

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365763	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Mifflin		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Crider Rd Mansfield, OH 44903	

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 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** 16453</p> <p>Based on medical record reviews, review of facility admission packet, and staff interviews, the facility failed to ensure the resident's advance directives were clearly identified in their medical record. This affected two (Residents #36 and #129) of 24 residents reviewed for advance directives. The facility census was 85.</p> <p>Findings include:</p> <p>1. Review of Resident #36's electronic medical record revealed an admission to the facility on [DATE]. Diagnoses included obstructive uropathy, malnutrition, and chronic kidney disease. The physician orders in the electronic record revealed Resident #36 was a Full code.</p> <p>Review of Resident #36's paper chart revealed there were two different advanced directive forms in a plastic sleeve in the front of the chart. There was a Full code document and also a Do Not Resuscitate (DNR) document, that were not dated.</p> <p>Interview with the Director of Nursing (DON) on [DATE] at 11:00 A.M. confirmed Resident #36's advanced directives were not clearly identified in the medical record. Resident #36 had Full code and DNR papers were in the same medical record.</p> <p>2. Review of Resident #129's medical record revealed an admission to the facility on [DATE]. Diagnoses included malnutrition and liver carcinoma.</p> <p>Review of Resident #129's electronic and paper medical record and physician orders revealed Resident #129 was a Full code status. However, Resident #129's paper chart also had a Do Not Resuscitate (DNR) form dated [DATE] in the front of the paper medical record.</p> <p>Interview with the Director of Nursing (DON) on [DATE] at 11:03 A.M. confirmed Resident #129 had changed from a Full code to DNR on [DATE]; however as of this time, the physician orders had not been updated. The DON revealed the facility's protocol currently does not include ensuring the physician was immediately notified and signs a change in code status.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility admission packet revealed each resident is provided upon admission and quarterly evaluations to determine their advanced directives. The facility has different forms to Full code and DNR wishes. The forms revealed Cardiopulmonary resuscitation (hereafter CPR) is initiated when a resident's breathing and/or heart function has ceased. CPR is the provision of assistance with breathing and heart function provided by facility staff by blowing air into the resident's lungs to stimulate breathing and by pressing on the chest to stimulate heart function. These procedures may or may not restart normal breathing and normal heart function, depending on many factors that your physician, or his/her designee, will discuss with you. You should ask your physician about this before making a decision. There is a risk of injury to the ribs or internal organs from pressing on the chest. Other minor injuries are possible from the mechanical trauma of CPR.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49793</p> <p>Based on record review and facility staff interview, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) for Resident #48 and the SNFABN and Notice of Medicare Non-Coverage (NOMNC) was not filled out correctly for Resident #16. This affected two (Residents #16 and #48) of two residents reviewed for discharged from skilled therapy but remained in the facility. The facility census was 85.</p> <p>Findings include:</p> <p>1. Review of Resident #16's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), and schizoaffective disorder. Resident #16 was receiving skilled services under Medicare part A from 01/11/24 to 02/10/24. Resident #16's record revealed Resident #16 remained in the facility.</p> <p>Review of Resident #16's SNFABN form/Form-CMS 10055, dated revealed the estimated cost category was monthly patient liability and did not include a dollar amount on the form. Review of Resident #16's NOMNC form/CMS-10123 revealed the telephone number was listed incorrectly for Quality Improvement Organization (QIO), named Livanta.</p> <p>Interview on 05/22/24 at 9:36 A.M. with Social Service Director (SSD) #25 verified Resident #16's SNFABN form did not include an estimated cost and the NOMNC form did not have the correct telephone number listed for QIO in case the resident requested an appeal.</p> <p>2. Review of Resident #43's medical record revealed the resident was readmitted to the facility on [DATE]. Diagnoses included paranoid schizophrenia, transient ischemic attack (TIA), and type II (2) diabetes mellitus with diabetic neuropathy. Resident #43 was receiving skilled services under Medicare part A from 03/08/24 through 05/06/24.</p> <p>Review of Resident #43's record revealed the facility initiated the discharge from Medicare part A when benefit days were not exhausted and provided a NOMNC form but failed to provide a SNFABN form to the resident or representative.</p> <p>Interview on 05/22/24 at 9:17 A.M. with Business Office Manager (BOM) #26 stated the process of issuing the ABN form to a resident or representative. The ABN form was issued when a resident was staying at the facility post Medicare benefit services and benefit days remain available.</p> <p>Interview on 05/22/24 at 9:36 A.M. with Social Service Director (SSD) #25 verified Resident #43 or representative were not issued the SNFABN form and they should have been issued the form. SSD #25 stated she gets confused sometimes as to which is part A or part B.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a resident had physician orders for oxygen use and failed to safely store the resident's oxygen. This affected three (Residents #17, #41, and #69) of five residents reviewed for respiratory care. The facility identified 23 resident who utilized supplemental oxygen. The facility census was 85.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure, and anxiety.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/30/24, revealed Resident #17 had moderately impaired cognition. Resident #17 required the use of supplemental oxygen and had shortness of breath while lying flat.</p> <p>Review of Resident #17's physician's orders revealed an order dated 02/08/24 for continuous supplemental oxygen at two to eight liters per minute (LPM) per nasal cannula.</p> <p>An observation on 05/19/24 at 4:11 P.M. of Resident #17's room revealed two metal portable oxygen tanks, not in use, that were not secured in a rack or holder. Registered Nurse (RN) #47 verified the findings at the time of observation and removed the unsecured tanks from the resident's room.</p> <p>2. Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, morbid obesity, and obstructive sleep apnea.</p> <p>Review of the significant change in status Minimum Data Set (MDS) 3.0 assessment, dated 03/14/24, revealed Resident #69's cognition was not assessed. Resident #69 required the use of supplemental oxygen and had shortness of breath while lying flat.</p> <p>Review of Resident #69's physician's orders revealed an order dated 02/06/24 for continuous supplemental oxygen at five liters per minute (LPM) per nasal cannula.</p> <p>An observation on 05/22/24 at 11:36 A.M. of Resident #69's room revealed one metal portable oxygen tanks, not in use and standing freely near the doorway to the room, that was not secured in a rack or holder. Licensed Practical Nurse (LPN) #82 verified the findings at the time of observation and removed the unsecured tank from the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Oxygen Safety, revised on 01/01/22, revealed it is the policy of the facility to provide a safe environment for all residents, staff, and the public. Oxygen cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty. The policy stated to protect cylinders from damage by not storing in locations where heavy objects may strike them or fall on them, or where they can be tipped over by foot traffic or door movement.</p> <p>16453</p> <p>3. Review of Resident #41's medical record revealed an admission to the facility on [DATE]. Diagnoses included pneumonia and heart disease. Review of the admission Minimum Data Set (MDS) assessment revealed Resident #41 was cognitively impaired and required the use of oxygen.</p> <p>Review of Resident #41's admission and current physician orders from 03/07/24 to 04/29/24 revealed no physician orders for oxygen use.</p> <p>Review of Resident #41's nurse notes dated 03/07/24 revealed oxygen was placed on the resident at two liters, upon return from the hospital. The nursing notes dated 04/30/23 at 10:32 A.M. revealed Resident #41 had even, unlabored respiration with oxygen at two liters.</p> <p>Review of the physician notes dated 03/09/24 revealed upon arrival to the facility, Resident #41's oxygen saturation level was in the low 80s and oxygen was placed on the resident.</p> <p>Observation of Resident #41 on 05/19/24 at 8:32 A.M. revealed Resident #41 had oxygen on via nasal cannula at two liters per minute. The oxygen tubing was observed connected to an oxygen concentrator inside her room. The concentrator was also observed with an undated humidification bottle with tubing that was not attached to anything.</p> <p>Interview with the Director of Nursing on 05/20/24 at 1:41 P.M. confirmed there was no oxygen orders placed in the chart upon admission and or re-admission and confirmed Resident #41 was using oxygen.</p> <p>Review of the facilities Oxygen Administration policy dated 10/20/20 revealed oxygen is administered under the orders of a physician, except in the case of an emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on observation, staff interview, record review, and policy review, the facility failed to ensure Resident #16 was free from a significant medication error. This affected one (Resident #16) of six residents reviewed for medication administration. The facility census was 85.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, depression, and muscle weakness.</p> <p>Review of Resident #16's Minimum Data Set (MDS) 3.0 quarterly assessment, dated 03/01/24, revealed the resident had intact cognition. Resident #16 was noted to have hallucinations and delusions and was not noted to reject any care or treatment. Resident #16 was noted to receive antipsychotic medications on a daily basis and a gradual dose reduction had been documented as clinically contraindicated.</p> <p>Review of Resident #16's physician's orders revealed an order dated 01/11/24 for Loxapine (an antipsychotic medication) 50 milligrams (mg) give three capsules daily at bedtime. Resident #16 also had an order dated 02/29/24 for loxapine succinate 10 mg give 15 capsules daily at bedtime. Both orders were open ended and active.</p> <p>Review of Resident #16's discharge instructions from an outside psychiatric provider, dated 02/13/24, included an order for loxapine 50 mg give three capsules daily at bedtime.</p> <p>Review of Resident #16's interdisciplinary progress notes from 04/01/24 to 05/21/24 revealed frequent medication administration record (MAR) notes recorded regarding the resident's ordered loxapine being unavailable from pharmacy. Resident #16's progress notes contained no evidence the provider had been notified regarding the missing doses.</p> <p>Review of Resident #16's MAR for April 2024 revealed both loxapine 50 mg give three capsules daily at bedtime and loxapine 10 mg give 15 capsules daily at bedtime were listed on the record. Resident #16's April 2024 MAR revealed six dates on which the resident did not receive either strength of the medication: 04/01/24, 04/02/24, 04/03/24, 04/04/24, 04/01/24, and 04/24/24. Resident #16's April 2024 MAR revealed 17 days Resident #16 was recorded as receiving both strengths of the loxapine medication: 04/06/24, 04/07/24, 04/10/24, 04/11/24, 04/15/24, 04/16/24, 04/17/24, 04/18/24, 04/19/24, 04/20/24, 04/21/24, 04/22/24, 04/23/24, 04/25/24, 04/26/24, 04/29/24, and 04/30/24.</p> <p>Review of Resident #16's Medication Administration Record (MAR) for May 2024 revealed both loxapine 50 mg give three capsules daily at bedtime and loxapine 10 mg give 15 capsules daily at bedtime were listed on the record. Resident #16's May 2024 MAR revealed Resident #16 received neither strength of the loxapine medication on 05/18/24. Resident #16's May 2024 MAR revealed nine days the resident was recorded as receiving both strengths of the loxapine medication: 05/01/24, 05/02/24, 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/14/24, 05/15/24, and 05/16/24.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 05/21/24 at 10:28 A.M. of Resident #16 revealed she was seated in her recliner chair in her room with her legs elevated. She was awake, alert, and answered questions appropriately.</p> <p>An interview on 05/21/24 at 10:48 A.M. with Unit Manager (UM) #92 revealed Resident #16 was supposed to only be on loxapine 150 mg once nightly at bedtime. UM #92 indicated the pharmacy was having difficulty filling the medication order with the medication being backordered, and the provider ordered a change in strength based on what the pharmacy was able to dose. UM #92 verified Resident #16 should not have had two separate orders for the loxapine, and that duplicate was an error. UM #92 verified Resident #16's MAR contained evidence of both duplicate administrations and duplicate omissions of the resident's ordered loxapine.</p> <p>An interview on 05/22/24 at 11:37 A.M. with the Director of Nursing (DON) and UM #92 revealed they believe the provider was aware of the missing doses as the providers were frequently in the building but verified Resident #16's medical record did not contain documentation that the provider was notified of the missed doses of medications.</p> <p>Review of an undated policy titled Medication Management and Administration Playbook revealed documenting medication administration includes the administration of routine medication, and if not administered, an explanation of why not. The standard of practice is to document the medications after administration. When a medication is not administered, the nurse documents the reason within the medical record. The provider should work with the interdisciplinary team (IDT) to review for any order changes. If a medication is not available, the nurse is responsible for attempting to procure the medication through back-up procedures or notification to the physician for further orders.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 48568</p> <p>Based on observation, resident and staff interviews, record review, and policy review, the facility failed to follow the menu and give residents the appropriate food. This affected three (Residents #28, #39, and #134) of six residents who had their meals and meal tickets reviewed. The facility census was 85.</p> <p>Findings include:</p> <p>1. Review of Resident #28's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease with late onset, dementia, and type II diabetes mellitus.</p> <p>Review of Resident #28's physician orders revealed an order dated 09/06/22 for a regular diet with regular texture and regular fluid with thin consistency.</p> <p>Review of Resident #28's lunch meal ticket dated 05/19/24 Sunday lunch, indicated the meal included a half cup of marinated cucumber salad.</p> <p>Observation on 05/19/24 at 11:45 A.M. revealed Resident #28's lunch was missing the marinated cucumber salad.</p> <p>Interview on 05/19/24 at 11:51 A.M. with State tested Nursing Aide (STNA) #67 confirmed Resident #28 did not receive the marinated cucumber salad that was stated on the meal ticket.</p> <p>Interview on 05/19/24 at 12:28 P.M. with Dietary Manager #113 stated the cook puts the food on the meal trays according to the meal ticket, the the dietary aide looks at it and then the STNA looks at it when trays were passed out as well.</p> <p>Review of Resident #28's food and beverage preference list revealed Resident #28 did not have dislike marked for any vegetables.</p> <p>2. Review of Resident #39's medical record revealed the resident was admitted on [DATE] with diagnoses including hypertensive heart and chronic kidney disease without heart failure, obesity, and other acute kidney failure.</p> <p>Review of Resident #39's physician orders revealed an order dated 03/30/22 for a no salt packet diet with regular texture and regular fluid with thin consistency.</p> <p>Review of Resident #39's lunch meal ticket dated 05/19/24 Sunday lunch, indicated the meal included a half cup of marinated cucumber salad.</p> <p>Observation on 05/19/24 at 12:09 P.M. revealed Resident #39's lunch was missing the marinated cucumber salad.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/19/24 at 12:10 P.M. with Dietary Aide #107 confirmed Resident #39 did not receive the marinated cucumber salad. Dietary Aide #107 said the cucumber salad was an oversight.</p> <p>Interview on 05/19/24 at 12:28 P.M. with Dietary Manager #113 stated the cook puts the food on the meal trays according to the meal ticket, the the dietary aide looks at it and then the STNA looks at it when trays were passed out as well.</p> <p>Review of Resident #39's food and beverage preference list revealed cucumbers were not listed as an option for a like or dislike.</p> <p>3. Review of Resident #134's medical record revealed the resident was admitted on [DATE] with diagnoses including multiple sclerosis, type II diabetes mellitus, and morbid obesity.</p> <p>Review of Resident #134's physician orders revealed an order dated 05/11/24 for a controlled carbohydrates diet with regular texture and regular fluid with thin consistency.</p> <p>Review of Resident #134's dinner meal ticket dated 05/21/24 Tuesday Dinner, indicated one rotisserie chicken thigh, half cup of garlic potato wedges, half cup of sliced carrots, one sugar cookie, and no bread/rolls/sandwiches per resident.</p> <p>Observation on 05/21/24 at 5:13 P.M. revealed Resident #134's dinner was missing the rotisserie chicken thigh, garlic potato wedges, sliced carrots, and sugar cookie.</p> <p>Interview on 05/21/24 at 5:13 P.M. with Resident #134 revealed she never indicated she did not want the food. Resident #134 said she likes all the food on the ticket except the sugar cookie.</p> <p>Interview on 05/21/24 at 5:18 P.M. with Activities Director #84 confirmed Resident #134 did not get a plate of food which includes the chicken, potatoes, and carrots. Activities Director #84 went and got Resident #134 another plate of food. Activities Director #84 confirmed this new plate included a dinner roll.</p> <p>Interview on 05/19/24 at 12:28 P.M. with Dietary Manager #113 stated the cook puts the food on the meal trays according to the meal ticket, the the dietary aide looks at it and then the STNA looks at it when trays were passed out as well.</p> <p>Review of Resident #134's food and beverage preference list revealed Resident #134 likes chicken, carrots, and potatoes. The preference list also stated No Bread.</p> <p>Review of the policy titled Resident Meal Service, dated 01/01/22, revealed nursing personnel will ensure that residents are served the correct food tray. Prior to serving the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident. If there is doubt, the Nurse Supervisor will check the written physician's order.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48568</p> <p>Based on observations, staff interviews, and policy review, the facility failed to datemark potentially hazardous food items in the walk-in cooler and maintain kitchen utensils in a safe and sanitary condition. This had the potential to affect all residents who reside in the facility and receive food from the kitchen. The facility census was 85.</p> <p>Findings include:</p> <p>1. Observations of the kitchen on 05/19/24 at 8:30 A.M. to 8:37 A.M. with Dietary Manager #113 revealed in the walk-in cooler, there were two blocks of sliced orange cheese stored undated, an open block of ham was stored undated, an open block of turkey breast was stored undated, an open pork loin was stored undated, and a large box of colored eggs with a label of activities was stored undated. Interview with Dietary Manager #113 confirmed the cheese, the ham, the turkey breast meat, the pork loin were not dated. Dietary Manager #113 stated the pork loin was cut Friday night and the colored eggs were from Easter (03/31/24).</p> <p>Review of the facilities Food Storage: Cold Foods policy dated 02/2023 revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p> <p>Review of the facilities Food Receiving and Storage policy dated 01/01/22 revealed foods stored in the refrigerator or freezer will be covered, labeled and dated (opened on and use by date).</p> <p>2. Observation and interview on 05/19/24 at 8:44 A.M. with Dietary Manager #113 revealed two rubber spatulas that were very chipped around the edges and scored across the middle were stored in the clean kitchen utensil storage drawer in the kitchen. Dietary Manager #113 confirmed the utensils were not usable and put them in the trash.</p> <p>Observation and interview on 05/19/24 at 8:45 A.M. with Dietary Manager #113 revealed a used spatula covered in yellow butter-like substance sitting on top of clean spatulas in the clean kitchen utensil storage drawer in the kitchen. Dietary Manager #113 verified the dirty spatula in the drawer and took it over to the washroom.</p> <p>Observation and interview on 05/20/24 at 2:55 P.M. with Dietary Manager #113 revealed another spatula with a corner torn off and it was scored in the middle that was sitting next to a puree machine. Dietary Manager #113 confirmed it was not a usable spatula.</p> <p>Review of the facilities Equipment policy dated 09/2017 revealed all foodservice equipment will be clean, sanitary, and in proper working order.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365763	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Mifflin		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Crider Rd Mansfield, OH 44903	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on observations, staff interviews, record review, and policy review, the facility failed to ensure appropriate transmission based precautions (TBP) were implemented for Resident #36. This affected one (Resident #36) of one resident reviewed for transmission based precautions. The facility identified only one resident on transmission based precautions. The facility census was 85.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #36 revealed an admitted [DATE]. Medical diagnoses included enterocolitis due to clostridium difficile and severe protein-calorie malnutrition.</p> <p>Review of Resident #36's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/15/24, revealed the resident's cognition was not assessed. Resident #36 was not recorded as having any behaviors or rejection of care. The resident was noted to be dependent on staff for toileting hygiene, had an indwelling urinary catheter and was always incontinent of bowel.</p> <p>Review of Resident #36's physician's orders revealed an order dated 03/19/24 for contact precautions related to clostridium difficile infection. Resident #36 also had an order dated 03/20/24 for vancomycin (an antibiotic) 125 milligrams (mg) one capsule every 12 hours related to recurrent clostridium difficile infection. The stop date for the vancomycin was listed as 06/10/24.</p> <p>Review of Resident #36's plan of care, revised on 03/19/24, revealed Resident #36 had an infection as evidenced by testing positive for clostridium difficile. Interventions included to administer medications and treatments as ordered, encourage fluids, and for contact isolation precautions.</p> <p>An observation on 05/19/24 at 8:24 A.M. revealed signage placed outside Resident #36's room indicating the resident required airborne and droplet isolation precautions.</p> <p>An observation and interview on 05/19/24 at 8:29 A.M. revealed State tested Nurse Aide (STNA) #72 walked into Resident #36's room to retrieve the resident's breakfast tray without applying any personal protective equipment (PPE). STNA #72 was not observed to wash her hands upon exiting the room. A follow up interview with STNA #72 immediately following the observation verified she did not wash her hands nor apply PPE, and stated the resident was no longer in isolation. STNA #72 stated the resident was previously in isolation for clostridium difficile infection in her stool, but was all better and the isolation signage was outdated.</p> <p>An interview on 05/19/24 at 8:31 A.M. with STNA #37 revealed Resident #36 was no longer in isolation and stated the resident had not required isolation precautions for approximately one month.</p> <p>An interview on 05/19/24 at 8:33 A.M. with Licensed Practical Nurse (LPN) #95 revealed she did not typically work the hallway she was working. LPN #95 stated she did not believe Resident #36 required current transmission based precautions. When questioned about the droplet isolation signage outside the room, LPN #95 stated she guessed staff should go by the signage because she was unsure if Resident #36 had a condition that required precautions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Arbors at Mifflin		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Crider Rd Mansfield, OH 44903	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 05/19/24 at 8:36 A.M. with the Director of Nursing (DON) revealed she assisted with the infection control program within the facility. The DON indicated Resident #36 had chronic clostridium difficile in her stool, hence the isolation precautions. The DON verified Resident #36 was totally incontinent of bowel and should be in contact isolation precautions. The DON verified the droplet/airborne isolation signage outside Resident #36's room was incorrect and removed the sign, stating she would replace it with the correct signage.</p> <p>An observation and subsequent interview on 05/21/24 at 3:55 P.M. revealed STNA #85 exit Resident #36's room and was not observed to wash her hands. There was no designated red biohazard bags or bins in the resident's room. STNA #85 stated the resident was in isolation for chronic clostridium difficile, but had been told by unnamed nurses that her infection was colonized. STNA #85 stated when performing incontinence care, the only PPE she wore was gloves.</p> <p>An interview on 05/21/24 at 4:10 P.M. with STNA #76 revealed she consistently cared for Resident #36 and was familiar with her care. STNA #76 stated she does not utilize any special precautions when caring for Resident #36, and denied wearing a gown when performing incontinence care. When Resident #36 was incontinent of bowel, the soiled brief was disposed of in regular, clear trash liners. Soiled linen was placed in clear trash liners and taken to the designated trash and linen receptacles in the soiled linen room at the end of the hall. STNA #76 stated when performing incontinence care, the only PPE she wore was gloves.</p> <p>An interview on 05/21/24 at 5:20 P.M. with the DON revealed Resident #36 had had recurrent clostridium difficile infections which had been on and off for years. The DON verified Resident #36 was still receiving active treatment, antibiotics, to treat her clostridium difficile infection. The DON verified contact isolation was the correct precautions and staff should wash their hands with soap and water upon exiting the room.</p> <p>Review of the policy titled Management of C. Difficile Infection, revised on 12/07/23, revealed all staff are to wear gloves and a gown upon entry into the resident's room and while providing care for the resident with c. difficile infection. Hand hygiene shall be performed by handwashing with soap and water. Maintain contact precautions for the duration of illness. Treatment for C. difficile will be in accordance with physician orders and current treatment guidelines.</p>		