STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365830	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryan Healthcare and Rehabilitation	1104 Wesley Avenue Bryan, OH 43506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure ongoing interventions were implemented to promote discharge from the facility were provided. This affected one (#4) of four sampled residents reviewed for discharge opportunity. The facility census was 82. Findings include: Resident #4 admitted to the facility on [DATE] with the diagnoses including, quadriplegia, cervical spinal cord injury, hypertension, type two diabetes mellitus, history of urinary tract infection, depression, colostomy, and urostomy. Review of the most current minimum data set assessment dated [DATE] Resident #4 was assessed with intact cognition, dependent on staff for activities of daily living including bed mobility, rejection of care four to six days during assessment period, received a therapeutic diet, had no identified weight loss, and admitted with a stage IV pressure ulcer. Review of the baseline care plan documentation dated 04/13/24 Resident #4 had an discharge goal to assist resident in establishing a discharge with interventions including; discuss resident desire for long-term placement, discuss resident desire for short-term placement. Resident is unsure at this time. Initiate anticipation of community resources. Involve family/resident representative as appropriate. On 04/19/24 a plan of care was developed. Resident #4's admission and documented anticipated to have a length of stay less than 90 days related to Resident/family desire to discharge home. Interventions included the following: Resident will have a post-discharge plan to meet needs after discharge. Arrange for home care services, equipment and support services as indicated prior to discharge. Assist resident / family to determine most appropriate post-discharge setting. Assist resident/family with developing realistic discharge plans related to medical, physical, emotional and other needs. Be alert for significant changes in status that could have an impact on the resident's ability to discharge per the discharge plan. Keep resident, physician, and responsible party updated as needed. Educate resident and family regarding current diagnoses and typical progression. Encourage identified post-discharge caregivers or support persons to attend discharge planning meeting with resident and Interdisciplinary Team with permission of resident and or responsible party. Identify areas of needed education and training and implement to increase resident and or family knowledge and comfort with specific care. Provide emotional support to resident and or family as the date for discharge approaches. Be alert for specific areas of anxiety or concern and attempt to address. (continued on next page)

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

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record lacked documentation assisting Resident #4 with discharge planning until Social Services notes on 06/11/24 at 11:41 A.M. which revealed Licensed Social Worker (LSW) #500 discussed discharge planning with the resident. Resident relayed her goal is to heal her wound then return home. She is on a waiver program and identified a case manager (CM). LSW advised will need to follow-up with her to consult with her services, recommended home health and assistance is available and in place, prior to discharge. On 06/19/24 at 2:54 P.M. LSW #500 documented speaking with CM and Resident #4 option to secure own residence again. CM reported Resident would need to be in facility for 60 days to qualify for a specific home agency. LSW #500 documented follow-up with home health agency with future referral and consult with CM for discharge purposes. No further documentation contained in the medical record included discharge progress or follow-up dialog. On 07/18/24 at 6:35 P.M. LSW #500 documented resident reported attempting to line up aides for when she discharged . The resident indicated she attempted to contact a home discharge agency and left a message. No documentation included attempts made by LSW #500 to assist with discharge planning. No further Social Service notes were contained in the medical record. Interview with LSW #500 on 08/28/24 at 8:51 A.M. revealed on 07/18/24 LSW provided Resident #4 information regarding a specific community agency to assist with discharge. Resident #4 is able to use computer to complete application. Resident left a detailed message with the agency. LSW #500 confirmed she had not returned to assist Resident #4 with progress toward home goal or to determine if resident needed assistance completing application process and associated discharge arrangements.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure interventions and monitoring were provided to a resident following difficulty consuming meal. This affected one (#3) of three sampled residents reviewed for meal time assistance in a facility census of 82. Findings include: Resident #3 admitted to the facility on [DATE] with the diagnoses including, chronic obstructive pulmonary disease, vascular dementia, repeated falls, chronic kidney disease, neuropathy, hypothyroidism, depression and cognitive communication deficit. Review of the most current minimum data set assessment dated [DATE] revealed Resident #3 had moderately impaired cognition, required set-up or clean-up assistance with eating, substantial to maximal assistance with activities of daily living, was incontinent of bowel and bladder, and received a mechanically altered diet. Review of nursing progress notes revealed on 08/03/24 at 6:56 P.M. at lunch today, resident struggled to eat a burrito that was served even after being cut up. Resident had an episode of choking. Back blows were administered, and resident was able to get food up and out. Resident #3 then struggled to eat dinner that had chunks of chicken. Resident was able to eat rice that was severed at lunch and noodles at dinner. Writer is changing resident diet to dysphagia advanced. Writer spoke with State tested Nursing Assistants (STNA's), and they also felt that this was in the resident's best interest because she does not have any dentures. On 08/05/23 physician orders included Speech Therapy evaluation and treatment three-five times a week for 30 days effective 08/05/24 for dysphagia management and regular diet with mechanical soft texture and thin liquid consistency for diet. According to Speech Therapy Progress Report between 08/05/24-08/20/24 listed dysphagia therapy to include patient and staff educated on safe swallow strategies. As of 08/20/24 progress included patient tolerated diet less than 5% overt signs and symptoms of oral/pharyngeal stasis/aspiration. Patient needs minimal to moderate cueing to complete 50% or more of meals. On 08/23/24 a nursing plan of care was implemented to address Resident #3's risk for choking related to need for mechanically altered diet and recent choking episode. Interventions included: Diet to be followed as prescribed. Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. Monitor, document, and report to nurse, dietitian and Physician (MD) as needed (PRN) for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, pocketing food in mouth. Refer to Speech therapy PRN. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/27/24 at 12:10 P.M. noted Resident #3 in her room in bed. Resident #3 bed was the second bed from the entry door and the privacy curtain was drawn, which obstructed the view of the resident from the corridor. Resident #3 was seated in bed with the head of the bed upright. The resident was attempting to eat a mechanically altered diet. No staff were in the room or observed monitoring the resident. Observation at 1:30 P.M. noted the resident with the curtain drawn, in bed seated leaning to the left. The resident's eyes were closed with spilled food debris and liquids on clothing and bed linen. 100% of meal was uneaten including burger, french fries, coffee, juice and ice cream. A container of strawberry health shake was spilled on bed linens. On 08/27/24 at 1:35 P.M. Surveyor summonsed STNA #302 to Resident #3's bedside. STNA #302 confirmed Resident #3 had not consumed the lunch meal. STNA #302 stated the tray was placed in the resident's room at 11:45 A.M. and staff had not returned to assist the resident. STNA #302 was unaware Resident #3 required monitoring with eating. On 08/28/24 at 11:57 A.M. interview with Regional Registered Nurse (RRN) #200 during a review of the medical record confirmed Resident #3 was not monitored as indicated and instructed on intake or swallowing during the lunch meal on 08/27/24.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff and resident interview, and facility bowel and bladder management policy, the facility failed to provide and implement interventions to address specific resident incontinence needs. This affected one (#1) of three sampled residents reviewed for incontinence maintenance. The facility census was 82. Findings include: 2. Resident #1 admitted to the facility on [DATE] with the diagnoses including, cerebral infarction, hemiplegia affecting left side, traumatic hemorrhage right cerebrum, hypertension, morbid obesity, dysarthria, anarthria, hypothyroidism, and dysphagia. Review of the most current minimum data set assessment dated [DATE] Resident #1 had intact cognition, limited range of motion to upper and lower extremities of one side, utilized a wheelchair for mobility propelled by staff, required substantial to maximal assistance with activities of daily living (ADL) including bed mobility, dependent on staff for transfer to and from bed, and was always incontinent of bowel and bladder. Review of nursing plans of care revealed the following: On 07/19/23 plan of care revised to address Resident #1's incontinence of bladder related to impaired mobility, cerebral vascular accident with interventions including incontinence care: frequent check and change per protocol. On 07/26/21 a nursing plan of care was revised to address Resident #1's bowel incontinence related to impaired mobility with the intervention to check resident every two hours and assist with toileting as needed, and check and change at regular intervals. On 07/30/24 a bowel and bladder assessment was completed and recorded the resident as always incontinent of bowel and bladder. Bladder history noted Resident #1 voids large amount each episode, resident doesn't request toileting, requires staff assist for toileting, and was unable to transfer to commode or toilet. The plan was to check and change. No further interventions were listed to address Resident #1's incontinence. Observations on 08/27/24 noted at 9:36 A.M. Resident #1 in bed and State tested Nurse Aide (STNA) #300 was preparing to provide the resident a bed bath. Interview with STNA #300 noted she was providing Resident #1 with morning activities of daily living including an incontinence check for the first time since assuming care at 6:00 A.M. STNA #301 also entered the room and proceeded to assist with resident care. STNA #301 stated the resident will notify staff when needing incontinence care. Observation noted Resident #1 with an adult incontinence brief which was clean. STNA #301 provided perineal care and placed a new brief with choice of clothing. At 10:37 A.M. Resident #1 was transferred to the wheelchair using a mechanical lift and the resident was propelled to the unit activities room. At 12:22 P.M. Resident #1 was observed in the unit activity room eating lunch. Resident #1 stated she sits in her wheelchair frequently up to and exceeding five hours without incontinence checks or repositioning. Continued observation noted Resident #1 to remain in the unit Activity room without repositioning or incontinence checks. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 1:40 P.M. interview with STNA #301 and Registered Nurse #402 during a review of Resident #1's point of care electronic documentation revealed no information indicating the resident required incontinence check and changes every two hours as per plan of care. STNA #301 confirmed she was unaware the resident required the two hour checks and confirmed the resident had not been repositioned or checked for incontinence since the resident was placed into the wheelchair. At 2:13 P.M. observation noted STNA #301 to propel Resident #1 to her room with assistance from RN #402 and placed the resident in bed using a mechanical lift. During the transfer STNA #301 asked Resident #1 if the resident was incontinent of bowel. Resident #1 replied she was not aware until that moment. STNA proceeded to assist the resident with incontinence care, removed the resident brief and discovered the resident incontinent of a small amount urine and medium formed stool contained in the brief. Following cleansing of the residents buttock, red areas were noted to the skin. RN #402 stated not to apply barrier cream and confirmed the reddened areas. RN #402 stated she would contact the physician for a possible treatment to the buttock. According to facility Bowel and Bladder Management policy dated 2018 the intent is to help resident maintain or improve bowel and bladder incontinence. Appropriate interventions shall be put into place when appropriate and may include: Encourage to utilize or assist resident to the bathroom at strategic periods of the day for that resident. Take in advance of need ([NAME]) if the resident is frequently incontinent of bowel and bladder and does not have the cognitive ability to follow directions, nursing will anticipate the need to void and assist resident to the bathroom more frequently. This deficiency represents non-compliance investigated under Master Complaint Number OH00156737.