STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Overbrook Center		STREET ADDRESS, CITY, STATE, ZIP CODE 333 Page Street Middleport, OH 45760	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of Medicare (MCR) liability notice letters, and staff interview, the facility failed to ensure residents, whose skilled nursing services ended with days remaining, received at least a 48 hour notice of their skilled service ending prior to their last covered day. They also failed to ensure those residents, whose skilled service ended and remained in the facility, were provided an Advanced Beneficiary Notice (ABN) as required. This affected three residents (#1, #17, and #56) of three residents reviewed for liability notices. Findings include: 1. Review of Resident #1's medical record revealed she was admitted to the facility on [DATE] with a readmitted [DATE]. Her diagnoses included schizophrenia, unspecified dementia, delusional disorder, and Bipolar disorder. Her payer status was MCR Part A before being switched to Medicaid (MCD). Review of a Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review Checklist revealed Resident #1 had a MCR Part A skilled service episode start date of 05/03/24. Her last covered day of Part A service was on 05/09/24. The facility staff indicated on the checklist that a CMS Notice of MCR Non-Coverage (NOMNC) CMS form 10123 was provided to the resident or their representative. They indicated a SNF ABN (CMS form 10055) was not provided to the resident/ representative, despite the resident remaining in the facility, after their skilled service ended. An explanation added, as to why an ABN was not provided, indicated the facility expected all charges to be covered by MCR. Review of Resident #1's NOMNC (CMS form 10123) revealed her current skilled service would end on 05/09/24. The form did not specify what skilled service was ending or the reason why. The notice was provided to the resident's representative over the phone on 05/09/24 (same day skilled service ended) and did not provide at least a 48 hour notice as required. 2. Review of Resident #17's medical record revealed she was originally admitted to the facility on [DATE] with a re-admission on 04/08/19. Her diagnoses included schizo-affective disorder, major depressive disorder, anxiety disorder, congestive heart failure, and chronic obstructive pulmonary disease. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's SNF Beneficiary Protection Notification Review checklist revealed the resident had a MCR Part A skilled services episode start date of 07/09/24. Her last covered day of MCR Part A services was on 07/14/24. The checklist indicated a NOMNC (CMS 10123 form) was provided to the resident. Again, the facility indicated on the checklist that an ABN (CMS form 10055) was not provided to the resident, as the facility expected all charges to be covered by MCR. Resident #17 remained in the facility, after their skilled service ended, which would have required an ABN form to be provided. 3. Review of Resident #56's medical record revealed the resident was initially admitted to the facility on [DATE], with a re-admitted [DATE]. Her diagnoses included metabolic encephalopathy, hallucinations, and hypertension. Review of Resident #56's SNF Beneficiary Protection Notification Review checklist revealed the resident had a MCR Part A skilled services episode start date of 05/19/24. Her last covered day of MCR Part A services was on 07/23/24. The checklist indicated a NOMNC (CMS 10123 form) was provided to the resident. Again, the facility indicated on the checklist that an ABN (CMS form 10055) was not provided to the resident, as the facility expected all charges to be covered by MCR. Resident #56 remained in the facility after her skilled service ended and should have received an ABN (CMS form 10055) as required. On 07/30/24 at 9:50 A.M., an interview with Business Office Manager (BOM) #109 revealed the facility's social worker was the one that handled liability notices, but was off this week and she was filling in. Resident #1, #17, and #56's liability notices were reviewed with the BOM, as provided by the facility. She confirmed all three residents remained in the facility, after their skilled services ended, and should have received an ABN notice (CMS form 10055). She further confirmed none of the three residents were provided an ABN and the explanation given on the SNF Beneficiary Protection Notification Review was the facility expected all charges to be covered by MCR, as was written on those forms. She acknowledged the ABN allowed the resident or their representative to indicate whether they wanted to continue to receive the skilled service while appealing the decision to end their skilled service. It was not intended to only be completed if the facility felt MCR would not cover all charges for the skilled services that had previously been received. She was not sure if the facility had the CMS 10055 that should have been used for all residents whose skilled services ended, had MCR days remaining, and remained in the facility. She further acknowledged Resident #1's representative was not provided a 48 hour notice prior to the end of the resident's last covered day of MCR Part A services as required. The facility's administrator denied they had a policy that directed them on how and when to complete liability notices when a resident's MCR Part A services ended.

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	365721	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overbrook Center	333 Page Street Middleport, OH 45760

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, staff and representative interviews, and record reviews, the facility failed to ensure timely and adequate nail care was completed for a resident who was dependent upon staff for Activities of Daily Living (ADLs). This affected one resident (#18) out of the three residents reviewed for ADL's during the annual survey. The facility census was 61. Findings include: Record review for Resident #18 revealed the resident was admitted to the facility on [DATE] and had diagnoses including senile degeneration of the brain, encounter for palliative care, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/13/24, revealed the resident was assessed to be rarely/never understood. The resident was assessed to be dependent upon staff for personal hygiene. Review of the care plan, revised 09/18/23, revealed the resident had an ADL self-care performance deficit. Interventions included showers two times a week with hair and nail care. Review of the care plan, dated 04/03/24, revealed the resident had skin impairment. Interventions included to keep the residents nails cut short to reduce the risk of scratching or injury from picking at skin. Telephone interview with Resident #18's representative on 07/29/24 at 10:52 A.M. confirmed staff at the facility did not trim and clean the fingernails of Resident #18. Representative #500 stated family completed nail care for the resident but had not been able to visit the facility in almost three weeks due to medical issues. Observation on 07/29/24 at 12:24 P.M. revealed Resident #18 was being assisted with the lunch meal by a facility nurse. Resident #18 was eating chips out of a bag with bare fingers. The resident's fingernails were long and jagged and had a layer of dark brown debris caked underneath them. Observation on 07/30/24 at 10:39 A.M. revealed Resident #18 was lying in bed and had a small area of dried blood to the right corner of the mouth. The resident's fingernails continue to be long and jagged with a layer of dark brown debris caked underneath them. Interview with Licensed Practical Nurse (LPN) #173 at the time of the observation confirmed the resident's fingernails were long and jagged and were in need of being trimmed and cleaned. LPN #173 additionally confirmed the resident had dried blood on the right corner of the mouth likely caused by the resident scratching or picking at the area.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident's pressure ulcer was assessed weekly for signs of healing/ infection as per the plan of care. This affected one resident (#59) of three residents reviewed for pressure ulcers. Findings include: Review of Resident #59's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included a stroke with hemiplegia/ hemiparesis affecting his left, non-dominant side, peripheral vascular disease status post peripheral vascular angioplasty, muscle weakness, need for assistance with personal care, cognitive communication deficit, aphasia, attention and concentration deficit, unspecified protein-calorie malnutrition, adult onset diabetes mellitus, congestive heart failure and anemia. Review of Resident #59's nursing admission assessment dated [DATE] revealed the resident was admitted to the facility with some bruising and skin tears to his upper extremities. He was not known to have any pressure ulcers when he was admitted to the facility. Review of Resident #59's progress notes revealed a nurse's note dated 07/15/24 at 11:45 A.M. that indicated the resident was found to have a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/ or shearing) to his left heel. The pressure ulcer measured 4.2 centimeters (cm) by 4.0 cm. Review of Resident #59's care plans revealed he had a care plan in place for having the potential for the development of a pressure ulcer related to his diagnoses. The care plan was updated to reflect the development of a pressure ulcer to his left heel on 07/15/24. The goal was for the pressure ulcer to show signs of healing and remain free from infection. The interventions included the need to administer treatments as ordered and to monitor the effectiveness of the treatments. They were to assess/ record/ monitor the wound healing weekly and prn to include measuring the length, width and depth where possible, assess and document status of wound perimeter/ wound bed and healing progress. They were to report improvements and declines to the physician. Review of Resident #59's wound assessments, under the assessment tab of the electronic medical record, revealed a skin observation tool was completed on 07/15/24, when the pressure ulcer was first noted. There was not a second wound assessment documented as having been completed until 07/30/24, when a pressure ulcer weekly observation tool was completed. There was a total of 15 days in between the date the pressure ulcer was first noted and documented on the skin observation tool and when it was further assessed as documented on the pressure ulcer weekly observation tool completed on 07/30/24. There was no documented evidence of the pressure ulcer being assessed the week of 07/22/24. Findings were verified by Licensed Practical Nurse (LPN) #156. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 10:45 A.M., an interview with LPN #156 revealed she was the facility's wound nurse. She was also the nurse that assessed, measured, and documented the wound's healing progress by doing weekly wound assessments. They previously were being conducted on Mondays, but she changed it to Tuesday to coincide with when the contracted wound company visited. She verified she had no documented evidence to show Resident #59's pressure ulcer was assessed the week of 07/22/24. She could not explain why the resident's pressure ulcer went 15 days between assessments. She confirmed wounds were to be assessed weekly to monitor for healing and signs of infection as per the resident's plan of care. The facility's Director of Nursing (DON) revealed they did not have a pressure ulcer policy that directed the staff on the ongoing monitoring of existing pressure ulcers. He reviewed the pressure ulcer policy that was provided, but confirmed it did not provide direction on ongoing monitoring of the pressure ulcer through weekly assessments.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, and record reviews, the facility failed to ensure oxygen tubing was changed according to physician orders. This affected one resident (#43) reviewed for respiratory care during the annual survey. The facility census was 61. Findings include: Record review for Resident #43 revealed the resident was admitted to the facility on [DATE] and had diagnoses including acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/15/24, revealed the resident was assessed to have mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 12. The resident was assessed to have been administered oxygen therapy during the review period. Review of the care plan, dated 06/13/24, revealed the resident had altered respiratory status. Interventions included oxygen administration at two to four liters per minute by nasal cannula. Review of the active physician order, dated 03/29/24, revealed an order to change oxygen tubing weekly on night shift. Observation on 07/29/24 at 9:24 A.M. revealed Resident #43 was lying in bed with oxygen being administered by nasal cannula. The oxygen tubing had a piece of tape adhered to it with a date of 05/30/24. Interview with Resident #43 on 07/29/24 at 9:25 A.M. confirmed staff changed oxygen tubing but the resident could not recall the last time it had been changed. Observation and interview with Unit Manager #157 on 07/29/24 at 9:33 A.M. confirmed the oxygen tubing for Resident #43 was labeled with a date changed of 05/30/24 and would be changed immediately by facility staff.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record reviews and staff interviews, the facility failed to ensure orders for as needed psychotropic medications included a duration of therapy and additionally failed to ensure psychotropic medications were administered for appropriate indications. This affected two residents (#18 and #25) out of the five residents reviewed for unnecessary medications during the annual survey. The facility census was 61. Findings include: 1. Record review for Resident #18 revealed the resident was admitted to the facility on [DATE] and had diagnoses including senile degeneration of the brain, encounter for palliative care, anxiety, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/13/24, revealed the resident was assessed to be rarely/never understood. The resident was assessed to have received anti-anxiety medications during the review period. Review of the active physicians order, dated 02/07/24, revealed an order for 0.5 milligrams (mg) of Ativan (an anti-anxiety medication) to be administered every eight hours as needed for anxiety. The order did not include a date for which the order was to be stopped. Interview with Unit Manager #157 on 07/31/24 at 11:53 A.M. confirmed the order for Resident #18's as needed Ativan did not include a date for which the medication was to be stopped. 33023 2. Record review of Resident #25 on 07/30/24 at 10:56 A.M. revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: otitis externa, chronic obstructive pulmonary disease, dementia with behavioral disturbance, right femur fracture, auditory hallucinations, cognitive communication deficit, mild intellectual disabilities, chronic kidney disease stage 3B, hearing loss, dysphagia, peripheral vascular disease, depression, benign prostatic hyperplagia, hypertension, and macular degeneration Review of the Minimum Data Set(MDS) assessment completed on 07/05/24 revealed this resident had moderate cognitive impairment. Review of Physician Orders revealed this resident received the following medications: Risperidone 0.5 mg 1 tablet by mouth twice daily for unspecified dementia. Review of current resident diagnoses revealed this resident does not have an active diagnosis of psychosis in the medical record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #901 on 07/30/24 at 11:37 A.M. verified Risperidone is to have an actual diagnosis and not just treating a symptom such as agitation. Interview with the Director of Nursing on 07/30/24 at 1:04 P.M., verified unspecified dementia is not an acceptable diagnosis for the use of Risperidone.