STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365745	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swanton Valley Rehabilitation and Healthcare Cente	401 W Airport Hwy Swanton, OH 43558

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, staff interview and review of the facility policy, the facility failed to ensure residents received a dignified assisted dining experience. This affected one (#30) of three residents observed for staff assistance with eating. The facility identified 12 additional residents (#4, #6, #21, #35, #37, #39, #42, #45, #49, #50, #58, and #64) who required staff assistance with eating. The facility census was 76. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses of heart failure, dementia and lack of coordination. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/24, revealed Resident #30 had severely impaired cognition. Further review revealed Resident #30 required partial/moderate staff assistance with eating. Review of the current care plan revealed Resident #30 had an activities of daily life (ADL) self-care performance deficit. Interventions included one person assistance with eating. Observation on 12/02/24 at 12:11 P.M. during meal service in the main dining room revealed Certified Nursing Assistant (CNA) #587 assisting Resident #30 with eating. CNA #587 stood next to Resident #30's wheelchair while offering her bites of chili and vegetables. Interview on 12/02/24 at 12:13 P.M. with CNA #587 confirmed she was standing while assisting Resident #30 with eating. CNA #587 stated she was aware staff should sit and be at eye level when providing meal assistance. CNA #587 stated she had been previously helping another resident and, therefore, was not sitting while assisting #30. Interview on 12/04/24 at 5:20 P.M. with the Director of Nursing (DON) confirmed staff should be seated at eye level with residents while providing assistance with eating. Review of the facility policy titled Assistance with Meals, dated September 2021, revealed residents who cannot feed themselves will be fed with attention to safety, comfort and dignity.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, resident interview, staff interview and review of facility policy, the facility failed to ensure room temperatures were comfortable for the residents. This affected four residents (#57, #19, #34 and #71) of four residents reviewed for comfortable room temperatures. The facility census was 76. Findings include: 1. Review of the medical record for Resident #57 revealed she was admitted on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of the annual Minimum Data Set (MDS) assessment, dated 09/02/24, revealed Resident #57 was cognitively intact. Observation on 12/02/24 at 8:35 A.M. revealed Resident #57 was sitting in a wheelchair in her room. The resident was wearing long sweatpants and a sweatshirt and had a blanket covering her. Concurrent interview with Resident # 57 revealed the she was cold. 2. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses of COPD and diabetes mellitus. Review of the quarterly MDS assessment, dated 11/08/24, revealed Resident #19 was cognitively intact. Observation on 12/02/24 at 11:28 A.M. revealed Resident #19 was wrapped in blankets in his room. Coinciding interview with Resident #19 revealed the resident complained of his room being cold. 3. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of COPD, asthma and chronic respiratory failure. Review of the quarterly MDS assessment, dated 10/28/24, revealed Resident #34 had mild cognitive impairment. Observation on 12/02/24 at 9:30 A.M. revealed Resident #34 curled in the fetal position in her bed, bundled under blankets pulled up to her chin. Concurrent interview with Resident #34 revealed she complained of her room being cold. 4. Review of the medical record for Resident #71 revealed an admitted [DATE] with diagnoses of multiple sclerosis and dementia. Review of the quarterly MDS assessment, dated 11/07/24, revealed Resident #71 had mild cognitive impairment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/03/24 at 9:15 A.M. revealed Resident #71 was in her room, dressed in long pants, a long sleeve shirt and a sweatshirt. Concurrent interview with Resident #71 revealed she complained of her room being cool. Interview on 12/02/24 at 2:03 P.M. with Maintenance Director (MD) #535 revealed the facility heat was not turned on yet. DM #535 further state it's warm enough compared to outside. Observation on 12/02/24 at 2:15 P.M. with MD #535 of room temperatures revealed Resident #19's room was 70.1 degrees Fahrenheit (F), Resident #34's room temperature was 70.3 degrees F, Resident #57's room temperature was 70.5 degrees F and Resident #71's room temperature was 69.2 degrees F. Coinciding interview with MD #535 verified Resident #19, Resident #34, Resident #57 and Resident #71's room temperatures were below 71 degrees F. Review of the facility policy titled Facility Temperature Policy, dated September 2021, revealed the facility was to provide comfortable and safe temperatures for the residents in the facility. Heating, ventilation, and air conditioning systems should be capable of maintaining an acceptable temperature range of 71-81 degrees Fahrenheit throughout resident areas.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, resident interview, staff interview and review of the medical record, the facility failed to ensure range of motion (ROM) exercises were provided to prevent further decline. This affected one (#46) of two residents reviewed for ROM. The facility census was 76. Findings include: Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, cerebrovascular infarction (stroke) affecting left side resulting in hemiplegia and hemiparesis, osteoarthritis, chronic obstructive pulmonary disease (COPD), type II diabetes mellitus, dysphagia, mood disorder, major depressive disorder, neuropathy, anxiety disorder, hypertension and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 10/06/24, revealed Resident #46 had moderately impaired cognition, had no refusals of treatment, had ROM impairment to one side upper and lower extremity and required substantial to maximal assistance with activities of daily living (ADLs). Review of the plan of care, revised 04/07/22, revealed Resident #46 had impaired neurological status related to cerebral vascular accident (stroke), hemiplegia (left side) and neuropathy. Interventions included the following: assist with normal daily tasks as needed, provide support to weakened left side and physical therapy (PT)/occupational therapy(OT)/speech therapy(ST) evaluation and treat as needed. Review of an OT evaluation and plan of treatment documentation revealed Resident #46 was to receive OT services between 09/04/24 and 10/03/24. Resident #46 was referred to OT skilled services by nursing staff due to increased joint tightness and stiffness at the affected left upper extremity. Caregiver goals included providing stretching to the affected left upper extremity and accept provided education. Observation on 12/02/24 at 8:50 A.M. revealed Resident #46 in bed with the left upper and lower extremities immobile. Resident #46's left hand was in a closed fist. Concurrent interview with Resident #46 revealed he was discharged from therapy and was utilizing a hand/wrist splint with exercises while in therapy. Resident #46 further stated since discharge from therapy, staff did not apply the splint or assist with exercises to the left upper and lower extremities. Interview on 12/03/24 at 8:39 A.M. with Certified Nurse Assistant (CNA) #595 revealed Resident #46 did not have a hand/wrist splint in use and no exercises were provided to the resident's left upper or lower extremities. Interview on 12/03/24 at 9:40 A.M. with Therapy Director (TD) #610 confirmed Resident #46 was discharged from therapy and was to have bedside exercises provided to his left upper and lower extremities. TD #610 stated no splint was ordered due to the resident reporting pain during application. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview on 12/03/24 at 11:48 A.M. with TD #610, during a review of OT functional maintenance program documentation, revealed on 11/15/24, CNA #595 was informed exercises were to be administered each day to Resident #46's upper and lower extremities. TD#610 confirmed no additional staff were informed of the maintenance program exercises. A follow-up interview on 12/03/24 at 11:55 A.M. with CNA #595 verified Resident #46 exercises were not provided daily and CNA #595 further stated she was not aware of the specific exercise regimen or functional maintenance program recommenced by therapy. Interview on 12/04/24 at 8:30 A.M. with the Director of Nursing (DON), during a review of Resident #46's medical record, verified there was no documentation contained in the record referring to the OT maintenance program or that ROM exercised were provided to Resident #46.

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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** 47057 Based on observation, resident interview, staff interview and review of facility policy, the facility failed to ensure oxygen was administered per physician orders. This affected three (#34, #57 and #5) of three residents reviewed for oxygen administration. The facility identified 10 residents who received oxygen therapy. The facility census was 76. Findings include: 1. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), asthma and chronic respiratory failure. Review of the current physician orders revealed Resident #34 was ordered oxygen at fours liter per minute (lpm) via nasal cannula (NC). Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/28/24, revealed Resident #34 had mild cognitive impairment. Review of the current care plan revealed Resident #34 had impaired respiratory status. Interventions included oxygen per physician orders. Observation on 12/02/24 at 9:16 A.M. of Resident #34 revealed her oxygen was applied and the oxygen concentrator was set at three lpm. Interview on 12/02/24 at 9:26 AM with Licensed Practical Nurse (LPN) #598 verified Resident #34's oxygen concentrator was set between two and three lpm and further confirmed the current physician's order was for oxygen at four lpm. 2. Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses of COPD and chronic respiratory failure. Review of the current physician orders revealed Resident #57 was ordered oxygen at four lpm via NC. Review of the annual MDS assessment, dated 09/02/24, revealed Resident #57 was cognitively intact. Review of the current care plan revealed Resident #57 had impaired respiratory status. Interventions included oxygen as ordered by the physician. Observation on 12/02/24 at 8:42 A.M. of Resident #57 revealed her oxygen was applied and the oxygen concentrator was set at two lpm. Concurrent interview with Resident #57 revealed the oxygen concentrator was to be set at four lpm. Interview on 12/02/24 at 9:24 A.M. with LPN #598 verified Resident #57's oxygen concentrator was set at two lpm and further confirmed the physician's order was for oxygen to be set at four lpm. 44815 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #5 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included COPD, congestive heart failure and dementia. Review of the annual comprehensive MDS assessment, dated 10/16/24, revealed Resident #5 had impaired cognition. Review of the physician's order dated 10/15/24 revealed Resident #5 received oxygen at three lpm via NC. Review of the current care plan for Resident #5 revealed she had impaired respiratory status related to COPD. Interventions included providing oxygen as ordered by the physician. Observation on 12/02/24 at 8:33 A.M. revealed Resident #5 lying in bed with oxygen applied and the oxygen concentrator was set at four lpm. Interview on 12/02/24 at 9:24 A.M. with LPN/Unit Manager (UM) #607 confirmed Resident #5's oxygen was running at four lpm. Further interview and concurrent review of the electronic medical record confirmed Resident #5's physician order for oxygen was three lpm. Review of the facility policy titled Oxygen Administration, dated September 2021, revealed oxygen therapy was the administration of oxygen at concentrations greater than room air with the intent of treating or preventing the symptoms and manifestations of hypoxia (low levels of oxygen in body tissues). The initial need is determined by documented hypoxemia or a physician order.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, medical record review, resident interview, staff interview and review of facility policy, the facility failed to ensure residents received routine dental services. This affected one (#40) of three residents reviewed for dental services. The facility census was 76. Findings include: Review of Resident #40's medical record revealed an admitted [DATE]. Diagnoses included dementia with psychotic disturbance, protein calorie malnutrition, muscle weakness, restlessness and agitation and anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 10/25/24, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of five, indicating the resident was severely cognitively impaired. Resident #40 required supervision with eating, and moderate assistance with oral hygiene. Resident #40 required a mechanically altered diet and had no broken or loosely fitting dentures, no mouth or facial pain and had no discomfort or difficulty with chewing at the time of the review. Review of the care plan, revised 10/01/24, revealed Resident #40 had dental problems related to poor nutrition and poor oral hygiene. Interventions included to complete oral hygiene at least daily, notify physician of any changes, medication and treatment as ordered and refer for dental services. Review of the Consent and Authorization to Treat for Ancillary Services, signed 02/08/23, revealed Resident #40's representative authorized dental services to be provided/arranged by the facility. Further review of Resident #40's medical record revealed no evidence Resident #40 was seen by the dentist. Observation on 12/02/24 at 8:48 A.M. of Resident #40 revealed she had one bottom tooth and the remaining upper teeth were brown, broken or missing. Coinciding interview with Resident #40 revealed the resident was alert and oriented. Resident #40 reported staff assisted with oral care but she was unsure of when she last saw a dentist. Resident #40 reported she did not think she had seen a dentist since her admission to the facility. Interview on 12/03/24 at 10:49 A.M. with the Administrator verified Resident #40 had not been seen by the dentist since she was admitted to the facility on [DATE]. The dentist came to the facility every three months and Resident #40 would be on the list for the next visit. The Administrator reported the dentist was there on 10/24/24 and would be back during the third week of January. Review of the facility policy titled, Availability of Services, Dental, revised August 2007, revealed dental services were available to all residents requiring routine and emergency dental care. Social Services was responsible for making necessary dental appointments.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, medical record review, resident interview, staff interview and review of facility policy, the facility failed to ensure adaptive equipment to support resident's independence was provided during meals. This affected one (#40) of six residents reviewed for dining. The facility census was 76. Findings include: Review of Resident #40's medical record revealed an admitted [DATE]. Diagnoses included dementia with psychotic disturbance, protein calorie malnutrition, muscle weakness, restlessness and agitation and anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 10/25/24, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of five, indicating Resident #40 was severely cognitively impaired. Resident #40 required supervision with eating and had no discomfort or difficulty with chewing at the time of the review. Review of the care plan, initiated 12/09/22, revealed Resident #40 was at risk for altered nutritional status related to dementia, depression and malnutrition. Interventions included encourage/provide intake of fluids throughout the day. Review of Resident #40's physician orders revealed an order dated 06/22/24 for a regular diet, mechanical soft texture, regular thin consistency, straws with liquids and fortified foods. Observation on 12/02/24 at 11:35 A.M. of the lunch meal service revealed Resident #40 sitting in the secured unit dining room. Resident #40 was provided a purple drink in a regular cup , with no straw, by Activity Aid (AA) #505. Observation on 12/02/24 at 11:41 A.M. revealed Resident #40 continued to sit at the table in the dining room with her drink in front of her. Resident #40's hands were observed to be tremoring slightly. The two other residents at the table were drinking independently from their cups. Continuous observation revealed at 11:49 A.M., Certified Nursing Assistant (CNA) #546 prompted AA #505 to get Resident #40 a lidded cup with a straw ([NAME] Cup) for her beverage. Coinciding interview with AA #505 revealed she did not help on the secured unit very often and was unaware Resident #40 required a special cup for her beverages and verified she provided Resident #40 with a regular cup. Continued observation on 12/02/24 at 11:55 A.M. of the lunch meal service revealed CNA #546 asked Resident #40 if she wanted her drink in a Kennedy cup and the resident responded yes. CNA #546 poured Resident #40's drink into the lidded cup with a straw and placed it in front of Resident #40. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/24 at 11:58 A.M. with Resident #40 revealed the resident was alert and aware. Resident #40 reported she was able to drink out of a regular cup but it was very hard for her. The lidded cup with the straw and handle helped her to drink independently and not spill it on herself. Resident #40 stated she wanted to drink the beverage she had been provided but needed the special cup so she did not make a mess and get it all over. Observation on 12/03/24 at 12:10 P.M. of the lunch meal service revealed Resident #40 sitting at a dining table in the secured unit dining room. Resident #40 was provided ice tea, with no straw or Kennedy cup, by AA #502. Resident #40 was observed using two hand to raise her regular cup to her mouth. Resident #40's hands were observed to be shaking while she drank. Resident #40 put the cup down, placed her head in her hands, appeared frustrated and pushed the cup away from her. Interview on 12/03/24 at 12:17 P.M. with CNA #546 verified Resident #40 required the use of a straw or a Kennedy cup for all of her drinks and she had not been provided one with her lunch meal. Review of the facility policy titled, Assistance with Meals, revised September 2021 revealed adaptive devices would be provided for residents who needed or requested them. These may include devices such as silverware with enlarged handles, plate guards, and or specialized cups.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37451 Based on observation and staff interview the facility failed to ensure dishes were cleaned and properly stored. This had the potential to affect 75 residents who received food from the kitchen. The facility identified one resident (#52) who received no food by mouth. The facility census was 76. Findings include: Observation on 12/02/24 at 8:12 A.M. of the kitchen revealed no designated storage area for clean cups, bowls, plates or trays. The clean clear bowls and adaptive equipment were stored on a rack in the dish room, cups were stored on the drink carts, trays were stored at the end of the steam table and opaque soup bowls were stored in racks under the steam oven. Observation on 12/03/24 at 9:58 A.M. of three coffee cups from 200 hall drink cart revealed a dried powdery residue coating on the inside of the cup. The residue could be easily removed by rubbing a finger across the coating. Coinciding interview with the Administrator verified the cups appeared unclean. Observation on 12/03/24 at 11:18 A.M. of the kitchenware storage rack in the dishwashing room revealed two plates and a bowl on the racks with food residue. In addition, the clear bowls were stacked wet with the bowl facing up. Coinciding interview with Corporate Dietary Manager (CDM) #610 verified the dishes had food debris and were stored improperly on the storage racks. CDM #610 confirmed the rack was for dishes that were to be washed and not clean dish storage. Observation on 12/03/24 at 11:43 A.M. of the meal delivery carts being prepared for lunch meal service revealed two clear bowls on the 400 hall serving cart with a brown substance on them and were unclean. Interview on 12/03/24 at 11:44 A.M. with CDM #610 verified the two clear bowls being used on the 400 hall food cart were unclean, removed them from the cart and replaced them with two clean clear bowls. Observation on 12/04/24 at 6:35 A.M. of the dish storage rack in the dishwashing room revealed the dishes appeared to be rewashed, were clean, were stacked properly but were stacked wet. Coinciding interview with Dietary Staff (DS) #511 verified the racks were for clean dishes, the dishes on the racks had been rewashed and were stacked wet.