. This affected one resident (#37) out of three residents (Resident #37, #27, #49) reviewed for wound care and four out of ten residents observed for medication administration. The facility census was 125 residents.</p> <p>Findings include:</p> <p>1. Clinical record review revealed Resident #2 was admitted on [DATE] with diagnoses including respiratory, cerebral and heart disease, bipolar disorder with psychotic features, depression, diabetes mellitus and gastroesophageal reflux disease.</p> <p>A review of Resident #2's physician orders indicated to administer the following medications orally between 7:00 A.M. and 11:00 A.M.:</p> <ul style="list-style-type: none"> - Tagamet 200 milligrams (mg) 200 mg administer two tablets. - Divalproex 125 mg, administer four capsules. - Eliquis 5 mg - escitalopram 10 mg - Metoprolol 25 mg administer one half a tablet. - mag-oxide 400 mg <p>An observation of Registered Nurse (RN) #405 on [DATE] at 7:10 A.M. revealed RN #405 obtained a cup and picked up the cup by placing her bare finger inside of the cup lip and then filled the cup of water to administer the above listed medications to Resident #2. While dispensing the Divalproex 125 mg medication from the punch card packaging, one capsule dropped on the cart. RN #405 picked up the capsule with her bare hand and placed the Divalproex 125 mg capsule in the medications cup with the other medications.</p> <p>Interview on [DATE] at 7:43 A.M. with RN #405 verified the above findings.</p> <p>2. Clinical record review revealed Resident #9 was admitted on [DATE] with diagnoses including cerebral palsy, diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, and hypothyroidism.</p> <p>A review of Resident #9's physician orders dated [DATE] to [DATE] indicated to administer two tablets of acetaminophen 325 mg orally every four hours as needed for pain.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on [DATE] at 7:29 A.M. of RN #405 administer two 325 mg acetaminophen tablets orally to Resident #9 revealed she dispensed the acetaminophen tablets in a medication cup. RN #405 proceeded to obtain a cup by touching the inside of the cup with her bare hand. RN #405 then filled the cup with water and carried the cup of water to Resident #9 who consumed the water to swallow the acetaminophen tablets.</p> <p>Interview on [DATE] at 7:43 A.M. with RN #405 verified the above findings.</p> <p>3. Clinical record review revealed Resident #87 was admitted on [DATE] with diagnoses including dementia with behaviors, atherosclerotic heart disease, hyperlipidemia, high blood pressure, gastroesophageal reflux disease, anemia, vitamin D deficiency, psychosis, depression, anxiety, and insomnia.</p> <p>Resident #87's physician orders dated [DATE] to [DATE] indicated to administer the following medications orally between 7:00 A.M. and 11:00 A.M. every day:</p> <ul style="list-style-type: none"> - senna 8.6 mg by mouth - rivastigmine 3 mg by mouth - quetiapine fumerate 12.5 mg by mouth - sertraline 25 mg by mouth - sertraline 50 mg by mouth <p>An observation on [DATE] at 8:13 A.M. of RN #504 administer the above listed medications to Resident #87 revealed a failure to perform hand hygiene prior to dispensing the above listed medications in a medication cup and then RN #504 proceeded to administer the medications to Resident #87. While dispensing the above listed medications for Resident #87, RN #504 obtained the sertraline 25 mg and sertraline 50 mg capsules and pulled each capsule apart with her bare hands and emptied the contents of the capsules with the rest of Resident #87's crushed medications in the medication cup. RN #53 failed to perform hand hygiene after administering the medications to Resident #87.</p> <p>An interview with RN #504 on [DATE] at 8:20 A.M. verified the above findings.</p> <p>4. Resident #120 was admitted on [DATE] with diagnoses including dementia with behaviors, neurocognitive disorder, chronic bronchitis, post-traumatic stress disorder, atherosclerotic heart disease, high blood pressure, depression, anxiety, osteoporosis, and diverticulosis of intestine.</p> <p>A review of Resident #120's physician orders dated [DATE] to [DATE] indicated to administer the following medication orally between 7:00 A.M. to 11:00 A.M. every day:</p> <ul style="list-style-type: none"> - clopidigrel 75 mg - donepezil 10 mg - memantine 5 mg <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- metoprolol 50 mg</p> <p>- sertraline 50 mg</p> <p>An observation on [DATE] at 7:49 A.M. of Medication Technician (MT) #522 administer the above listed medications to Resident #120 revealed she obtained a cup by touching the inside lip of the cup with her bare hand. MT #522 then proceeded to fill the cup with water and handed the cup of water to Resident #120. Resident #120 drank the water to assist her with swallowing the medications.</p> <p>Interview on [DATE] at 7:55 A.M. MT #522 and Licensed Practical Nurse (LPN) #422 verified the above finding.</p> <p>The facility policy and procedure titled Hand Hygiene revised [DATE] indicated all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applied to all staff working in all locations within the facility. The policy indicated staff should perform hand hygiene before preparing or handling medications and between resident contacts and listed additional guidance for performing had hygiene during other circumstances.</p> <p>The facility policy and procedure titled Medication Administration revised on [DATE] indicated the policy explanation and compliance guidelines included:</p> <ol style="list-style-type: none"> 1. Keep medication cart clean, organized, and stocked with adequate supplies. 2. Cover and date fluids and food. 3. Identify resident by photo in the medication administration record. 4. Wash hands prior to administering medication per facility protocol and product. 5. Knock or announce presence. 6. Explain purpose of visit. 7. Provide privacy. 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 9. Position resident to accommodate administration of medication. 10. Review medication administration record to identify medication to be administered. <ol style="list-style-type: none"> a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. If other than by moth route, administer in accordance with facility policy for the relevant route of administration (i.e., injection, eye, ear, rectal, etc.).</p> <p>12. Identify expiration date. If expired, notify nurse manager.</p> <p>13. Remove medication from source, taking care not to touch medication with bare hand.</p> <p>14. Administer medication as ordered in accordance with manufacturer specifications.</p> <p>a. Provide appropriate amount of food and fluid.</p> <p>b. Shake well to mix suspensions.</p> <p>c. Crush medications as ordered. Do not crush medications with do not crush instructions.</p> <p>15. Observe resident consumption of medication.</p> <p>16. Wash hands using facility protocol and product.</p> <p>17. Sign medication administration record after administered. For those medications requiring vital signs, record the vital signs onto the Medication Administration Record (MAR).</p> <p>18. If medication is a controlled substance, sign narcotic book.</p> <p>19. Report and document any adverse side effects or refusals.</p> <p>20. Correct any discrepancies and report to nurse manager.</p> <p>51072</p> <p>5. Review of Resident #37's medical record revealed the resident was admitted to the facility on [DATE] with primary diagnosis of Alzheimer's disease. Resident #37 developed an in-house unstageable area to his left heel on [DATE] and a treatment order at that time, dated [DATE], indicated to cleanse left heel with Normal Saline, and apply foam dressing every day.</p> <p>Review of the most recent wound measurements dated [DATE] revealed the wound to Resident #37's left heel measured 0.22 centimeters squared (cm2) x 0.4 centimeters (cm) in length x 0.65 cm in width. There was no exudate, the wound edges were attached, the tissue surrounding the wound was dry and flaky, and the wound was 100 percent eschar (dead tissue) and no slough.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 10:29 A.M., an observation of a dressing change for Resident #37, with Licensed Practical Nurse (LPN) #403 and LPN #481, revealed LPN #403 opened the foam dressing, removed it from its packaging, dated and initialed the dressing, and then the dressing on the bed sheet next to Resident #37. After cleansing the wound, LPN #403 retrieved the foam dressing from the bed sheet and applied the dressing to Resident #37's left heel. Interview at the time of observation with LPN #403 verified she placed the foam dressing on the bed sheet without a barrier. LPN #403 also verified a barrier was not placed under the resident's wound prior to the wound care. LPN #403 stated that was how she always did it. When asked if LPN #403 ever used a barrier between the bed sheet and the foam dressing or the wound, LPN #403 replied I can.</p> <p>Review of the facility Clean Dressing Change policy, revised on [DATE], revealed staff were to place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160414.</p>		