

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Bath Manor Special Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2330 Smith Road Akron, OH 44333	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734</p> <p>Based on record review and interview, the facility failed to timely ensure a comprehensive treatment plan was in place to properly drain, monitor, and dress Resident #125's chest tube. This affected one resident (Resident #125) of three residents reviewed for quality of care.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #125 revealed an admitted [DATE] and a discharge to the hospital on 04/01/24. Diagnoses included acute and chronic diastolic heart failure, end stage renal disease and cardiomyopathy.</p> <p>Review of the hospital discharge orders dated 03/15/24 revealed the orders did not identify how to care for the chest tube or how often it should be drained and how often the dressing should be changed.</p> <p>Review of an email dated 03/15/24 from the Admission Director to the facility care team revealed the facility was aware Resident #125 had a chest tube upon admission.</p> <p>Review of the care plan initiated on 03/17/24 revealed a goal to manage Resident #125's diagnosis of congestive heart failure. The interventions for CHF did not identify any care or monitoring of the resident's chest tube. Resident #125's medical record did not indicate why the resident had a chest tube.</p> <p>Review of Resident #125's physician orders and medical record revealed no evidence of orders to drain, monitor, or care for chest tube until 03/18/24.</p> <p>Review of the physician orders and Treatment Administration Records (TAR) for March 2024 revealed an order dated 03/18/24 for the chest tube to be drained every three days and as needed. The chest tube was initially drained on 03/19/24 then subsequently drained on 03/20/24, 3/22/24, 03/25/24, 03/26/24, 03/27/24, 03/28/24, 03/29/24, 03/30/24 and 03/31/24. On 03/19/24 orders to drain the chest tube three times a week and record volume was put in place.</p> <p>Further review of the medical record and TAR revealed the facility did not order a dressing change to Resident #125's chest tube until 03/26/24 that included drain daily and as needed, access site and drain using sterile technique. Replace dressing using sterile technique and record volume. The order did not specify the type of dressing required.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365847
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/16/24 at 9:30 A.M. with Director of Nursing in review of hospital paperwork showed Resident #125's chest tube was last drained on 03/15/24 before admission and the facility was aware of the chest tube prior to admission without specific care orders.</p> <p>Interview on 04/16/24 at 9:30 A.M. with Certified Nurse Practitioner (CNP) #900 revealed she addressed the admission orders and acknowledged the resident had a chest tube upon admission. She confirmed there were not orders to care for the chest tube upon admission. A subsequent interview at 10:10 A.M. with the CNP #900 revealed the hospital did not know the proper diagnoses for the chest tube. She stated they used it because of fluid build-up. It was meant to be temporary.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00152477.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #121's incontinence care was completed timely. This affected one resident (Resident #121) out of three residents reviewed for incontinence care. The facility census was</p> <p>Findings include:</p> <p>Review of Resident #121's medical record revealed an admitted [DATE] and diagnoses included altered mental status, unspecified dementia, unspecified severity with agitation, type two diabetes mellitus with diabetic chronic kidney disease.</p> <p>Review of Resident #121's care plan dated 04/14/23 included Resident #121 was incontinent of bladder and bowel. Resident #121 would receive assistance with toileting, maintained comfortable, clean and dry, and free from skin breakdown. Interventions included to provide incontinence care as needed, and monitor peri-area for redness, irritation, skin excoriation and breakdown. Resident #121 had noncompliance related to history of noncompliance at home with not taking medications and refusing care. Resident #121 would not have any negative outcomes related to noncompliance through the next review. Interventions included to explain procedures prior to starting them and the benefits of the procedure, and to notify Resident #121's physician of noncompliance per routine and as needed.</p> <p>Review of Resident #121's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #121's Brief Interview for Mental Status was not assessed. Resident #121 was always incontinent of urine and bowel. Resident #121 had no impairment of the upper or lower extremities. Resident #121 required substantial to maximal assistance with toileting and personal hygiene.</p> <p>Review of the facility Daily Staffing assignments revealed State tested Nursing Assistant (STNA) #700 was assigned to care for Resident #121 on 04/18/24 from 6:00 A.M. until 2:00 P.M. STNA #701 was assigned to care for Resident #121 on 04/18/24 from 2:00 P.M. until 5:00 P.M.</p> <p>Review of Resident #121's progress notes on 04/18/24 from 6:00 A.M. through 4:00 P.M. did not reveal evidence Resident #121 refused to have her incontinence brief changed or she had redness to her buttocks, abdomen, crease of right thigh, perineal area, and posterior thighs.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/18/24 at 4:02 P.M. of STNA #701 revealed she walked into Resident #121's room, Resident #121 was sitting in a wheelchair in her room near her bed, and a large puddle of liquid was observed underneath the wheelchair. STNA #701 found a dry towel and soaked up the large puddle of liquid, and wiped the floor dry with the towel. Observation of the towel revealed it was wet with a large amount of dirt on the towel and it was hard to determine if the puddle under Resident #121's wheelchair was urine. STNA #701 left the room and returned with Licensed Practical Nurse (LPN) #702, and the two of them assisted Resident #121 to stand up, and sit on the edge of the bed. Observation revealed when Resident #121 stood up her pants were drenched with urine and the seat of the wheelchair was extremely wet with urine. Before assisting Resident #121 to sit on the side of the bed STNA #701 slid Resident #121's pants down and observation of her incontinence brief revealed it was saturated with urine and hanging down and away from her body. LPN #702 and STNA #701 helped Resident #121 into a lying position and proceeded to provide incontinence care. When Resident #121's brief was removed along with being saturated with urine a moderate to large greenish-brown semi-formed bowel movement could be seen in the brief. Resident #121's buttocks, inner buttocks, upper posterior thighs and perineal area were reddened, and Resident #121 cried out in pain when STNA #701 was cleansing her buttocks and perineal area. Observation of Resident #121's anterior upper thigh, crease of her right leg, and abdomen near the crease of her right leg revealed a large, reddened, irritated area of skin. LPN #702 and STNA #701 confirmed Resident #121's buttocks, inner buttocks, upper posterior thighs and perineal area were reddened, and Resident #121 had a large reddened, irritated area in her right leg crease, right thigh and abdomen. STNA #701 left the room to find Wound Nurse (WN) #703. WN #703 arrived and confirmed the large red area to Resident #121's right leg crease and abdomen and said she would need to call Resident #121's Nurse Practitioner to discuss the treatment.</p> <p>Interview on 04/18/24 at 4:02 P.M. with STNA #701 revealed Resident #121's incontinence brief looked like it had not been changed for awhile and it was not on her and it was not her who was responsible because she just took over the care of Resident #121 at 2:00 P.M. STNA #701 stated STNA #700 took care of her from 6:00 A.M. until 2:00 P.M. and STNA #700 did not say anything about Resident #121's incontinence brief needing changed before she left.</p> <p>Interview on 04/18/24 at 4:02 P.M. with LPN #702 revealed she was not aware and no STNA had reported to her Resident #121 had a large reddened, irritated area on the crease of her right thigh and abdomen and she was not aware Resident #121 had redness on her buttocks, inner buttocks, and perineal area.</p> <p>Review of Resident #121's progress notes dated 04/18/24 at 5:00 P.M. included Resident #121's Nurse Practitioner was contacted and informed Resident #121 had redness in lower abdomen, groin and side fold areas. Resident #121's Nurse Practitioner gave instructions to wash the area with mild soap, pat dry and apply nystatin powder (treats fungal or yeast infections) twice a day for fourteen days.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00152597 and Complaint Number OH00152477.</p>		