

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  09/18/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567</b></p> <p>Based on medical record review, interview, and review of the facility policy, the facility failed to ensure timely notification of death of the legal guardian for Resident #119. This affected one resident (#119) of three residents who were reviewed for notification of significant incidents or changes in condition. The facility census was 118.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #119 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure, extended spectrum beta lactamase (ESBL) resistance, hypothyroidism, major depressive disorder, end stage renal disease, thrombocytopenia, severe protein-calorie malnutrition, dysphagia, myxedema coma, dysphagia, and abnormalities of gait and mobility. Further review of the medical record revealed a discharge date of [DATE] after expiring in the facility.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment completed on [DATE] revealed Resident #119's cognitive function was severely impaired, and she was receiving Hospice care.</p> <p>Review of the face sheet revealed Resident #119 had a legal guardian. Further review of the face sheet revealed the legal guardian was the responsible party, and the face sheet listed the name, address, telephone number, and email address for the legal guardian. The face sheet also listed a spouse as an emergency contact.</p> <p>Review of the admission documents revealed a court document which appointed guardianship of Resident #119's person and estate to the listed legal guardian on the face sheet as of [DATE]. The court document specified the appointed legal guardian had the power to perform all duties of a guardian, indefinitely.</p> <p>Review of the progress notes revealed a progress note date [DATE] timed 9:06 P.M. indicating Resident #119 passed away at 8:45 P.M., the Director of Nursing (DON) was notified at 8:53 P.M., the Hospice provider was notified at 8:55 P.M., and the listed emergency contact was notified at 9:20 P.M. The note did not indicate the legal guardian was contacted. An additional progress note, dated and timed for [DATE] at 9:21 P.M. revealed the spouse of Resident #119 was notified of her death and told the facility which funeral home he wished to use.</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
---	-------	-----------

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  09/18/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated [DATE] at 12:28 A.M. revealed the Hospice nurse arrived at the facility at 9:51 P.M. and notified the physician that Resident #119 had expired at 8:45 P.M. There were no documented evidence indicating Resident #119's legal guardian was notified of her death on the evening or night she expired.</p> <p>Review of the social services progress note dated [DATE] at 10:46 A.M. revealed the legal guardian of Resident #119 called and left a message requesting the time of death and funeral home information from the facility, and Social Worker #509 returned the call and provided the requested information at that time.</p> <p>Telephone interview on [DATE] at 2:48 P.M. with Licensed Practical Nurse (LPN) #504 confirmed once she and LPN #633 verified the absence of vital signs, she notified Hospice and a man she referred to as either the resident's boyfriend, fiancée, or spouse., that Resident #119 had expired. When asked if the legal guardian was contacted, said she was trying to figure out who she was supposed to notify so she called the person listed as an emergency contact, who was also listed as the spouse. During the interview, LPN #504 confirmed she did not know that Resident #119 had a legal guardian or that the daughter was involved in Resident #119's care and should have been listed as the family contact.</p> <p>Interview on [DATE] at 3:44 P.M. with the legal guardian for Resident #119 confirmed the facility did not notify her of Resident #119's passing on the date of her death. During the interview, the legal guardian confirmed she was responsible for all medical and financial decisions and was to be informed of any changes, including death. The legal guardian further confirmed she should have been called, regardless of whether it was after what was normal business hours, and that her answering service would have taken the message and forwarded it to her so she could have informed the resident's family. At the time of the interview, the legal guardian stated Resident #119, and her spouse had been estranged for quite some time, since before she was admitted to the facility, and that it was the resident's daughter who remained involved in Resident #119's care and with whom she communicated. The legal guardian further confirmed Resident #119's daughter visited her mother in the facility frequently and was devastated she was not afforded the opportunity to come to the facility before her mother's body was released to the funeral home (because the legal guardian was not informed timely), despite Resident #119's passing away during what the legal guardian referred to as normal waking hours.</p> <p>Review of the facility policy titled Resident Change in Condition Policy, [DATE], revealed the Physician/Provider, family, and the residents responsible party were to be notified of a significant change in condition.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157657.</p>		

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  09/18/2024
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48567</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, interview, review of drug information on triamcinolone 0.1% cream (a topical corticosteroid) on Drugs.com, and review of the facility policy the facility failed to ensure ongoing care and services remained appropriate and failed to address repeated concerns voiced by state tested nurse aides (STNAs) regarding a black discoloration in Resident #82's percutaneous endoscopic gastrostomy (PEG) tube (a surgically placed feeding tube into the stomach) resulting in the resident being transferred to the hospital related to a clogged PEG tube with maggots noted in the tube. This affected one resident (#82) of three residents reviewed for tube feedings and had the potential to affect twelve residents (#67, #68, #70, #71, #72, #73, #74, #75, #76, #77, #81, and #82) whom the facility indicated were receiving nutrition via an enteral feeding tube. The facility census was 118.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #82 revealed an admitted [DATE]. Resident #82 was sent out to the hospital on 08/22/24 and returned to the facility on [DATE]. Diagnoses included acute respiratory failure, type two diabetes mellitus, aphasia, cognitive communication deficit, cerebral aneurysm, and obesity.</p> <p>Review of wound progress note dated 03/13/24 for Resident #82 revealed the moisture associated skin damage (MASD) to the open area around the PEG tube site was healed and that the treatment of triamcinolone 0.1% cream with calcium alginate (dressing for heavily draining wounds) and split gauze was to be continued each shift as a preventative measure.</p> <p>Review of physician order dated 04/08/24 for Resident #82 revealed an order to check enteral tube placement each shift. Further review of the orders revealed a physician order dated 04/04/24 for PEG tube site care as follows: cleanse the PEG tube site with wound cleanser, pat dry, apply triamcinolone 0.1%, and cover with calcium alginate and split gauze dressing each shift and as needed.</p> <p>Review of the care plan revealed Resident #82 was noted on 04/25/24 to be at risk for skin breakdown related to incontinence, diabetes mellitus, picking at skin, and extensive assistance for bed mobility. Additionally, the care plan revealed Resident #82 had a potential for altered nutritional status secondary to dysphagia and nothing by mouth status. Intervention dated 05/08/24 included the administration of tube feeding and flushes and provision of tube site care per physician orders and facility policy.</p> <p>Review of the care plan revealed Resident #82 required staff assistance for ADL. Further review of the care plan dated 05/17/24 revealed Resident #82 was non-compliant with care at times, including showers, refusal of tube feeding at times, and picking at her PEG tube site. On 09/16/24, an additional care plan problem was added to reflect Resident #82 declined to have her PEG tube replaced (there was no date of occurrence related to PEG replacement refusal). Interventions included education related to complications of non-compliance and physician notification.</p> <p>(continued on next page)</p>		

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  09/18/2024
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>Review of Nurse Practitioner (NP) communication notes with the facility dated 06/07/24 revealed Resident #82's PEG tube was malfunctioning, and attempt was made for exchange. The communication notes also indicated Resident #82 refused PEG tube replacement multiple times, and the tube feeding was infusing with no further issues.</p> <p>Review of progress notes from 05/01/24 to 08/21/24 revealed no indications of redness or other signs of infection to Resident #82's PEG tube site and revealed no documented evidence of attempts to schedule a PEG tube replacement.</p> <p>Review of weekly skin check dated 08/21/24 for Resident #82 completed by Licensed Practical Nurse (LPN) #528 revealed no indication abdominal redness and no documented evidence of concerns related to the stoma.</p> <p>Review of nursing progress note dated 08/22/24 timed at 2:16 A.M. revealed Resident #82 complained of itching on her stomach while nurse was hanging a new tube feed set up. Resident #82's PEG site was noted to be red with purulent drainage. A hole was found on the tube near the bumper (which rests on the edge of the skin) that was leaking enteral feed. The on-call NP was notified, and Resident #82 was sent to the emergency room .</p> <p>Review of witness statement dated 08/22/24 from LPN #640 revealed she went to change the tube feeding bag and Resident #82 stated she was having pain and itching at the dressing site. LPN #640 went to look at the dressing site and noticed maggots around the site. LPN #640 alerted Registered Nurse (RN) #624 to come assist cleaning the site. Both nurses observed a hole in the side near the PEG bumper, and Resident #82 was sent to the hospital.</p> <p>Review of the witness statement dated 08/22/24 from RN #624 revealed she was called down by another nurse to observe Resident #82's PEG site and after lifting the PEG bumper she observed maggots. Dakin fluid (a cleaning solution) was used to kill them, and no more maggots reappeared. Resident #82's PEG tube was noted to have a hole in the side near the bumper and tube feed was leaking out of the tube. The on-call NP was notified, and Resident #82 was sent out for evaluation.</p> <p>Review of hospital admission note dated 08/22/24 timed at 2:51 P.M. revealed Resident #82 presented to the hospital with a PEG tube issue and abdominal pain with stercoral colitis and possible cystitis. The hospital admission notes further revealed Resident #82 was transferred from the nursing home to the hospital due to a clogged PEG tube with maggots noted in PEG tube.</p> <p>Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #82 had severely impaired cognition. Resident #82 was dependent on staff for activities of daily living (ADL), received nothing by mouth, and received nutrition though enteral tube feedings.</p> <p>Review of nursing progress note dated 08/25/24 timed at 6:28 P.M. revealed Resident #82 returned from the hospital following treatment and a PEG tube replacement.</p> <p>Interview on 09/16/24 at 8:50 A.M. with Unit Manager #518 stated she was unaware of any concerns related to resident feeding tubes and denied knowledge of black discoloration in feeding tubes or the presence of maggots. She denied being informed by STNA's of black discoloration in the PEG tube.</p> <p>(continued on next page)</p>		

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  09/18/2024
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>Interview on 09/16/24 at 9:58 A.M. with the Director of Nursing (DON) confirmed Resident #82 was sent to the hospital on 08/22/24 for drainage coming out of her PEG tube insertion site and maggots found near the tube insertion site. The DON further confirmed Resident #82 had a blockage in the tube and while at the hospital the tube was replaced. During the interview the DON stated PEG site treatment had been completed the night before and no concerns were noted.</p> <p>Interview on 09/16/24 at 10:51 A.M. with NP #654 confirmed she noticed some leaking from the PEG tube site back in May 2024 and tried to get her an appointment for a consult for replacement, but no return phone call was received despite trying several times. NP #654 also confirmed Resident #82's PEG tube did not appear to be leaking as of 06/28/24, and Resident #82 declined a follow up appointment for the PEG tube. NP #654 also stated she discussed PEG tube replacement with Resident #82 again on 07/31/24, but she declined, stating it was not leaking and stated was experiencing no pain. On 08/22/24 the on-call NP was called at 1:30 A.M. and was informed Resident #82's PEG site was reddened with purulent drainage and itching at the site. It was also reported the PEG tube portion where the piston went attached had a blackened area and what the facility nurse reported to look like maggots around the bumper. Resident #82 was sent to the emergency room (ER) for treatment. NP #654 revealed Resident #82's history of picking at her skin and pulling at the PEG tube dressing may have made her more susceptible to infection. NP #654 confirmed she was unable to determine how long the blackened portion of the PEG tube was there as it had not been there when she last saw Resident #82 on 07/31/24 and was not aware of the blackening until 08/22/24 when Resident #82 was sent to the ER for evaluation and treatment.</p> <p>Interview on 09/16/24 at 12:06 P.M. with LPN #582 confirmed Resident #82 picked at her skin and pulled at her PEG tube. LPN #582 further confirmed Resident #82's PEG tube was to be cleansed twice a day and covered with a split gauze around it for skin protection. Ther was no mention of triamcinolone 0.1% or calcium alginate. During the interview, LPN #582 confirmed she was aware of moisture around the PEG insertion site, and the NP's recommendation for PEG replacement but denied knowledge of skin redness or the PEG tube appearing black in color.</p> <p>Interview on 09/16/24 at 1:35 P.M. with State tested Nurse Aide (STNA) #591 revealed she had noticed tube feeding formula leaking from Resident #82's PEG tube and had also reported the PEG tube was discolored and had black on the inside to nursing at least ten times. STNA #591 further stated Resident #82's PEG tube did not look like other residents' feeding tubes and had been discolored for several months. STNA #591 stated when giving a bed bath to Resident #82, she would clean around the dressing and would ask the nurse to replace the dressing. During the interview, STNA #591 stated she never noticed redness, swelling, or drainage coming from the PEG site, but had reported tube feeding product leaking from the PEG tube.</p> <p>Phone interview on 09/16/24 at 5:17 P.M. with STNA #523 revealed she had reported Resident #82's PEG tube leaking to a nurse who no longer worked at the facility and had told Unit Manager #518 about Resident #82's PEG tube having black inside back in May of 2024.</p> <p>(continued on next page)</p>		

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  09/18/2024
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>Phone interview on 09/16/24 at 5:25 P.M. with RN #624 confirmed she was aware the reddened area around Resident #82's PEG tube for about a month prior to being sent to the hospital but she thought it was getting better. RN #624 also stated she noticed the PEG tube had a black color that appeared to be mold about a week prior to the incident and had reported it to LPN #630 at the end of her shift. (Review of the progress notes revealed no documentation of the assessment findings or report of the findings). RN #624 further confirmed the night Resident #82 was sent out, and aide had reported the tube feeding was leaking in her bed, and Resident #82 was complaining of itching of her entire abdomen. During the interview, RN #624 confirmed when she examined the PEG tube, she noticed a hole in the peg tube and noticed clear mucous-like drainage around the tube site bumper with approximately ten maggots under it.</p> <p>A follow up phone interview on 09/16/24 at 5:45 P.M. with LPN #630 (who previously had stated she was unaware of any concerns related to tube feeding or maggots) revealed Resident #82's PEG tube was discolored from medications but denied noticing any black discoloration that appeared to be mold. LPN #630 further stated the area around Resident #82's PEG tube was reddened, and a treatment of calcium alginate had been in place.</p> <p>Phone interview on 09/16/24 at 5:56 P.M. with STNA #549 revealed she had reported Resident #82's PEG tube being black inside for several months. STNA #549 stated she had reported it more than once to Unit Manager #518 over the past three of four months and stated she knew the nurses saw the color of the PEG tube because they are the ones who administer her tube feeding each day. STNA #549 also confirmed the area around the PEG tube was reddened, and the nurse was doing a treatment for it.</p> <p>Interview on 09/17/24 at 1:05 P.M. with NP #654 revealed she would not order calcium alginate to be applied to healed skin because it could cause skin irritation, especially with prolonged use, but she also confirmed calcium alginate could be used if there was chronic drainage, then she deferred any further questions to the wound nurse.</p> <p>Interview on 09/1/24 at 2:10 P.M. with LPN #528 revealed she completed a head-to-toe assessment for Resident #82 on 08/21/24 and found no concerns, such as redness or drainage, related to her PEG tube site.</p> <p>Review of the drug information on triamcinolone cream on Drugs.com (<a href="https://www.drugs.com/triamcinolone-acetonide-cream.html">https://www.drugs.com/triamcinolone-acetonide-cream.html</a> , an online pharmaceutical encyclopedia) revealed the medication was not indicate for prolonged use and could increase the risk of skin irritation, including redness, itching, burning, and irritation, as well as atrophy of the epidermis. Further review of the triamcinolone cream drug information page revealed, when applicable, a recommendation to hold application of the cream until an infection can be controlled.</p> <p>Review of the facility policy titled Enteral Feeding Tube(s) Policy, last reviewed 09/29/21, revealed enteral tube entrance sites were to be monitored at least daily. Further review of the policy revealed enteral feeding tube sites did not require a dressing unless there was continued drainage or discharge, and if a dressing was used, it should be only one layer thick.</p> <p>The deficient practice was corrected on 08/23/24 when the facility implemented the following corrective actions:</p> <p>The physician was notified on 08/22/24 upon becoming aware of the PEG tube site status.</p> <p>(continued on next page)</p>		

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  09/18/2024
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>The ordered treatment was completed, and Resident #82 was transferred to the hospital on 08/22/24. A head-to-toe assessment was completed on Resident #82 prior to hospital transfer.</p> <p>On 08/22/24, pest control was contacted to spray for flies as a facility precaution.</p> <p>On 08/22/24 and 08/23/24, the DON and/or designee completed a full house audit on all residents that had tracheostomies, enteral feeding tubes, wounds, and Foley catheters with no adverse findings.</p> <p>Braden scale skin risk assessments were reviewed and updated for all residents on 08/22/24 and care plans were reviewed and updated as indicated. The consulting wound Provider was contacted for any areas requiring further evaluation and treatment.</p> <p>Commencing on 08/22/24 and finishing on 08/23/24, the maintenance department completed internal and external checks on all doors, windows, and screens to ensure no holes or cracks were identified.</p> <p>All nursing staff completed education on changes in condition, PEG tube site care/dressing changes, skin checks, showers, and reporting adverse findings by 08/23/24. Staff not working on 08/22/24 or 08/23/24 were contacted and educated by telephone. Any staff unable to be reached were not able to work until the education was completed and newly hired staff were to receive the education as part of the orientation and training process.</p> <p>On 08/23/24, the DON/designee continued with another whole house audits on all residents that had tracheostomies, enteral feeding tubes, wounds, and foley catheters.</p> <p>To maintain ongoing compliance: 1) The DON/designee audited all enteral feeding tube dressing sites daily and as needed and audited staff on change in condition procedure and notifications, 2) the DON/designee were to audit all new admissions and current residents with feeding tubes three times a week for three weeks, and then weekly, to ensure all insertion sites are cleaned and inspected for signs of infection, skin breakdown or contamination, and 3) all audit results were to be forwarded to the Quality Assurance and Performance Improvement (QAPI) committee for review and further recommendations.</p> <p>During the interview on 09/16/24 at 9:58 A.M. with the DON, she confirmed the facility completed audits on all residents with PEG tube, trach stomas, catheters, and wounds to ensure there were no other concerns related to new signs of infection or other concerns. She further confirmed the facility continued audits for three weeks and did not find any other concerns.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157145.</p>		