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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365741 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/04/2024 |
| NAME OF PROVIDER OR SUPPLIER Ashtabula County Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 5740 Dibble Road Kingsville, OH 44048 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570</p> <p>Based on record review and interview, the facility failed to ensure Resident #115's guardian was informed and gave consent for Resident #115 to be discharged from the facility. This affected one resident (Resident # 115) of the three residents reviewed for discharge. The facility census was 114.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #115 was admitted to the facility on [DATE] and discharged from the facility on 08/12/24. Guardian #392 was listed as the responsible party guardian and emergency contact #1. Resident #115's mother was the emergency contact #2. Medical diagnoses included pulmonary edema, Asperger's syndrome, diabetes, bipolar, hypertension, glaucoma, dependence on renal dialysis, depression, and anemia.</p> <p>Review of the Minimum Data Set (MDS) 3.0 Discharge Return Not Anticipated assessment dated [DATE] revealed discharge was unplanned to home. Resident #115 had moderate impairment for decision making. Resident #115 displayed physical behaviors. Resident #115 needed set up for eating. Maximum assistance was needed for oral hygiene. Moderate assistance was needed for toilet hygiene, bathing and dressing. Resident #115 needed moderate assistance to roll left and right in bed, sit on the side of the bed, lie back in bed , stand and transfer from bed. Moderate assistance was needed to walk ten feet. Resident #115 received hemodialysis.</p> <p>Review of the Health Status Note dated 08/12/24 at 2:41 P.M. written by Licensed Practical Nurse (LPN) #344 , revealed Resident #115's mother stated she wanted to take Resident #115 home. The physician was notified. This note stated Residents guardian [NAME] was also notified of residents discharge from the facility.</p> <p>Review of the document titled Probate Court of Ashtabula County Letters of Guardianship, dated 08/07/23, revealed Catholic Charities of Ashtabula County shall be appointed Guardian of Resident #115, an incompetent and the duties of the Guardian shall be discharged by the appointed agent Guardian #392. As Guardian, powers were person only for an indefinite time period. The document was signed by the Probate Judge.</p> <p>Review of medical record Discharge Summary dated 08/12/24 revealed Resident #115 was discharged from the facility to home and Resident #115's mother signed the Discharge Summary along with LPN #344.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview with Healthcare Compliance Investigator(HCI) #391 on 11/04/24 at 8:34 A.M. revealed the facility allowed Resident #115 and his mother to sign themselves out because of behaviors Resident #115 was displaying. The legal guardian was not notified until after Resident #115 was discharged from the facility. This was not a planned discharge. The guardian wanted Resident #115 to remain in the facility. HCI #391 also stated the mother missed some health appointments while Resident #115 was home.</p> <p>Interview on 11/04/24 at 12:20 P.M. with Social Service Director (SSD) #375 revealed Resident #115's discharge was considered an impromptu discharge. SSD #375 verified the facility did not have the legal guardianship paperwork in the medical record so they were not aware of it. SSD #375 stated during the next care conference social work would bring up no guardianship paperwork was in the chart. SSD #375 also stated the social worker did not set up skilled care for home because Resident #115's mom was to be the caregiver.</p> <p>Interview on 11/04/24 at 12:30 P.M. with Unit Manager Licensed Practical Nurse (LPN) #344 revealed she called the physician to notify the physician of Resident #115's request to leave the facility. LPN #344 stated she did not call the guardian because there was no paperwork in the chart during Resident #115's discharge. LPN #344 stated she called the guardian when Resident #115 left. LPN #344 stated Resident #115 did not make safe decisions. LPN #344 stated the facility still discharged the resident despite the guardian not approving of the discharge.</p> <p>Interview on 11/04/24 at 12:40 P.M. with the Director of Nursing (DON) revealed a text message was sent on 08/12/24 at 12:05 P.M. to physician regarding Resident #115 wanting a discharge home. The DON was unable to provide a text message to the guardian and could not verifying the guardian was notified by text or phone call on 08/12/24. The DON stated Resident #115 created an uproar with staff in the facility.</p> <p>Interview with Guardian #392 on 11/04/24 at 1:22 P.M. revealed she did speak with the nurse staff on Saturday 08/10/24 regarding Resident #115's behaviors and Resident #115 wanted to be discharged . Guardian #392 told the facility she did not agree with Resident #115's discharge to home. Guardian #392 stated she was notified on 08/12/24 during an unannounced visit at 2:00 P.M. to the facility to check on Resident #115. Guardian #392 stated she did not sign in because this was an unannounced visit. Guardian #392 stated the facility did not notify her prior to Resident #115's discharge and the guardian paper work should have been sent in with the hospital paperwork on admission. The Guardian #392 stated the facility did not call her on 08/12/24 prior to Resident #115 discharge because she had no missed calls or voice messages from the facility. Guardian #392 stated the facility did not prepare Resident #115 for a safe discharge. The Guardian stated Resident #115 had been placed at another facility and passed away in October 2024 due to complications from COVID-19 related pneumonia.</p> <p>Review of the facility policy titled, Notice of Transfer and/or Discharge, dated April 2011, revealed a resident or representative sponsor would be given 30 days notice of impending transfer or discharge from a facility except if the transfer was necessary for the resident welfare and the resident needs could not be met in the facility. Consent of Notice: the resident or representative sponsor would be provided the following information, the reason for discharge, the effective date, the location.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159196</p> | | |