

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365738	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Woodridge Boulevard Fairfield, OH 45014	

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 0565</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 organize and participate in resident/family groups in the facility.</p> <p>34291</p> <p>Based on Resident Council minutes review, staff and resident interviews, and policy review, the facility failed to ensure resolutions were provided to the residents after resident council meetings. This had the potential to affect all of the residents who attended resident council. The census was 66.</p> <p>Findings included:</p> <p>Review of the Resident Council Minutes from 08/28/23 through 08/30/24 revealed there were meetings but no resolutions to the problems discussed in the meeting.</p> <p>Interview with Activity Director (AD) #11 on 09/16/24 at 1:57 P.M. revealed she had been the director for three weeks. She stated she couldn't find any resolutions for the past Resident Council Meetings.</p> <p>During a Resident Council Meeting with Residents #1 and #13 on 09/17/24 at 10:52 A.M. revealed they have resident council meetings, but nothing is done about their complaints and they don't hear a resolution about the concerns during the next meeting.</p> <p>Interview with the Administrator on 09/17/23 at 3:30 P.M. confirmed she had not followed-up on all the concerns from the Resident Council Meetings and didn't write anything down about what she did. She stated the previous activity director didn't do the concern forms after the resident council meetings. She waited till the new activity director was hired to start the process of the concern forms after the resident council meetings.</p> <p>Review of the policy titled, Resident Council, dated 04/01/17 revealed Resident Council Response Form will be utilized to track issues and their resolution. The facility de partment related to any issues will be responsible for addressing the item(s) of concern.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069</p> <p>Based on medical record review, staff interviews, and policy review, the facility failed to ensure residents had accurate advance directives in place. This affected two (#9 and #40) out of three residents reviewed for advance directives. The facility census was 66.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, bipolar disorder current episode manic without psychotic features, hypothyroidism, and tremor.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively intact. Resident #40 was assessed to require supervision for eating, partial to moderate assistance for oral hygiene, and upper body dressing, substantial to maximal assistance for bathing, lower body dressing, personal hygiene, and bed mobility, and was dependent for toileting and transfer.</p> <p>Review of the physician orders for Resident #40 in the electronic health record (EHR) revealed an order dated 08/10/23 for Do Not Resuscitate (DNR) Comfort Care Arrest.</p> <p>Review of the paper chart for Resident #40 revealed a sheet of paper marked full code as well as an undated DNR form checked DNR comfort care arrest.</p> <p>Interview on 09/16/24 at 8:24 A.M. with the Director of Nursing verified Resident #40's chart indicated both full code and DNR for advance directives and the accurate code status was unclear.</p> <p>33023</p> <p>2. Record review of Resident #9 revealed the resident was admitted to the facility on [DATE] with the following medical diagnoses: osteomyelitis, cognitive communication deficit, chronic obstructive pulmonary disease, adult failure to thrive, muscle weakness, contractures, urinary tract infection, anemia, anxiety, dysphagia, edema, metabolic encephalopathy, venous insufficiency, chronic embolism and thrombosis, open wound to left thigh, and alcohol abuse.</p> <p>Review of the Minimum Data Set(MDS) assessment completed on 08/29/24 revealed the resident had intact cognition.</p> <p>Review of physician orders revealed this resident is a full code for advance directives in the electronic health record.</p> <p>Review of paper chart revealed no indication of screening for resident preference in regards to advance directives. All admission documents were not completed upon admission and were not filled out by staff.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Regional Director of Clinical Services #505 on 09/16/24 at 12:46 P.M. verified a proper screening of advance directives had not been completed.</p> <p>Review of the policy titled, Advanced Care Planning/Advance Directive Policy and Procedure, reviewed 08/2023, revealed upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate an advance directive, and all advance directive documents would be maintained in the resident's medical record.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069</p> <p>Based on medical record review, interviews, and policy review, the facility failed to hold care conferences as required. This affected one (#13) out of one resident reviewed for care conferences. The facility census was 66.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus without complications, myasthenia gravis without acute exacerbation, cardiac murmur, psoriasis, vitamin b deficiency, syncope and collapse, anemia, vascular dementia, unspecified severity with psychotic disturbance, hyperlipidemia, major depressive disorder, and anxiety disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had moderately impaired cognition. Resident #13 was assessed to require setup assistance for eating, and supervision for oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, and transfer.</p> <p>Further review of the medical record for Resident #13 revealed no documentation related to a care conference in over a year.</p> <p>Interview on 09/15/24 at 12:09 P.M. with Resident #13 revealed she had not had a care conference.</p> <p>Interview on 09/18/24 at 09:20 A.M. with the Director of Nursing (DON) verified the facility had no documentation of a care conference for Resident #13 in months.</p> <p>Review of the undated policy titled, Care Planning - Interdisciplinary Team, revealed every effort would be made to schedule care plan meetings at the best time of the day for the resident and family.</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>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** 42728</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents received timely and required assistance with meals. This affected one resident (#51) out of the three residents reviewed for Activities of Daily Living (ADLs) during the annual survey. The facility census was 66.</p> <p>Findings include:</p> <p>Record review for Resident #51 revealed the resident was admitted to the facility on [DATE] and had diagnoses including spinal stenosis, serous retinal detachment of the right eye, and feeding difficulties.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was assessed to require limited assistance from one staff member for eating and to have highly impaired vision.</p> <p>Review of the care plan dated 09/09/21 revealed the resident was at risk for decline in ADL function. Interventions included to offer assistance with meals.</p> <p>Further review of the care plan dated 09/09/21 revealed the resident was at risk for impaired visual function. Interventions included to explain tray set up with meals using a clock as guideline and to specifically tell resident where items were placed.</p> <p>Review of the active physicians order dated 11/14/22 revealed the resident was to receive a mechanical soft/cut up foods texture diet.</p> <p>Observation on 09/16/24 at 9:01 A.M. revealed Resident #51 was sitting in his wheelchair with the breakfast meal set up on a tray table in front of him. The resident had a small bowl of grits, scrambled eggs, and a piece of toast on the tray. The resident was eating scrambled eggs using his fingers. Food debris was observed on the residents lap and on the floor under the resident. No staff were present in the room.</p> <p>Observation on 09/16/24 at 12:22 P.M. revealed State tested Nursing Assistant (STNA) #102 entered the room of Resident #51 and set up the residents lunch meal on the tray table in front of him. Once finished setting up the lunch meal, STNA #102 exited the room. Resident #51 began utilizing a regular fork to attempt to eat the chopped up food on the tray and was dropping a large amount of the food on his lap and the floor. Resident #51 confirmed he was unable to see well enough to feed himself his meal without dropping some of it.</p> <p>Observation on 09/17/24 at 8:45 A.M. revealed Resident #51 was attempting to eat ground sausage from his plate using a regular fork. A large amount of the sausage was being pushed off the plate or dropped through the floor as the resident attempted to consume it.</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>Observation and interview with STNA #4 on 09/17/24 at 8:48 A.M. confirmed Resident #51 could not see well and had difficulties feeding himself. STNA #4 confirmed a large portion of the residents meal had been dropped onto the resident and the floor beneath him.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on medical record review, observations, staff and resident interviews, review of the activity calendar, and policy review, the facility failed to ensure residents were invited and were able to participate in the activities outside of their room. This affected three residents (#38, #58 and #319) of three reviewed for activities. The census was 66.</p> <p>Findings include:</p> <p>1. Medical record review for Resident #38 revealed an admitted [DATE].</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #38 was cognitively intact. His functional status was dependent for transfers.</p> <p>Review of the activity preferences assessment dated [DATE] revealed Resident #38 said it was somewhat important to keep up with the news, music, doing things with groups of people, and favorite activities.</p> <p>Review of care plan for Resident #38 dated 08/21/24 revealed he was at risk for alteration in activity participation. The interventions was to familiarize resident with nursing home environment and activity programs on regular basis.</p> <p>Review of activity participation from 09/01/24 through 09/18/24 revealed Resident #38 had documentation for computer, news, and television.</p> <p>Interview with Resident #38 on 09/16/24 at 7:57 A.M. revealed he wasn't invited to activities and would like to participate if he got invited. He stated he has to have a slide board to get out of bed.</p> <p>2. Medical record review for Resident #58 revealed an admitted [DATE].</p> <p>Review of the admission MDS dated [DATE] for Resident #58 revealed she was cognitively intact.</p> <p>Review the activity preferences assessment dated [DATE] revealed Resident #58 said it was somewhat important to keep up with the news, music, doing things with groups of people, and favorite activities.</p> <p>Review of care plan for Resident #58 dated 08/09/24 revealed she was at risk for alteration in activity participation. The interventions was to familiarize resident with nursing home environment and activity programs on regular basis.</p> <p>Review of activity participation from 09/01/24 through 09/18/24 revealed Resident #58 had documentation for news, television, and socializing in her room.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #58 on 09/17/24 at 9:14 A.M. revealed the facility has activities, but she wasn't invited to go to them and would like to go. She stated she was a two-person assist for getting out of bed.</p> <p>3. Medical record review for Resident #319 revealed an admitted [DATE]. Further review of the medical record revealed h was cognitively intact and required limited assistance for transfers.</p> <p>Review the activity preferences assessment dated [DATE] revealed Resident #319 was not assessed for activities.</p> <p>Review of activity participation from 09/10/24 through 09/18/24 revealed Resident #319 had documentation for news and socializing in his room.</p> <p>Review of the care plan dated 09/13/24 for Resident #319 revealed he was at risk for alteration in activity participation. The interventions was to familiarize resident with nursing home environment and activity programs on regular basis. Provide a calendar of activities to the resident.</p> <p>Interview with Resident #319 on 09/15/24 at 2:35 P.M. revealed he had not been invited to activities and would like to know what they have to offer.</p> <p>Review of the activity calendar dated 09/15/24 revealed the following activities:</p> <p>9:30 A.M. morning chat</p> <p>10:30 A.M. bible study</p> <p>2:00 P.M. resident choice</p> <p>3:00 P.M. gospel music</p> <p>Review of the activity calendar dated 09/16/24 revealed the following activities:</p> <p>9:30 A.M. morning chat</p> <p>10:30 A.M. pretty nails</p> <p>2:00 P.M. blackjack</p> <p>3:00 P.M. daily news</p> <p>Observations on 09/15/24 at 2:00 P.M. revealed no activities observed for residents on the first floor. At 3:00 PM. there was no gospel music activity taking place. Further observations during these times revealed no staff going around asking residents to attend activities.</p> <p>During observation of activities for the first floor on 09/16/24 from 9:30 A.M. to 9:36 A.M. revealed there was no staff inviting residents for a morning chat. At 10:24 A.M. through 10:36 A.M. there was no pretty nails being done for the residents. At 10:40 A.M. the Activity Director (AD) #11 and an Activity Aide (AA) #9 were observed in the office. AA #10 was on the second floor.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with AA #10 on 09/16/24 at 11:21 A.M. revealed AA #12 did the activities on both floors on 09/15/24. She stated there were only a few residents on the first floor who wanted to come to activities and the rest were not interested. AA #12 admitted she didn't have a chance to come down to the first floor to ask any of the residents to come to activities on the second floor on 09/16/24. She stated she would try to go down to the first floor and ask residents if they wanted to come to activities.</p> <p>Review of policy entitled, Activities, dated 01/01/20 revealed it is the policy of the facility to provide activity programming to promote the physical, mental and psychosocial well-being of each resident. Activity programs are designed to meet the interests of the residents and encourage independence and interaction in the community. Residents are encouraged, but not required to participate in activity programming.</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** 33023</p> <p>Based on record review, observation, and interviews, the facility failed to provide adequate supervision for residents who smoke and proper storage of smoking materials for two residents (#27 and #65), and failed to provide proper supervision and services following a fall in the facility which affected one resident (Resident #44). This affected three residents (#27, #44, and #65) out of five residents reviewed for accident hazards. The facility census was 66.</p> <p>Findings include:</p> <p>1. Record review of Resident #27 revealed the resident was admitted to the facility on [DATE] with the following medical diagnoses: cerebral infarction, human immunodeficiency virus, hemiplegia affecting left side, traumatic subdural hematoma, osteomyelitis, epilepsy, hyperlipidemia, malignant neoplasm of the ovaries, tobacco use, osteomyelitis, convulsions, atrial flutter, gastro-esophageal reflux disease, tricuspid valve stenosis, hypertension, depression, anxiety, opioid abuse with withdrawal, viral Hepatitis C.</p> <p>Review of the Minimum Data Set(MDS) assessment completed on 08/02/24 revealed the resident had intact cognition.</p> <p>Review of the Smoking assessment dated [DATE] revealed the resident was noted with limited range of motion to her upper extremities. Review of the Smoking assessment dated [DATE] revealed the resident frequently drops ashes on herself.</p> <p>Review of the smoking care plan for Resident #27 revealed the resident was a supervised smoker who was to be supervised by staff. This resident also required a smoking apron to be worn while smoking. Additionally, per the resident's care plan, all smoking materials were to be kept at the nurses station.</p> <p>Observation of Resident #27 on 09/16/24 at 09:11 A.M. revealed this resident had multiple smoking materials in her room including a lighter, cigarettes, and vape stick.</p> <p>Observation on the first floor smoking area on 09/16/24 at 3:27 P.M. revealed Resident #27 and Resident #53 were observed outside smoking on first floor designated smoking area, no fire extinguisher or blanket was in the area. On the second floor, the smoking area has a fire blanket in the area but no extinguisher present.</p> <p>Interview with the Assistant Director of Nursing #98 on 09/16/24 at 3:30 P.M. verified the second floor designated smoking area has fire blanket but no extinguisher. She additionally verified independent smokers are to smoke on the first floor and supervised smokers on the second floor.</p> <p>Interview with the Director of Nursing on 09/17/24 at 03:52 P.M. verified the care plan for Resident #27 states this resident is a supervised smoker.</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>Interview with the Director of Nursing on 09/17/24 at 05:06 P.M. verified all smoking materials have been removed from the room of Resident #27.</p> <p>2. Record review of Resident #44 revealed the resident was admitted to the facility on [DATE] with the following medical diagnoses: diabetes mellitus type II, muscle weakness, abnormalities of gait and movement, dementia, depression, malignant neoplasm of the prostate, debility, hyperlipidemia, repeated falls, Alzheimer's disease, hypotension, anemia, and cognitive communication deficit.</p> <p>Review of the Minimum Data Set(MDS) assessment completed on 07/19/24 revealed the resident had severe cognitive impairment.</p> <p>Review of the most recent fall assessment revealed the resident has had multiple falls and was considered a high risk for falls.</p> <p>Review of the nursing note on 9/16/24 at 9:20 A.M. revealed a visitor noted resident on the floor and asked for help. Upon evaluation the resident was noted to be laying on his right side facing the window. The resident began to yell out when being positioned to be moved. Physician called and ordered for the resident to be sent to the emergency room for evaluation. Skin tear to right elbow noted. Brother called and updated.</p> <p>Review of the nursing note on 9/16/24 at 12:54 P.M. revealed Resident #44 returned from the emergency room visit with no broken bones, no abnormalities noted. No new orders. Right elbow skin tear cleaned, dried, antibiotic ointment applied and wrapped with dry dressing and Kerlex.</p> <p>Observation of Resident #44 on 09/16/24 revealed Resident #44 fell to the floor in the second floor dining/activity room at approximately 8:20 A.M. Multiple staff observed and did not respond to the resident. Six staff members were observed to walk by until surveyor stopped one of them and asked if the resident was going to be helped. Resident #44 was provided with response by staff at approximately 8:28 A.M. due to surveyor intervention. Resident was in the room with two other residents in wheelchairs and no staff present. Resident had complaints of back pain during assessment by staff.</p> <p>Interview with the Director of Nursing on 09/16/24 at 10:25 A.M. verified Resident #44 fell to floor unattended while in the 2nd floor dining room. Verified no staff response or assessment for eight minutes, with multiple staff walking by the area.</p> <p>34291</p> <p>3. Medical record review for Resident #65 revealed an admitted [DATE]. His medical diagnoses included renal insufficiency and acute post-hemorrhagic anemia.</p> <p>Review of Resident #65's Minimum Data Set (MDS) dated [DATE] revealed Resident #65 was cognitively intact. His functional status was setup or clean-up for eating, supervision or touching assistance for bed mobility, toileting, and transfers.</p> <p>Review of the care plan dated 07/12/24 for Resident #65 revealed he was at risk for injury related to smoking. An intervention was to keep smoking items at the nursing station.</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>Review of Resident #65's smoking assessment dated [DATE] revealed he followed the facility's procedure on location and time of smoking.</p> <p>Observation of Resident #65 on 09/16/24 at 8:57 A.M. revealed he had a cigarette in his mouth with a pack of cigarettes lying on his bedside table. At the time of the interview the resident said he was an unsupervised smoker and permitted to keep smoking materials in his room.</p> <p>An observation was made on 09/16/24 at 2:45 P.M. revealed Resident #65 was coming in from smoking and walked down the hall to his room and there wasn't any signs of smoking materials. State tested Aide (STNA) #78 asked him if he had smoking materials on him and he admitted he had cigarettes and a lighter which the aide removed from him.</p> <p>During an interview with STNA #78 on 09/16/24 at 2:50 P.M. confirmed Resident #65 had smoking materials on him and stated he was supposed to keep them at the nursing station in a pouch and she would get him a pouch.</p> <p>Review of the Smoking Policy revealed a revision date of July 2024 and the following guidelines: All smoking material, cigarettes, cigars, lighters, etc. will be kept at the nurse station or designated area. Smoking will be supervised by staff or volunteers during supervised smoking times unless determined by facility independent smoking assessment that resident is safe to smoke without supervision. The use of nicotine vape electronic smoking devices will be used outside the facility in the designated smoking area.</p>		

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NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Woodridge Boulevard Fairfield, OH 45014	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on observations, interviews, record reviews, and review of facility policies, the facility failed to ensure care and services were provided to prevent a decline in nutritional status. This affected five residents (#3, #20, #34, #44, and #51) out of eight residents reviewed for nutrition. The facility census was 66.</p> <p>Findings include:</p> <p>1. Record review for Resident #20 revealed the resident was admitted to the facility on [DATE] and had diagnoses including chronic respiratory failure, difficulty walking, and muscle weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to have intact cognition. The resident was assessed to have significant weight loss and to have a mechanically altered diet.</p> <p>Review of the care plan revised 08/12/24 revealed the resident had potential for alteration in nutrition/hydration. Interventions included provide diet as ordered and obtain weights as ordered.</p> <p>Review of the active physicians order dated 03/14/24 revealed the resident was to receive a health shake three times a day for weight loss.</p> <p>Review of the Registered Dietitian progress note dated 08/10/24 revealed the resident had triggered for a significant weight loss of 29 pounds equaling 12 percent in 180 days. Oral intake would not elicit that type of weight loss. Fluid shifts may contribute to weight fluctuations. Please re-weigh and weigh weekly for four weeks.</p> <p>Review of the physicians orders for Resident #20 revealed no orders for weekly weights had been in place since 03/14/24.</p> <p>Review of the recorded weights for Resident #20 revealed a weight of 213.8 on 08/05/24 and 213.8 pounds on 09/10/24, No weights were documented to have been obtained between 08/05/24 and 09/10/24.</p> <p>Observation on 09/15/24 at 12:41 P.M. revealed State tested Nursing Assistant (STNA) #8 delivered the lunch meal to Resident #20. The resident's meal ticket was present on the tray and contained instructions the resident was to have a frozen nutritional treat. Interview with STNA #8 at the time of the observation confirmed no frozen nutritional treat or other supplement was present on the resident's meal tray. STNA #8 confirmed the kitchen staff was to provide nutritional supplements on residents meal trays.</p> <p>Interview with Licensed Practical Nurse (LPN) #60 on 09/16/24 at 7:45 A.M. confirmed nutritional supplements were provided on meal trays by the kitchen staff.</p> <p>Observation on 09/16/24 at 9:04 A.M. revealed Resident #20 was sitting up in bed consuming the breakfast meal. The meal ticket on the residents tray contained instructions the resident was to have a frozen nutritional treat. No frozen nutritional treat or other supplement was present on the tray.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 09/16/24 at 12:52 P.M. revealed there were no frozen nutritional treats, health shakes, or other supplements present in the facility kitchen to distribute to residents. Interview with Dietary Supervisor #26 at the time of the observation confirmed the facility had run out of dietary supplements and would receive more on 09/17/24 when the delivery truck arrived.</p> <p>Observation on 09/17/24 at 8:45 A.M. revealed Resident #20 was consuming the breakfast meal and did not have ordered dietary supplements on the tray. Interview with STNA #4 at the time of the observation confirmed there was not a frozen nutritional treat, health shake, or other supplement present on the residents tray.</p> <p>Interview with Registered Dietitian (RD) #501 on 09/17/24 at 9:30 A.M. confirmed dietary supplements should be provided as ordered to prevent weight loss and promote weight gain. RD #501 confirmed there had been concerns with facility staff not implementing dietary recommendations or obtaining weights.</p> <p>Interview with the Director of Nursing (DON) on 09/18/24 at 12:10 P.M. confirmed the recommendations to re-weigh Resident #20 and obtain weights weekly for four weeks made by RD #501 on 08/10/24 had not been implemented.</p> <p>2. Record review for Resident #51 revealed the resident was admitted to the facility on [DATE] and had diagnoses including spinal stenosis, serous retinal detachment of the right eye, and feeding difficulties.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident was assessed to have intact cognition. The resident was assessed to have significant weight loss and to have a mechanically altered diet.</p> <p>Review of the care plan dated 07/09/24 revealed the resident had a potential for alteration in nutrition/hydration. Interventions included to provide supplements as ordered and obtain weights as ordered.</p> <p>Review of the physicians order dated 04/08/24 revealed an order for a Magic Cup to be provided with all meals.</p> <p>Review of the physicians order dated 08/12/24 revealed an order for Boost to be provided with meals for weight loss.</p> <p>Review of the physicians order dated 08/12/24 revealed an order for the resident to be weighed weekly for four weeks.</p> <p>Review of the recorded weights for Resident #51 revealed the resident weighed 132.0 pounds on 08/13/24 and 133.0 pounds on 09/03/23. No weights were documented to have been obtained from 08/13/24 to 09/03/24.</p> <p>Observation on 09/15/24 at 12:50 P.M. revealed STNA #49 delivered the lunch meal to Resident #51. The residents meal ticket was present on the meal tray and contained instructions the resident was to have a mighty shake. Interview with STNA #49 at the time of the observation confirmed there was not a might shake, Boost, or other supplement present on the residents tray.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 09/16/24 at 9:01 A.M. revealed Resident #51 was consuming the breakfast meal. The meal ticket present on the tray contained instructions for the resident to have a mighty shake with every meal. No mighty shake or Boost was present on the tray for the resident to consume.</p> <p>Observation on 09/16/24 at 12:22 P.M. revealed STNA #102 delivered the lunch meal to Resident #51. The resident meal ticket was present on the meal tray and contained instructions the resident was to have a mighty shake. Interview with STNA #102 at the time of the observation confirmed supplements were provided by the kitchen staff and the residents tray did not have any present.</p> <p>Observation on 09/16/24 at 12:52 P.M. revealed there were no frozen nutritional treats, health shakes, or other supplements present in the facility kitchen to distribute to residents. Interview with Dietary Supervisor #26 at the time of the observation confirmed the facility had run out of dietary supplements and would receive more on 09/17/24 when the delivery truck arrived.</p> <p>Interview with Licensed Practical Nurse (LPN) #60 on 09/16/24 at 2:51 P.M. confirmed dietary supplements such as mighty shakes and Boost were provided to residents on their meal trays by dietary staff and not nursing staff.</p> <p>Observation on 09/17/24 at 8:45 A.M. revealed Resident #51 was consuming the breakfast meal. No mighty shake, Boost, or other dietary supplement was present on the tray. Interview with STNA #4 at the time of the observation verified there were no dietary supplements present on the residents meal tray.</p> <p>Interview with Registered Dietitian (RD) #501 on 09/17/24 at 9:30 A.M. confirmed dietary supplements should be provided as ordered to prevent weight loss and promote weight gain. RD #501 confirmed there had been concerns with facility staff not implementing dietary recommendations or obtaining weights.</p> <p>Interview with the DON on 09/18/24 at 12:10 P.M. confirmed weekly weights had not been obtained for Resident #51 as ordered by the physician.</p> <p>33023</p> <p>3. Record review of Resident #44 revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: diabetes mellitus type II, muscle weakness, abnormalities of gait and movement, dementia, depression, malignant neoplasm of the prostate, debility, hyperlipidemia, repeated falls, Alzheimer's disease, hypotension, anemia, and cognitive communication deficit.</p> <p>Review of the MDS assessment completed on 08/29/24 revealed this resident had severe cognitive impairment.</p> <p>Review of physician orders revealed the resident was ordered a regular diet with double portions with house supplements to be provided with meals three times a day.</p> <p>Review of nutritional notes from 09/11/24 revealed a weight loss of five percent or more in the last month or loss of ten percent or more in last six months. This resident has been identified as having a 7.7 pound weight loss in the last thirty days. Resident is not on a prescribed weight-loss regimen.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of lunch meal on 09/15/24 at 12:09 P.M. revealed this resident was served a single portion of lunch, was not served what appeared to be double portions. Resident also did not receive nutritional supplement.</p> <p>Observation of lunch meal on 09/16/24 at 12:13 P.M. revealed a single portion of lunch served. No nutritional supplement provided on lunch meal tray.</p> <p>Observation and interview on 09/17/24 at 5:10 P.M. with LPN #64 while she was feeding Resident #44, revealed the resident was served one portion and no double portions was indicated on the meal ticket. LPN #64 further verified no supplement was provided with the meal.</p> <p>Interview with the DON on 09/18/24 at 01:55 P.M. verified a lot of problems between dietary and nursing. Verified residents not receiving proper diet or supplements.</p> <p>44069</p> <p>4. Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnoses included urinary tract infection, asthma, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, tremor, myasthenia gravis without acute exacerbation, rhabdomyolysis, syncope and collapse, anemia, anxiety disorder, edema, vitamin deficiency, and hypokalemia.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #3 had moderately impaired cognition. Resident #3 was assessed to require setup assistance for eating, supervision for oral hygiene, upper body dressing, and toileting, and partial to moderate assistance for bathing, lower body dressing, personal hygiene, bed mobility, and transfer.</p> <p>Review of the plan of care initiated on 06/12/18 revealed Resident #3 had the potential for nutritional alteration related to dysphagia, anemia, anxiety, dementia, hypertension, and hypokalemia. Interventions included administer medications as ordered, assist with meals as needed, honor food preferences, monitor labs, and review weights and notify physician and responsible party of significant weight change.</p> <p>Review of the nutritional assessment dated [DATE] revealed Resident #3 was at risk for malnutrition.</p> <p>Review of the weights for Resident #3 revealed she weighed 154 pounds on 06/23/24, 140 pounds on 07/05/24, 135 pounds on 07/17/24, 137 pounds on 08/05/24, and 137 pounds on 09/10/24.</p> <p>Review of the active and discontinued orders for Resident #3 from 07/15/24 to 09/16/24 revealed no orders for weekly weights for four weeks or supplements.</p> <p>Review of the weight change progress note for Resident #3 dated 07/15/24 revealed Resident #3 was noted to have had a significant weight loss. The recommendations were weekly weights for four weeks and a house supplement daily.</p> <p>Review of the nutrition assessment progress note for Resident #3 dated 08/16/24 revealed a recommendation for house shake three times a day with meals.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the nutrition assessment progress note for Resident #3 dated 09/16/24 stated continue to recommend house shake three times a day with meals.</p> <p>Further review of the medical record revealed no indication house shakes were ordered or provided to Resident #3.</p> <p>Interview on 09/17/24 at 9:39 A.M. with Registered Dietitian #501 revealed there had been issues with the facility not implementing recommendations, including obtaining weights.</p> <p>Interview on 09/17/24 at 1:53 P.M. with the Director of Nursing (DON) verified the nutritional recommendations had not been implemented.</p> <p>5. Review of the medical record for Resident #34 revealed an admitted [DATE]. Diagnoses included displaced apophyseal fracture of left femur, cerebral infarction, type two diabetes mellitus without complications, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atherosclerotic heart disease of native coronary artery without angina pectoris, congestive heart failure, hyperlipidemia, occlusion and stenosis of left carotid artery, major depressive disorder, anxiety disorder, bipolar disorder, and peripheral vascular disease.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 was assessed to require setup assistance for eating, supervision for oral hygiene, upper body dressing, and bed mobility, and partial to moderate assistance for toileting, bathing, lower body dressing, personal hygiene, and transfer.</p> <p>Review of the plan of care initiated on 02/24/23 revealed Resident #34 had the potential for alteration in nutrition related to congestive heart failure, hypertension, hyperlipidemia, peripheral vascular disease, major depressive disorder, and type two diabetes mellitus without complications. Interventions included administer medications as ordered, assist resident with meals as needed, honor food preferences, monitor labs, obtain weights as ordered, provide diet as ordered, and offer meal substitutions as needed.</p> <p>Review of the nutritional assessment dated [DATE] revealed Resident #34 was at risk for malnutrition.</p> <p>Review of the weights for Resident #34 revealed she weighed 168 pounds on 06/10/24, 160 pounds on 07/05/24, 161 pounds on 07/16/24, 151 pounds on 08/08/24, and 148 pounds on 09/10/24.</p> <p>Review of the active and discontinued physician orders from 08/12/24 to 09/16/24 revealed no orders for liquid protein or weekly weights for four weeks.</p> <p>Review of the nutrition assessment progress note dated 08/12/24 revealed Resident #34 had a recent significant weight loss. The recommendation was to weigh weekly for four weeks.</p> <p>Review of the nutrition progress note dated 08/20/24 revealed Resident #34 had a change in skin integrity, and a new recommendation of liquid protein daily was made.</p> <p>Review of the nutrition assessment progress note dated 08/28/24 revealed Resident #34 continued to be at risk for malnutrition. The note also stated continue to recommend liquid protein daily.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of the medical record revealed no orders or evidence liquid protein was provided to Resident #34.</p> <p>Interview on 09/17/24 at 9:39 A.M. with Registered Dietitian #501 revealed there had been issues with the facility not implementing recommendations, including obtaining weights.</p> <p>Interview on 09/17/24 at 1:50 P.M. with the DON verified the nutritional recommendations had not been implemented.</p> <p>Review of the policy titled, Weight Management Program and Weight Gain/Loss Policy, revised 08/2024, revealed all residents would be weighed monthly and as ordered. The policy also indicated the DON, or designee would review high-risk weight change progress notes daily and address accordingly.</p> <p>Review of the undated policy titled, Medical Nutrition Therapy Recommendations, revealed recommendations from the registered dietician or designee would be implemented, or the reason for non-implementation would be documented in a timely manner.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157199.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on resident record reviews, staff interviews, and review of facility policy, the facility failed to ensure communication between the facility and dialysis center was maintained. This affected one resident (#18) reviewed for dialysis. The facility census was 66.</p> <p>Findings include:</p> <p>Record review for Resident #18 revealed the resident was admitted to the facility on [DATE] and had diagnoses including pleural effusion, dependence on renal dialysis, and moderate protein-calorie malnutrition.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to have moderately impaired cognition. The resident was assessed to have received dialysis while a resident of the facility.</p> <p>Review of the care plan revised 04/29/21 revealed the resident was on dialysis. Interventions included resident to attend dialysis on Tuesdays, Thursdays, and Saturdays.</p> <p>Review of the progress notes dated 07/01/24 through 09/17/24 revealed no documentation of the resident refusing to attend dialysis appointments.</p> <p>Review of the dialysis communication forms for 07/2024, 08/2024, and 09/2024 revealed dialysis communication forms had only been completed for dialysis appointments on 07/02/24, 07/16/24, 07/27/24, 09/07/24, and 09/10/24. No dialysis communication forms were available for 10 dialysis appointments attended in 07/2024, 12 dialysis appointments attended in 08/2024, or four dialysis appointments attended in 09/2024.</p> <p>Interview with Assistant Director of Nursing (ADON) #98 on 09/17/24 confirmed dialysis communication forms were to be completed for every dialysis appointment attended by Resident #18. ADON #98 confirmed numerous dialysis communication forms had not been completed for Resident #18.</p> <p>Review of the facility policy titled Dialysis Care, reviewed 08/2024, revealed it was the policy of the facility to ensure residents that receive dialysis are safe, well assessed, and that the facility collaborates care with the dialysis center. Facilities shall use a form to communicate between the dialysis center with each visit. The nurse will complete an assessment of the resident prior to leaving the facility and upon return to the facility for each dialysis visit.</p>		

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<p>F 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>34291</p> <p>Based on personnel record review and staff interview the facility failed to ensure State tested Nurse Aides (STNA) were given a 90-day evaluation. This affected all of the resident's who reside in the facility. The census was 66.</p> <p>Findings included:</p> <p>Review of STNA #1's personnel file revealed they were hired on 05/22/24. There wasn't any evidence the STNA had a 90-day evaluation.</p> <p>Review of STNA #2's personnel file revealed they were hired on 05/22/24. There wasn't any evidence the STNA had a 90-day evaluation.</p> <p>Interview with the Human Resource Director (HR) #13 on 09/18/24 at 11:50 A.M. confirmed she was new to this position and the 90-day evaluations had not been completed.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>42728</p> <p>Based on observations and interviews, the facility failed to ensure daily staffing information was posted for residents and visitors to view. This had the potential to affect all residents residing in the facility. The facility census was 66.</p> <p>Findings include:</p> <p>Observation on 09/15/24 at 9:15 A.M. revealed no daily staffing information was posted in the facility for residents and visitors to view.</p> <p>Observation and interview with Registered Nurse (RN) #91 on 09/15/24 at 9:22 A.M. confirmed there was an empty plastic holder located at the nursing station on the first floor of the facility. RN #91 confirmed the daily staffing posting was normally placed in the holder but was not there. RN #91 confirmed she was not able to locate the daily staffing posting to put in the holder.</p> <p>Observation on 09/15/24 at 10:38 A.M. revealed the daily staffing information had still not been posted in the plastic holder at the nurses station or any other conspicuous area of the facility.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 33023</p> <p>Based on record review and interview, the facility failed to conduct proper medication regimen reviews by a licensed pharmacist as required. Additionally, the facility failed to ensure the physician responded timely to a pharmacy recommendation for Resident #51. This affected five residents (Residents #13, #27, #44, #51, and #57) out of five residents reviewed for unnecessary medications. The facility census was 66.</p> <p>1. Record review of Resident #27 revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: cerebral infarction, human immunodeficiency virus, hemiplegia affecting left side, traumatic subdural hematoma, osteomyelitis, epilepsy, hyperlipidemia, malignant neoplasm of the ovaries, tobacco use, osteomyelitis, convulsions, atrial flutter, gastro-esophageal reflux disease, tricuspid valve stenosis, hypertension, depression, anxiety, opioid abuse with withdrawal, viral Hepatitis C.</p> <p>Review of the Minimum Data Set (MDS) assessment completed on 08/02/24 revealed this resident had intact cognition.</p> <p>Review of medication regimen reviews revealed all were completed monthly with the exception of 03/24 as the facility could not provide evidence of review being completed for March 2024 for this resident.</p> <p>Interview on 09/18/24 at 12:10 P.M. with the Director of Nursing (DON) verified there was no evidence of a medication regimen review completed by the pharmacist for March 2024.</p> <p>2. Record review of Resident #44 revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: diabetes mellitus type II, muscle weakness, abnormalities of gait and movement, dementia, depression, malignant neoplasm of the prostate, debility, hyperlipidemia, repeated falls, Alzheimer's disease, hypotension, anemia, and cognitive communication deficit.</p> <p>Review of the MDS assessment completed on 07/19/24 revealed this resident had intact cognition.</p> <p>Review of medication regimen reviews revealed all were completed monthly with the exception of 03/24 as facility could not provide evidence of review being completed for March 2024 for this resident.</p> <p>Interview on 09/18/24 at 12:10 P.M. with the Director of Nursing (DON) verified there was no evidence of a medication regimen review completed by the pharmacist for March 2024.</p> <p>3. Record review of Resident #57 revealed this resident was admitted to the facility on [DATE] with the following medical diagnoses: transient cerebral ischemic attack, chronic respiratory failure, obstructive sleep apnea, diabetes mellitus type II, hemiplegia and hemiparesis, chronic kidney disease, hypertension, muscle weakness, congestive heart failure, myocardial infarction, polycythemia vera, atherosclerosis, hyperlipidemia, and cognitive communication deficits.</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 - Some</p>	<p>Review of the MDS assessment completed on 06/30/24 revealed this resident had severe cognitive impairment.</p> <p>Review of medication regimen reviews revealed all were completed monthly with the exception of 03/24 as facility could not provide evidence of review being completed for March 2024 for this resident.</p> <p>Interview on 09/18/24 at 12:10 P.M. with the Director of Nursing (DON) verified there was no evidence of a medication regimen review completed by the pharmacist for March 2024.</p> <p>42728</p> <p>4. Record review for Resident #51 revealed the resident was admitted to the facility on [DATE] and had diagnoses including spinal stenosis, serous retinal detachment of the right eye, and feeding difficulties.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident was assessed to have intact cognition.</p> <p>Review of the Monthly Medication Reviews by the Licensed Pharmacist for Resident #51 revealed no review had been completed for the resident for 03/2024.</p> <p>Review of the pharmacy Physician Recommendation Form dated 08/05/24 revealed a recommendation to discontinue one order for Mirtazepine as two active orders were in place resulting in a duplication of therapy. The physician signed the recommendation as being reviewed on 09/12/24, 38 days after the recommendation had been made.</p> <p>Interview with the DON on 09/18/24 at 12:10 P.M. confirmed there was no monthly review of medications completed in 03/2024 for Resident #51. The DON additionally confirmed pharmacy recommendations were to be reviewed by the physician within 30 days of being made.</p> <p>44069</p> <p>5. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus without complications, myasthenia gravis without acute exacerbation, cardiac murmur, psoriasis, vitamin b deficiency, syncope and collapse, anemia, vascular dementia, unspecified severity with psychotic disturbance, hyperlipidemia, major depressive disorder, and anxiety disorder.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #13 had moderately impaired cognition. Resident #13 was assessed to require setup assistance for eating, and supervision for oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, and transfer.</p> <p>Review of the completed medication regimen reviews revealed the facility had no documentation a review had been completed for March 2024.</p> <p>Interview on 09/18/24 at 12:10 P.M. with the Director of Nursing (DON) verified there was no evidence of a medication regimen review completed by the pharmacist for March 2024.</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 - Some</p>	<p>Review of the policy titled Documentation and Communication of Consultant Pharmacist Recommendations, dated 08/2020, revealed the consultant pharmacist worked with the facility to establish a system whereby the consultant pharmacist's observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations and are responded to in an appropriate and timely fashion. Recommendations are acted upon and documented by the facility staff and/or provider. If the prescriber does not respond to a recommendation made to him/her within 30 days, the Director of Nursing and/or consultant pharmacist may contact the Medical Director.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on observation, and staff and resident interviews, the facility failed to ensure residents knew what they were being fed on a daily basis. This affected six (#59, #64, #4, #38, #58 and #319) of eight reviewed for food. There was one resident identified as nothing by mouth to eat. The census was 66.</p> <p>Findings included:</p> <p>Interview with Resident #59 on 09/15/24 at 12:18 P.M. revealed he didn't receive a menu and didn't know what he was going to be served on a daily basis. Observation in the room revealed no menu.</p> <p>Interview with Resident #64 on 09/15/24 a 12:30 P.M. revealed she didn't receive a menu and didn't know for her three meals what she was going to receive. Observation in the room revealed no menu.</p> <p>Interview with Resident #4 on 09/15/24 at 2:14 P.M. revealed she didn't receive a menu and didn't know what she was going to receive for her three meals. Observation in the room revealed no menu.</p> <p>Interview with Resident #38 on 09/16/24 at 8:00 A.M. revealed he didn't receive a menu and didn't know what he was going to receive for his three meals. Observation in the room revealed no menu.</p> <p>Interview with Licensed Pratical Nurse (LPN) #57 on 09/17/24 at 8:30 A.M. revealed the dietician manager will go around to the residents and get the resident likes and dislikes and the resident will receive their three meals per the menu for the day.</p> <p>Interview with State tested Nursing Aide (STNA) #94 on 09/17/24 at 8:36 A.M. revealed whatever is on the menu the residents will receive for the meals.</p> <p>Interview with Resident #58 on 09/17/24 at 11:59 A.M. revealed she doesn't receive a menu and hasn't received one since admitted [DATE]. Observation in the room revealed no menu.</p> <p>Interview with Resident #319 on 09/17/24 at 2:43 P.M. revealed he doesn't receive a new menu. He is a new admission and doesn't know where he can find a menu to look at. Observation in the room revealed no menu.</p> <p>Interview with the Dietary Manager (DM) #23 on 09/18/24 at 8:30 A.M. revealed she will meet with the residents and record their preferences and then the residents will receive what is on the menu. She stated the residents don't get to pick what they want off the menu.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>44069</p> <p>Based on observations, interviews, and policy review, the facility failed to ensure meals were palatable and served at appropriate temperatures. This had the potential to affect 65 out of 66 residents as the facility identified one resident (#19) who did not consume food from the kitchen. The facility census was 66.</p> <p>Findings include:</p> <p>Interviews on 09/15/24 from 10:50 A.M. to 2:11 P.M. with Residents #1, #12, #13, #23, and #27 revealed the food was cold and not cooked properly.</p> <p>Observation on 09/16/24 at 11:30 A.M. of meal temperatures before the start of the meal service revealed the chicken thigh was 184 degrees Fahrenheit (F), the mashed potatoes were 183 degrees F, and the green beans were 181 degrees F.</p> <p>Observation on 09/16/24 at 12:33 P.M. of a test tray on the second floor after all resident meal trays had been passed revealed the chicken thigh was 100 degrees F, the mashed potatoes were 100 degrees F, and the green beans were 100 degrees F. Interview at the time of the observation with Dietary Supervisor #26 verified the temperatures and indicated the temperature should be at least 135 degrees F.</p> <p>Observation on 09/17/24 at 12:30 P.M. of a test tray revealed the rice was chewy and undercooked. Interview at the time of the observation with Dietary Supervisor #26 verified she had tasted the rice, and it was undercooked.</p> <p>Review of the policy titled Food Temperatures, dated 2021, revealed all hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees F.</p> <p>42728</p> <p>2. Observation on 09/16/24 at 8:18 A.M. revealed the meal cart containing residents breakfast meal trays was sitting at the end of the hallway. One nurse was present on the hallway conducting medication administration. No additional staff were present in the hallway.</p> <p>Observation on 09/16/24 at 8:25 A.M. revealed the meal cart containing residents breakfast meal trays remained at the end of the hallway. No staff had begun passing breakfast meal trays to residents.</p> <p>Observation on 09/16/24 at 8:33 A.M. revealed one State tested Nursing Assistant (STNA) arrived and began pushing the meal cart down the hallway.</p> <p>Observation on 09/16/24 at 8:36 A.M. revealed an additional STNA arrived on the hallway and began passing breakfast meal trays out to residents.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 09/16/24 at 8:48 A.M. revealed the two STNAs continue passing breakfast meal trays to residents on the hallway. Additional staff arrive to the hallway to assist.</p> <p>On 09/16/24 at 8:56 A.M. the last breakfast meal tray is removed from the meal cart. Dietary Supervisor #26 removes the lid from the tray and obtains the temperature of foods using a facility thermometer. Dietary Supervisor #26 confirmed the temperature of the scrambled eggs on the plate is 80 degrees Fahrenheit (F) and the temperature of the grits is 98 degrees F. Dietary Supervisor #26 confirmed temperatures of the foods were at a level that would not be palatable for residents.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157199.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>34291</p> <p>Based on observation, and staff and resident interviews, the facility failed to ensure residents were able to choose an alternative meal. This affected six (#59, #64, #4, #38, #58 and #319) of eight reviewed for food alternatives. The census was 66.</p> <p>Findings included:</p> <p>1. Observation was made on 09/15/24 at 12:15 P.M. revealed there were not any postings for meal alternatives for the residents.</p> <p>Interview with Resident #59 on 09/15/24 at 12:18 P.M. revealed he wasn't able to choose from an alternative menu if he didn't like his meal that was served. Observation in the room revealed no alternatives for meals.</p> <p>Interview with Resident #64 on 09/15/24 a 12:30 P.M. revealed she wasn't able to choose from an alternative menu if she didn't like his meal that was served. Observation in the room revealed no alternatives for meals.</p> <p>Interview with Resident #4 on 09/15/24 at 2:14 P.M. revealed she wasn't able to choose from an alternative menu if she didn't like his meal that was served. Observation in the room revealed no alternatives for meals.</p> <p>Interview with Resident #38 on 09/16/24 at 8:00 A.M. revealed he wasn't able to choose from an alternative menu if he didn't like his meal that was served. Observation in the room revealed no alternatives for meals.</p> <p>Interview with Licensed Practical Nurse (LPN) #57 on 09/17/24 at 8:30 A.M. revealed she didn't know where the list of alternatives were for the residents and confirmed it wasn't posted anywhere for the residents to see.</p> <p>Interview with State tested Nursing Aide (STNA) #94 on 09/17/24 at 8:36 A.M. revealed there was a list of alternatives given to the residents upon admission, but she went to a new admission's room, Resident #319, and looked for the alternative menu and she couldn't find it and the resident said she didn't give it to him.</p> <p>Interview with Resident #58 on 09/17/24 at 11:59 A.M. revealed she wasn't able to choose from an alternative menu if she didn't like her meal that was served. Observation in the room revealed no alternatives for meals.</p> <p>Interview with Resident #319 on 09/17/24 at 2:43 P.M. revealed he wasn't able to choose from an alternative menu if he didn't like his meal that was served. Observation in the room revealed no alternatives for meals.</p> <p>42728</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Observation on 09/15/24 at 12:50 P.M. revealed State tested Nursing Assistant (STNA) #49 entered the room of Resident #51 and Resident #20 to deliver the lunch meal tray to Resident #51. Resident #51 asked STNA #49 what was being served on the tray to which STNA #49 replied ham, sweet potatoes, vegetables, pears, and cornbread. Resident #51 asked if they had any additional food items as he did not like what was served to him. STNA #49 replied there were hamburgers and hot dogs available as alternatives. Resident #51 and Resident #20 both requested a hot dog. No substitution menu was available for review in the residents room. STNA #49 took the lunch meal tray of Resident #51 and exited the room.</p> <p>Observation on 09/15/21 at 1:15 P.M. revealed STNA #49 returned to the room of Resident #51 and Resident #20 and delivered a plate containing only a hamburger to both residents. STNA #49 stated the kitchen did not have hot dogs available. STNA #49 confirmed she was not sure if any additional foods were available as substitutions.</p> <p>Interviews with Resident #51 and Resident #20 on 09/15/21 at 1:19 P.M. confirmed both residents had requested a hot dog but had received a hamburger instead. Resident #51 and Resident #20 confirmed they did not want a hamburger but ate what was delivered from the kitchen as they were unsure if there were any additional food items available.</p> <p>Review of the policy titled, Offering Food Replacements at Meal Times, undated revealed the director of food and nutrition services will maintain a list of meal alternates available, which will be provided to the nursing staff. The following page lists the items that will be available for food replacement at all meals. It is the responsibility of the nursing staff to know the alternates available for the meal.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44069</p> <p>Based on observations, interviews, and policy review, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect 65 out of 66 residents as the facility identified one resident (#19) that had not consumed food from the kitchen. The facility census was 66.</p> <p>Findings include:</p> <p>Observation on 09/18/24 at 8:50 A.M. of the kitchen revealed a large puddle of dirty water bubbling and pooling under the dishwasher that extended to the middle of the walkway between the side of the kitchen with the dishwasher and the other side that included the three-compartment sink. Interview at the time of the observations with Dietary Aide #21 verified the water puddle.</p> <p>Observations on 09/18/24 from 8:50 A.M. to 9:05 A.M. of the kitchen revealed a dusty vent above the steam table where food is served. There were also ceiling tiles near the steam table that were drooping and discolored. Interview at the time of the observations with Dietary Director #23 verified the dusty vent and the ceiling tiles. Dietary Director #23 stated the roof has been leaking, which caused the issues with the ceiling tiles.</p> <p>Review of the undated policy titled, Cleaning and Sanitation of Dining and Food Service Areas, revealed staff would maintain the cleanliness and sanitation of the dining and food service areas.</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** 42728</p> <p>Based on record reviews and staff interviews, the facility failed to ensure accurate documentation of medications administered to residents. This affected one resident (#51) out of the five residents reviewed for unnecessary medications during the annual survey. The facility census was 66.</p> <p>Findings include:</p> <p>Record review for Resident #51 revealed the resident was admitted to the facility on [DATE] and had diagnoses including spinal stenosis, serous retinal detachment of the right eye, and feeding difficulties.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to have intact cognition.</p> <p>Review of the active physicians orders for Resident #51 revealed the resident had duplicate orders in place for the medications Guaifenesin, Glucagon, Loperamide, Omeprazole, Potassium, and Tamsulosin.</p> <p>Review of the Medication Administration Record (MAR) from 08/01/24 through 09/15/24 revealed the scheduled medications Potassium and Tamsulosin had been documented as being administered twice at the same time each day. The medication Omeprazole had been documented as being administered at both 6:00 A.M. and 7:30 A.M. each day.</p> <p>Interview with Licensed Practical Nurse (LPN) #60 on 09/16/24 at 2:51 P.M. confirmed Resident #51 had duplicate orders for medications to be administered. LPN #60 confirmed only one dose of the medications Potassium and Tamsulosin were administered to the resident but were documented as though two doses were administered. LPN #60 confirmed night shift administered and documented the first dose of Omeprazole at 6:00 A.M. and then day shift administered and documented the second dose of Omeprazole at 7:30 A.M. LPN #60 stated it should not hurt Resident #51 to receive two doses of Omeprazole instead of the one dose the resident should receive.</p> <p>Interview with the Director of Nursing (DON) on 09/16/24 at 3:30 P.M. confirmed Resident #51 had duplicate orders in place for the administration of Guaifenesin, Glucagon, Loperamide, Omeprazole, Potassium, and Tamsulosin when there should only be one order. The DON confirmed he was removing the duplicate orders for the resident at the time of the interview.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>44069</p> <p>Based on observations and interview, the facility failed to ensure kitchen equipment was working properly. This had the potential to affect 65 out of 66 residents as the facility identified one resident (#19) that had not consumed food from the kitchen. The facility census was 66.</p> <p>Findings include:</p> <p>Observations on 09/18/24 from 8:50 A.M. to 9:05 A.M. of the kitchen revealed the garbage disposal did not function properly, the dishwasher leaked, there was a broken oven and refrigerator, and the three-compartment sink did not fill and drain properly.</p> <p>Interviews on 09/18/24 from 8:50 A.M. to 9:05 A.M. with Dietary Aide #21, Dietary Supervisor #26, and Dietary Director #23 verified the malfunctioning kitchen equipment. Dietary Aide #21 stated the dishwasher had leaked for months, and a wet vacuum must be used to drain the three-compartment sink. Dietary Supervisor #26 reported rags must be placed in the three-compartment sink to keep it filled. Dietary Director #23 verified the broken oven and refrigerator still in the kitchen. Dietary Director #23 also stated the garbage disposal had been out of order, and staff had to use the trash cans or the wet vacuum to clean up food waste.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>34291</p> <p>Based on observation, staff and resident interview, and policy review the facility failed to ensure to provide a clean and maintained environment. This affected 17 (#63, #06, #47, #21, #319, #65, #58, #64, #59, #38, #04, #66, #36, #43, #51, #20, and #26) of 17 residents reviewed for homelike environment. The census was 66.</p> <p>Findings included:</p> <p>1. Interview and observation of Resident #63's room on 09/15/24 at 10:40 A.M. revealed the floors were sticky and the resident said they remain sticky. There was a light over the bed when she turned it on it flickered. She said it had been like that and she told the housekeeper about it. There were four scrapes on the wall behind the bed, holes in the wall behind the toilet paper, wallpaper coming off under the sink area, ceiling tiles warped in the bathroom over the shower, dust coming off the blind, frosted glass on the right side her window from improper sealing, the blind had a yellowish substance on it, cobwebs on the right side of the window, and there was water damage next to the air conditioner unit.</p> <p>Observation of Resident #6's room on 09/15/24 at 11:14 A.M. revealed the floors were sticky, there was rust in the shower, the caulking had come off the floor in front of the shower.</p> <p>Observation of Resident #47's room on 09/15/24 at 11:19 A.M. revealed the floor were sticky, cobwebs in the window sill, base boards in the room under the window had a brownish substance on them and the floors had a black substance on them. The floor in the bathroom had a black substance on them. Interview with the resident revealed the floors were usually sticky.</p> <p>Observation of Resident #21's room on 09/15/24 at 11:24 A.M. revealed there was rust in the shower and the floor in the bathroom is coming up from the sub floor.</p> <p>Interview and observation of Resident #319's room on 09/15/24 at 11:28 A.M. revealed he didn't think his room looked the greatest. The window on the right of his two-part window was frosted coated (seal failure) that won't come off, the wallpaper is peeling in the room, the floors were sticky, the shower was leaking and when it was turned on it trickled with water.</p> <p>Observation and interview with Resident #65 on 09/15/24 at 11:50 A.M. revealed there were cobwebs next to the HVAC system, and in the windowsill, and the floors were sticky and the resident said they stay sticky. The water pressure in the shower was trickling, The tile was coming up behind the toilet area.</p> <p>Interview and observation of Resident #58's room on 09/15/24 at 11:59 A.M. revealed there were splashes of red droplets on the blind, dust falling off the blind and a built up substance on them, and cobwebs in the window. She stated her room has been this way since she admitted .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Woodridge Boulevard Fairfield, OH 45014	

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 09/15/24 at 12:09 P.M. with Resident #64 revealed there were splashes of red droplets on the blinds and dust on them and built up dirt, cobwebs in the window, and she stated this has been like this since 06/12/24 when she moved into the facility. The floors were dirty and sticky.</p> <p>Observation of Resident #59 on 09/15/24 at 12:18 P.M. revealed blinds were broken with red droplets on them, windowsills had a black substance in them, floor in the bathroom tile is pulling away from the walls, black substance on the floor of the bathroom, rust in the shower, vent in the ceiling in bathroom is dirty with dust and rusted, and the floors were sticky in the room.</p> <p>Observation and interview with Resident #38 on 09/15/24 at 12:19 P.M. revealed he thought housekeeping was half and half. His floor was sticky, tile is coming away from the walls in the bathroom, and rust in the shower.</p> <p>Observation and interview with Resident #4 on 09/15/24 at 12:51 P.M. revealed she didn't think her environment was clean. Her blinds had a red substance on them, the wall across from the left side of her bed was scraped all the way down the wall, and her chair for visitors had a broken arm on it.</p> <p>Observation of Resident #66's room on 09/15/24 at 2:52 P.M. revealed glass on the right side of the windows had the frosted glass that doesn't come off and obstructs the view of the resident to the outside, dust is coming off the blinds in the room and has a yellowish substance on them.</p> <p>Observation of Resident #36's room on 09/15/24 at 2:02 P.M. revealed his floor was sticky, cobwebs were in the window and his blind had a orange substance on it.</p> <p>Observation of Resident #43's room on 09/15/24 at 2:25 P.M. revealed the floor was sticky, cobwebs in the window, windows dirty, plaster coming off the wall by the toilet seat, bathroom smells like urine, the raised toilet seat had a dark yellow spot between where it connects to the toilet, the silicone around the bathroom floors was brownish, and the tile was wrinkled in the bathroom.</p> <p>Interview with Maintenance Assistant (MA) #46 on 09/15/24 at 2:58 P.M. revealed he was only fixing pressing issues in the facility and he had looked in the rooms for repairs, but didn't have anything documented.</p> <p>Tour of all of the above mentioned rooms and interviews with Housekeeping Supervisor (HSKS) #31 and Maintenance Supervisor (MS) #48 on 09/16/24 from 12:30 P.M. to 1:07 P.M. confirmed all of the observations.</p> <p>33023</p> <p>2. Observation of Resident #26's room on 09/15/24 at 01:17 P.M. revealed the room smelled of urine and the mattress was unmade with large cuts in the top surface of the mattress.</p> <p>Observation of Resident #26's room on 09/16/24 at 09:50 A.M. revealed the room remained with odor of urine. Bed was unmade with large cuts in the top surface of the mattress.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview of Resident #26's room on 09/17/24 at 3:07 P.M. revealed large cuts in the top surface of the mattress and a strong odor of urine. Interview with the Director of Nursing verified the urine odor and large cuts in the surface of the mattress.</p> <p>42728</p> <p>3. Observation of Resident #51 and Resident #20's room on 09/16/24 at 7:55 A.M. revealed there was a large amount of food debris lying on the floor. Patches of black film and dirt were present on many areas of the floor. The cobase behind the bed of Resident #51 had fallen off and was lying on the floor allowing the empty space behind the wall to be visible. Interview with State tested Nursing Assistant (STNA) #102 at the time of the observation verified the floors in the room were dirty and in need of being cleaned and the cobase behind Resident #51's bed had fallen off.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157500.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>42728</p> <p>Based on observations, interviews, and review of facility policy, the facility failed to ensure effective pest control was maintained throughout the facility. This had the potential to affect the 66 residents residing in the facility. The facility census was 66.</p> <p>Findings include:</p> <p>1. Observation on 09/15/24 at 8:55 A.M. revealed Resident #13 was lying in bed asleep. The residents breakfast meal tray was on the bedside table. Three flies were observed crawling on the table and breakfast meal tray.</p> <p>Observation on 09/15/24 at 9:00 A.M. revealed there were two flies on the door frame of Resident #3's room.</p> <p>Observation on 09/15/24 at 10:43 A.M. revealed there were several gnats flying around the room of Resident #45. Interview with Resident #45 at the time of the observation confirmed flies and gnats were a problem in the facility.</p> <p>Interview with Resident #1 on 09/15/24 at 10:50 A.M. confirmed the facility had a problem with flies and gnats. Resident #1 confirmed it was hard to eat a meal without flies landing on the food.</p> <p>Observation on 09/15/24 at 11:27 A.M. revealed there were several flies present in the room of Resident #14 and Resident #16. The flies were landing on the tray table and food of Resident #14. Interview with Resident #14 at the time of the observation confirmed there were always flies present in the room and they often landed on the resident's food while he was trying to eat.</p> <p>Observation on 09/15/24 at 12:20 P.M. revealed there were multiple flies present in the room of Resident #16 and Resident #39. The flies were landing on the residents' sheets and tray tables.</p> <p>Interview with STNA #8 on 09/15/24 at 12:41 P.M. confirmed the facility had a problem with flies and gnats being present in resident rooms and care areas.</p> <p>44069</p> <p>2. Observation on 09/17/24 at 11:45 A.M. in the kitchen of the tray line service revealed multiple flies were flying and landing on the steam table, which was verified by Dietary Supervisor #26 at the time of the observation.</p> <p>3. Observations on 09/18/24 qt 8:50 A.M. of the kitchen revealed flies and gnats around the dishwasher and three-compartment sink, which was verified by Dietary Aide #21.</p> <p>Review of the policy titled Pest Control Policy, dated 08/2016, revealed the important of pest control in providing a living environment of adequate health and safety for residents.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157500 and Complaint Number OH00157199.</p>		