

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2024
NAME OF PROVIDER OR SUPPLIER  Ayden Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE  4293 Monroe St Toledo, OH 43606	

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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on review of the medical record, review of hospital documentation, resident and staff interview, and review of email correspondence, the facility failed to ensure meal accommodations were made to honor religious fasting preferences. This affected one (#21) of one resident reviewed for religious preferences. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses of choric obstructive pulmonary disease, type II diabetes mellitus, and nutritional deficiency.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had intact cognition and required setup and clean-up assistance for eating.</p> <p>Review of Resident #21's weight history revealed weights were obtained on 03/05/24, 04/04/24, 04/26/24, 05/02/24, and 06/03/24. No significant weight loss occurred between 03/05/24 and 06/03/24.</p> <p>Review of a nutrition progress note dated 04/16/24 revealed Dietetic Technician (ST) #261 recommended weekly weights for four weeks and a nutritional supplement twice daily due to decreased meal intake putting Resident #50 at risk for malnutrition.</p> <p>Review of a provider note dated 04/22/24 revealed Resident #21 had a decline over the past few days and was no longer able to feed herself. Resident #21 seemed very weak and fatigued and would be sent to the emergency room for a proper work up.</p> <p>Review of a hospital history and physical dated 04/22/24 revealed Resident #21 was admitted to the hospital on 04/22/24 for hyponatremia (low sodium in the blood). Additionally, the document revealed Resident #21 was noted to have hyponatremia and hypokalemia (low potassium in the blood) due to poor oral intake.</p> <p>Review of a provider's progress note/readmission assessment, after her hospitalization , dated 04/30/24, revealed Resident #21 had been fasting for [NAME] and could not eat at proper times.</p> <p>Review of a progress note dated 07/10/24 revealed Resident #21 fasted for [NAME] from the beginning of April 2024 until the end of May 2024.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the current care plan for Resident #21 revealed no guidance regarding her preference to fast during [NAME] or any interventions the facility would do to accommodate her religious preference.</p> <p>Interview on 07/11/24 at 8:28 A.M. with Resident #21 revealed she fasted for [NAME]. Resident #21 stated it meant she did not eat from sun up until sun down. Resident #21 stated she honored [NAME] during the month of May. Resident #21 stated she was not offered food or meals after dark.</p> <p>Interview on 07/11/24 at 8:57 A.M. with Dietary Supervisor (DS) #149 revealed she was aware Resident #21 fasted for [NAME]. DS #149 stated Resident #21 was not consistent about fasting for [NAME] and would eat during the daylight hours some days. DS #149 stated the kitchen always sent Resident #21's meal trays for breakfast, lunch, and dinner during the regular meal service. DS #149 stated she did not provide meals to Resident #21 after dark, but stated the staff were aware Resident #21 could receive snacks or nutrition supplements at any time of the day.</p> <p>Review of an email dated 07/17/24 at 1:26 P.M. from Corporate Registered Nurse #260 confirmed Resident #21's care plan did not include interventions for addressing adequate nutrition while fasting during [NAME].</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>45751</p> <p>Based on resident interview, staff interview, review of Resident Council minutes, review of call light audits, and policy review, the facility failed to thoroughly address Resident Council concerns in a timely manner. This had the potential to affect 18 (#1, #8, #9, #11, #12, #17, #22, #24, #29, #33, #35, #41, #44, #45, #49, #52, #53, and #65) residents who regularly attended Resident Council meetings. The facility census was 67.</p> <p>Findings include:</p> <p>Review of Resident Council minutes dated 09/29/23 revealed nursing concerns regarding food sitting too long on the food cart.</p> <p>Review of Resident Council minutes dated 11/27/23 revealed nursing concerns regarding, on the weekends, first shift food carts are passed slower.</p> <p>Review of Resident Council minutes dated 12/27/23 revealed nursing concerns regarding call light response times were slow on all shifts and weekends, and food/meal pass took too long at times.</p> <p>Review of Resident Council minutes dated 01/25/24 revealed nursing concerns regarding call lights, medication administration, meal carts, staffing, noise levels, and smoking times.</p> <p>Review of Resident Council minutes dated 02/22/24 revealed nursing concerns that residents wanted to continue to monitor call lights and smoking times starting on time.</p> <p>Review of Resident Council minutes dated 03/22/24 revealed food carts on first and second shift need to be passed faster to prevent food from getting cold.</p> <p>Review of Resident Council minutes dated 04/19/24 revealed call lights were slow to be answered and food carts on the hall sit too long on first and second shift.</p> <p>Review of Resident Council minutes dated 05/24/24 revealed call light response times on second and third shift need observation and food temperatures need observed while on carts.</p> <p>Review of Resident Council concern forms revealed no follow up of resident concerns was provided for the months prior to January 2024 or after March 2024.</p> <p>Review of a Resident Council concern form dated 01/25/24 revealed leadership was performing periodic call light audits and leadership explained that meal carts come up at different times.</p> <p>Review of a Resident Council concern form dated 02/22/24 revealed managers assessed and communicated with their partners and monitoring was completed with call light observations.</p> <p>Review of a Resident Council concern form dated 03/22/24 revealed management was to monitor state tested nurse aides (STNAs) passing trays for meals and assisting if needed.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of audits for call lights provided by the Director of Nursing (DON) revealed call lights were monitored in four rooms on 07/17/23 and 0721/23, one room was monitored on 11/06/23 and 11/09/23, two rooms were monitored on 11/10/23, and one room was monitored on 02/15/24. No other audits were provided for call light monitoring or meal tray pass on the hallways.</p> <p>Interview on 07/11/24 at 9:11 A.M. with Resident #9 revealed the facility did not always act on the concerns of the Resident Council and there was not much follow through.</p> <p>Interview on 07/15/24 at 8:35 A.M. with Activities Director (AD) #101 verified Resident Council had many repeated concerns at each meeting, and was not aware of what the follow up to the concerns was. AD #101 stated she took the resident concerns from the meetings to the Administrator.</p> <p>Review of policy titled, Resident Council, dated April 2017, revealed a Resident Council Response form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. The Quality Assurance and Performance Improvement (QAPI) committee will review information and feedback from the Resident Council as part of their quality review. Issues documented on council response forms may be referred to the Quality Assurance and Performance Improvement (QAPI) committee, if applicable, with examples such as the issue is of serious nature or if there is a pattern.</p>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>45751</p> <p>Based on observation, resident interview, and staff interview the facility failed to post a notice of the availability of survey results from the preceding three years in areas of the facility that are prominent and accessible to the public. This had the potential to affect all 67 residents. The facility census was 67.</p> <p>Findings include:</p> <p>Observation on 07/15/24 at 8:57 A.M. of all hallways revealed no signage noted regarding the location of the survey results binder or how to access the survey results.</p> <p>Interview on 07/11/24 at 9:11 A.M. with Resident #9 revealed the resident did not know where the survey results binder was located.</p> <p>Interview on 07/11/24 at 9:59 A.M. with State tested Nurse Aide (STNA) #121 revealed the survey binder was located on the bookshelf outside of the locked doors as you enter the facility. STNA #121 verified there was not a posting as to where to find the survey results. STNA #121 stated the residents could see the binder if they went out and families could see it when they came in the facility.</p> <p>Observation on 07/11/24 at 10:04 A.M. of the survey binder in the front lobby revealed no signage revealing the survey binder location. The survey binder was observed standing up and the front of the binder had a white sheet which indicated it contained survey results.</p> <p>Interview on 07/11/24 at 10:07 A.M. with Receptionist #248 verified there was no posting placed for where the survey results binder was located. Receptionist #248 stated that people would ask where the binder was if they wanted to see it.</p> <p>Interview on 07/11/24 at 10:39 A.M. with Resident #6 revealed the resident did not know where the survey results were located.</p> <p>Interview on 07/11/24 at 10:43 A.M. with Resident #325 revealed the resident denied knowing or hearing about any survey results that residents could view.</p> <p>Interview on 07/11/24 at 10:46 A.M. with Resident #38 revealed the resident denied knowing where the survey results were located.</p> <p>Interview on 07/11/24 at 10:59 A.M. with Resident #40 revealed the resident denied knowing where the survey results are posted and did not know that the facility had such a binder.</p> <p>Interview on 07/11/24 at 1:59 A.M. with Administrator verified the survey results were located at the front entrance, and verified there was no signage or posting to let residents or the public know where to locate the survey binder.</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45751</p> <p>Based on medical record review and staff interview, the facility failed to ensure completed Minimum Data Set (MDS) assessments were completed and transmitted within required timeframes. This affected two (#43 and #61) of two residents reviewed for MDS assessment submission. The facility census was 67.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #43 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included human immunodeficiency virus (HIV), malignant neoplasm of the rectum and anal canal, rectal polyp, Alzheimer's disease, Parkinson's disease, and neoplasm of the colon.</li> </ol> <p>Review of Resident #43's MDS assessments revealed no MDS was completed for a death in the facility on 02/27/24. Further review of the resident's MDS assessments revealed the last completed MDS assessment was on 02/14/24 for admission.</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #61 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included acute kidney failure, elevated white blood cell count, congestive heart failure, hypertension, ventricular premature depolarization, insomnia, cognitive communication deficit, and altered mental status.</li> </ol> <p>Review of Resident #61's MDS assessment dated [DATE] for death in facility revealed the MDS assessment was completed, however, it was not transmitted.</p> <p>Interview on 07/09/24 at 3:55 P.M. with MDS Nurse #164 verified Resident #43's and Resident #61's MDS assessments for death in the facility were not completed or transmitted within required timeframes. MDS Nurse #164 verified the last MDS assessment completed for Resident #43 was the admission MDS assessment, and verified Resident #61's death in facility MDS was completed but never transmitted.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's status. This affected one (#33) of 26 residents reviewed for MDS assessments. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease and chronic respiratory failure.</p> <p>Review of the admission nursing observation dated 05/18/24 revealed Resident #33 received oxygen therapy at three liters per minute via nasal cannula.</p> <p>Review of the provider progress note dated 05/20/24 revealed Resident #33 required oxygen via nasal cannula and was receiving oxygen at the time of the provider's visit.</p> <p>Review of the comprehensive admission MDS assessment dated [DATE] revealed Resident #33 had intact cognition and indicated Resident #33 was not on oxygen therapy.</p> <p>Review of a physician order dated 07/08/24 revealed Resident #33 received oxygen via nasal cannula at three liters per nasal cannula.</p> <p>Interview on 07/15/24 at 9:50 A.M. with Corporate Registered Nurse (RN) #260 confirmed Resident #33 was coded incorrectly in the 05/23/24 MDS assessment for not using oxygen.</p> <p>45751</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45751</p> <p>Based on medical record review, staff interview, and policy review the facility failed to implement a care plan to address the resident's desire to smoke. This affected one (#64) of four residents reviewed for smoking. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #64 revealed a most recent re-admitted [DATE] with diagnoses including intestinal obstruction, anterior dislocation of the right humerus, retroperitoneal hematoma, fracture of the right fibula, fracture of the shaft of the right tibia, hypertension, cognitive communication deficit, and post-traumatic stress disorder.</p> <p>Review of an admission smoking assessment dated [DATE] revealed Resident #64 was a current smoker and assessed as safe to smoke with supervision. Further review of the smoking assessment revealed a notation the smoking plan of care was updated.</p> <p>Review of Resident #64's care plan dated 04/16/24 revealed no smoking care plan as of 07/09/24.</p> <p>Interview on 07/09/24 at 10:15 A.M. with Director of Nursing (DON) verified Resident #64 did not have a smoking care plan in place.</p> <p>Review of policy titled, Care Plans, Comprehensive Person-Centered, dated October 2018, revealed the comprehensive, person-centered care plan will include measurable objectives and timeframe's, incorporate identified problem areas, reflect the resident's expressed wishes regarding care and treatment goals, and reflect treatment goals, timetables, and objectives in measurable outcomes.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31638</p> <p>Based medical record review, resident interview, staff interview, and policy review, the facility failed to conduct care conferences as required. This affected eight (#9, #14, #17, #30, #34, #57, #59, and #62) of 26 residents reviewed for care conferences. The facility census was 67.</p> <p>Findings Included:</p> <p>1. Review of Resident #9's medical record revealed an admitted [DATE]. Diagnoses included infection/inflammatory reaction due to internal left hip prosthesis, chronic obstructive pulmonary disease, peripheral vascular disease, alcoholic cardiomyopathy, chronic kidney disease, alcoholic hepatitis, alcohol abuse, and femur fracture.</p> <p>Review of Resident #9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a high cognitive function.</p> <p>Review of Resident #9's most recent care plan revealed the resident was at risk for alteration in activity participation related to a significant health change. The resident tired easy and her pain level may hinder participating in activities she enjoyed in the past.</p> <p>Review of Resident #9's care plan conference summaries revealed the resident received a quarterly care plan conference 04/27/23, 08/10/23, and 05/07/24.</p> <p>Interview with Resident #9 on 07/08/24 at 10:54 A.M. revealed care conferences were not held timely and she would like to have them quarterly.</p> <p>2. Review of Resident #34's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, hemiplegia, alcohol abuse, and bipolar disorder.</p> <p>Review of Resident #34's annual MDS assessment dated [DATE] revealed he had a high cognitive function.</p> <p>Review of Resident #34's care conference summary revealed the last meetings were 05/11/23, 08/03/23, and 01/16/24.</p> <p>3. Review of Resident #57's medical record revealed an admitted [DATE]. Diagnoses included cerebral infarction, anxiety, bipolar disorder, cocaine abuse, aphasia, and schizoaffective disorder.</p> <p>Review of Resident #57's quarterly MDS assessment dated [DATE] revealed he was rarely understood due to a speech deficit but could understand others.</p> <p>Review of Resident #57's care conference summary revealed his last care conferences were held 08/09/23 and 02/05/24.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #62's medical record revealed an admitted [DATE]. Diagnoses included osteomyelitis of the right femur, liver cancer, lung cancer, malnutrition, tachycardia, absence of the right leg below the knee, bone cancer, and a pressure ulcer on admission.</p> <p>Review of Resident #62's quarterly MDS assessment dated [DATE] revealed the resident had a high cognitive function.</p> <p>Review of Resident #62's care conference summary revealed the resident had only one conference on 01/30/24.</p> <p>Interview with Resident #62 on 07/09/24 at 8:05 A.M. revealed he had only one care conference and he wished to have them quarterly.</p> <p>5. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy, atherosclerotic heart disease of native coronary artery, heart failure, major depressive disorder, acquired absence of right leg above knee, chronic atrial fibrillation, and essential (primary) hypertension.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #14 was cognitively intact.</p> <p>Review of care conference documentation revealed the most recent care conference was held on 12/09/20.</p> <p>6. Review of the medical record revealed Resident #17 was admitted on [DATE]. Diagnoses included other sequelae of cerebral infarction, chronic combined systolic and diastolic heart failure, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder recurrent, and schizoaffective disorder.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #17 was cognitively intact.</p> <p>Review of care conference documentation, dated the last two years, revealed Resident #17 had care conferences on 06/30/22, 08/04/22, 07/20/23, 10/20/23, and 01/29/24.</p> <p>Interview on 07/09/24 at 7:57 A.M. with Resident #17 revealed he had not had regular care plan conferences while in the facility.</p> <p>7. Review of the medical record revealed Resident #30 was admitted on [DATE]. Diagnoses included schizophrenia, major depressive disorder recurrent, generalized anxiety disorder, and cognitive communication deficit.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #30 was cognitively intact.</p> <p>Review of care conference documentation, dated the last two years, revealed Resident #30 had care conferences on 07/12/22, 08/31/23, and 12/07/23.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses including cerebral infarction, acute kidney failure, hemiplegia/hemiparesis following cerebral infarction affecting the non-dominant side, type two diabetes, gastrointestinal hemorrhage, major depressive disorder, chronic hepatitis C, hypertension, unspecified convulsions, and chronic metabolic acidosis.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #59 was cognitively intact. Resident #59 required partial to moderate assistance for activities of daily living.</p> <p>Review of a care conference summary dated 02/06/24 revealed the initial care conference was completed on this date.</p> <p>Interview on 07/10/24 at 8:43 A.M. with Social Services Director (SSD) #210 verified Resident #14, Resident #17, and Resident #30 did not have timely care conferences scheduled.</p> <p>Follow-up interview with SSD #210 on 07/11/24 at 8:16 A.M. verified care conferences should have been held in November 2023 and February 2024 for Resident #9, should have been held in November 2023 and April 2024 for Resident #34, should have been held in November and May 2023 for Resident #57, should have been held in April 2024 for Resident #62, and should have been held in May 2024 for Resident #59; however, the facility failed to do so. SSD #210 verified care conferences are to be held quarterly; however, the care conferences were not populating with the MDS assessment for some reason and were missed.</p> <p>Review of policy titled, Care Plans, Comprehensive Person-Centered, dated October 2018 revealed the interdisciplinary team (IDT), in conjunction with the resident and their family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care planning progress will facilitate the resident and/or representative and be completed at least quarterly in conjunction with the required quarterly MDS assessment.</p> <p>41528</p> <p>45751</p>

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NAME OF PROVIDER OR SUPPLIER  Ayden Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4293 Monroe St Toledo, OH 43606	

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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>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> 44815</p> <p>Based on medical record review and staff interview, the facility failed to ensure consulted wound care specialist orders were completed. This affected one (#175) of three residents reviewed for wounds. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #175 revealed an admitted [DATE] and a discharge date to home on 06/13/24. Diagnoses included type II diabetes mellitus and cutaneous abscess of the left foot.</p> <p>Review of the comprehensive admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #175 had intact cognition and displayed no rejection of care. Resident #175 required substantial /maximal assistance for toileting. Further review revealed Resident #175 had an infection of a diabetic foot ulcer, a surgical wound, and moisture associated skin damage.</p> <p>Review of a consultant wound care physician progress note dated 04/30/24 revealed an initial assessment was completed on Resident #175 and identified she had irritant dermatitis from body fluid to her buttocks. The physician ordered a zinc oxide barrier cream three times per day for at least ten days.</p> <p>Review of Resident #175's physician orders and treatment administration records (TARs) for April and May 2024 revealed the treatment orders for zinc oxide barrier cream were not initiated.</p> <p>Interview on 07/11/24 at 7:48 A.M. with the Director of Nursing (DON) confirmed the treatment orders were not initiated and stated the facility used their own barrier cream, but could not provide any documentation the barrier cream was applied.</p> <p>This deficiency represents continued non-compliance investigated under Complaint Number OH00154935. This deficiency is a recite to the complaint survey completed 06/06/24.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528</b></p> <p>Based on medical record review, observation, resident interview, staff interview, and facility policy review, the facility failed to ensure residents had timely access to vision services. This affected one (#17) of two residents reviewed for vision services. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #17 was admitted on [DATE]. Diagnoses included other sequelae of cerebral infarction, chronic combined systolic and diastolic heart failure, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder recurrent, and schizoaffective disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively intact and had corrective lenses.</p> <p>Interview on 07/09/24 at 7:59 A.M. with Resident #17 revealed his glasses had been broke for at least a month or two and indicated the glasses needed a screw replaced. Resident #17 stated he was unable to wear his glasses in the current condition.</p> <p>Observation on 07/09/24 at 8:00 A.M. of Resident #17's glasses revealed the glasses were on top of the bedside table with one temple (arms of the frames that extend behind the ears) missing and a screw missing from the hinge.</p> <p>Interview on 07/10/24 at 7:57 A.M. with Social Services Director (SSD) #210 revealed the optometrist was just in the facility earlier that week and Resident #17 was not on the list to be seen.</p> <p>Follow-up interview on 07/10/24 at 10:40 A.M. with Resident #17 stated Activities Director (AD) #101 was present when his glasses broke and was aware.</p> <p>Interview on 07/10/24 at 10:47 A.M. with AD #101 denied knowledge of Resident #17's glasses breaking, and stated Resident #17 previously wore glasses and was not sure when he stopped.</p> <p>Review of a policy titled, Sensory Impairments, revised March 2018, revealed the staff and physician will identify approaches to help the resident improve or compensate for sensory deficits. For example, they may refer visually impaired individuals for a vision evaluation and/or corrective lenses.</p> <p>Review of a policy titled, Social Services Referrals, revised December 2008, revealed social services personnel shall coordinate most resident referrals with outside agencies.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on observation, staff interview, medical record review, review of a mattress manual, and review of the facility policy, the facility failed to ensure pressure wound treatments were completed as ordered and wound care interventions were in place and functioning appropriately. This affected two (#16 and #56) of three residents reviewed for wounds and pressure reducing interventions. The facility census was 67.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses of bullous pemphigoid and type II diabetes mellitus.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition and a stage four pressure ulcer (Full-thickness skin and tissue loss).</p> <p>Review of Resident #16's current care plan revealed he had a pressure ulcer to the left heel due to immobility. Interventions included to administer treatments as ordered. Additionally, Resident #16 had potential/actual impairment to skin integrity with blisters noted on the body due to an autoimmune disorder bullous pemphigoid. Interventions included applying bilateral heel boots to protect the skin while in bed.</p> <p>Review of Resident #16's physician order dated 06/25/24 revealed treatment directions to cleanse the wounds with wound cleanser, pat dry, apply blue foam to the left heel, and wrap with kerlix every other day.</p> <p>Observation on 07/15/24 at 9:10 A.M. of wound care completed on Resident #16 with Assistant Director of Nursing (ADON) #109 revealed Resident #16 was lying in bed on his back watching television and his heel boots were lying on the dresser across the room from his bed. The left heel wound dressing was intact and dated 07/12/24.</p> <p>Interview with ADON #109 on 07/15/24 at 9:16 A.M. verified Resident #16's pressure relieving boots were not in place and Resident #16's wound care was not completed as ordered on 07/14/24 as evidence by the wound dressing currently on the resident dated 07/12/24.</p> <p>Review of the policy, Skin Management Program, dated April 2023, revealed interventions identified in the care plan will be implemented.</p> <p>2. Review of Resident #56's medical record revealed an admitted [DATE]. Diagnoses included atrial fibrillation, tachycardia, rheumatoid arthritis with multiple sites, alkalosis, hypokalemia, and a history of falling.</p> <p>Review of Resident #56's quarterly MDS assessment dated [DATE] revealed the resident's cognition was intact. She had an impairment on both sides of upper extremity and required substantial/maximal assistance for lying to sitting.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #56's care plan revealed she was at risk for impaired skin integrity related to difficulty ambulating, infection, and cardiac impairments. Intervention included a pressure reducing mattress.</p> <p>Review of Resident #56's wound evaluation and management summary dated 11/07/23 revealed a recommendation for a low air loss mattress.</p> <p>Interview with Resident #56 on 07/08/24 at 9:56 A.M. revealed she was equipped with an air mattress but it had not been working for over a week she was lying in a hole.</p> <p>Observation of the mattress control panel at the foot of the bed on 07/08/24 at 10:02 A.M. revealed the power was on and the control was set at the highest level, 350, with static off.</p> <p>Interview with Licensed Practical Nurse (LPN) #218 on 07/08/24 11:13 A.M. verified that Resident #56's mattress had no air and was flat. LPN #218 verified she was unaware of the situation.</p> <p>Interview with ADON #109 on 07/08/24 at 12:10 P.M. verified Resident #56's therapeutic mattress was broken and had no air. ADON #109 was unaware of how long the mattress had been defective.</p> <p>Review of the mattress manual revealed to ensure a firm mattress place one hand between the mattress and the foam base and feel the patient's buttocks.</p> <p>Review of the facility policy titled, Assistive Devices and Equipment, dated July 2017, revealed our facility provides, maintains, trains and supervises the use of assistive devices and equipment for residents. Staff and volunteers will be trained and will demonstrate competency on the use of devices and equipment prior to assisting or supervising residents.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154935.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45751</p> <p>Based on observation, medical record review, resident interview, staff interview, and policy review the facility failed to ensure the facility maintained safe smoking practices as care planned and per the facility smoking policy. This directly affected four (#33, #59, #64, and #328) of four residents reviewed for smoking with the potential to affect all 15 (#1, #6, #7, #27, #28, #29, #33, #34, #41, #45, #46, #47, #59, #64, and #328) residents who smoke. Additionally, the facility failed to ensure fall interventions were in place as care planned. This affected one (#14) of three residents reviewed for falls. The facility census was 67.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses including cerebral infarction, acute kidney failure, hemiplegia/hemiparesis following cerebral infarction affecting the left non-dominant side, type two diabetes, gastrointestinal hemorrhage, major depressive disorder, chronic viral hepatitis C, hypertension, unspecified convulsions, and chronic metabolic acidosis.</p> <p>Review of a smoking assessment dated [DATE] revealed Resident #59 could light his own cigarette and was safe to smoke with supervision.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact. Resident #59 required partial/moderate assistance for activities of daily living.</p> <p>Review of the care plan dated 05/21/24 revealed Resident #59 was at risk for injury related to smoking cigarettes. Interventions included to provide supervision at all times for smoking and smoking items to be kept at the nurse's station.</p> <p>Review of the smoking policy signed by Resident #59, with no date, revealed two cigarettes are allotted during each smoke break. All cigarettes and lighters will be placed in smoke bags and given to staff.</p> <p>Interview on 07/10/24 at 10:04 A.M. with Resident #59 verified he had his own cigarettes and he did not give them to the nurse when he comes back inside from smoking.</p> <p>2. Review of the medical record for Resident #64 revealed a re-admitted [DATE] with diagnoses including intestinal obstruction, anterior dislocation of the right humerus, retroperitoneal hematoma, nondisplaced fracture of the coracoid process of the right shoulder, fracture of the right fibula, fracture of the shaft of the right tibia, hypertension, cognitive communication deficit, dislocation of the right shoulder joint, and post-traumatic stress disorder.</p> <p>Review of a smoking policy signed by Resident #64 dated 04/15/24 revealed two cigarettes are allotted during each smoke break. All cigarettes and lighters will be place in smoke bags and given to staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the MDS assessment dated [DATE] revealed Resident #64 was cognitively intact. Resident #64 required extensive assist for activities of daily living with the exception of eating, oral hygiene, and personal hygiene which was supervision/touching assistance.</p> <p>Review of the care plan dated 07/10/24 revealed Resident #64 was at risk for injury related to smoking cigarettes. Interventions included to provide supervision at all times for smoking and smoking items were to be kept at the nurse's station.</p> <p>Review of a smoking assessment dated [DATE] revealed Resident #64 was safe to smoke with supervision and the smoking care plan was updated.</p> <p>Interview on 07/10/24 at 7:46 A.M. with Resident #64 verified he kept his cigarettes and lighter in his room. Observation at the time of the interview revealed a pack of cigarette on his over the bed table in his room.</p> <p>3. Review of the medical record for Resident #328 revealed an admitted [DATE] with diagnoses including displaced comminuted fracture of the right tibia, displaced [NAME] fracture of the right tibia, low back pain, schizophrenia, psychoactive substance abuse, and hypertension.</p> <p>Review of a care plan dated 07/04/24 revealed Resident #328 was at risk for injury related to smoking cigarettes. Interventions include to provide supervision at all times for smoking and smoking items were to be kept at the nurse's station.</p> <p>Review of a smoking assessment dated [DATE] revealed Resident #328 could light his own cigarette and required supervision.</p> <p>Review of a smoking agreement signed on 07/05/24 revealed Resident #328 consented to the smoking policy and to have cigarettes and lighters secured at the nurse's station. The resident also consented to follow the smoking schedule posted with supervision from a staff member.</p> <p>Interview on 07/10/24 at 3:07 P.M. with Resident #328 verified he kept his cigarettes and lighter in his nightstand drawer. The resident verified he did not give his cigarettes or lighter to the nurse.</p> <p>Observation on 07/08/24 at 1:22 P.M. of residents waiting to go outside to smoke revealed one unidentified resident with a pack of cigarettes he took out of a black grocery bag. Two other unidentified residents were observed with a single cigarette in their hand. There were a total of 10 residents observed lined up to go outside to smoke at 1:29 P.M. One unidentified female resident was observed with a pack of cigarettes in her bra. Resident #328 came out to smoke after the other residents were outside and obtained three cigarettes from another resident. Resident #328 was observed to smoke one cigarette and take the other two cigarettes back into the facility in his right hand. Resident #328 was not observed giving the cigarettes to any staff member. One staff member in the smoking area observing the smoke break. One unidentified female resident in a wheelchair placed her pack of cigarettes in the pocket on the back of her wheelchair. Staff was not observed collecting any cigarettes from the residents to place back in the toolbox that was brought outside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 07/08/24 at 1:45 P.M. with Activities Director (AD) #101 verified the residents take their cigarettes and lighters back with them. AD#101 identified there were four residents who who smoke that have their cigarettes in the toolbox, but all the rest of the residents that smoke had their cigarettes and lighters in their possession.</p> <p>Interview on 07/09/24 at 10:15 A.M. with the Director of Nursing (DON) stated that it was in the admission policy if a resident was deemed safe to keep their own cigarettes and lighters on their person. The DON verified that Resident #59 and Resident #328's care plans included interventions that cigarettes are to be kept at the nurse's station. The DON verified the facility was a supervised smoking facility and no resident was deemed independent for smoking.</p> <p>4. Review of the medical record for Resident #33 revealed an admitted [DATE] with a diagnosis of chronic obstructive pulmonary disease.</p> <p>Review of the comprehensive admission MDS assessment dated [DATE] revealed Resident #33 had intact cognition.</p> <p>Review of the smoking assessment completed 05/17/24 revealed Resident #33 was safe to smoke with supervision. The smoking assessment included a smoking care plan with an intervention for smoking items to be kept at the nurse's station.</p> <p>Observation and interview on 07/08/24 at 10:25 A.M. revealed Resident #33 sitting in his room with a lighter and cigarettes in his pocket. Resident #33 stated he was allowed to keep his smoking materials with him, and kept them in his pocket at night.</p> <p>Review of policy titled, Smoking Policy-Residents, dated July 2017, revealed resident's without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision.</p> <p>5. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy, atherosclerotic heart disease of native coronary artery, heart failure, major depressive disorder, acquired absence of right leg above knee, chronic atrial fibrillation, and essential (primary) hypertension.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #14 was cognitively intact and required substantial assistance with toileting, hygiene, showering, and lower body dressing. Resident #14 had one fall with no injury.</p> <p>Review of the most recent care plan revealed Resident #14 was at risk for falls and potential injury. Interventions included bed against the wall, mat to the floor, and a perimeter mattress.</p> <p>Observation on 07/09/24 at 9:15 A.M. revealed Resident #14 in bed. The bed was not against the wall, did not have a perimeter mattress, and did not have a floor mat.</p> <p>Interview on 07/09/24 at 2:53 P.M. with State tested Nurse Aide (STNA) #178 verified Resident #14's bed was not against the wall and no floor mat was in place. STNA #178 stated she was unaware what a perimeter mattress was but agreed the mattress was a regular air mattress with no sides.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Continued observations throughout the survey from 07/09/24 to 07/11/24 revealed all three identified failed interventions continued to not be in place.</p> <p>Review of a policy titled, Managing Falls and Fall Risk, revised March 2018, revealed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The staff will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154935.</p> <p>44815</p> <p>41528</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45751</p> <p>Based on observation, staff interview, resident interview, and policy review the facility failed to ensure residents received timely and adequate assistance with incontinence care. This affected one (#62) of two residents reviewed for incontinence. The facility census was 67.</p> <p>Findings Included:</p> <p>Review of Resident #62's medical record revealed an admitted [DATE]. Diagnoses included osteomyelitis the right femur, liver cancer, lung cancer, malnutrition, tachycardia, absence of the right leg below the knee, bone cancer, and a pressure ulcer on admission.</p> <p>Review of Resident #62's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a high cognitive function and required substantial/maximal assistance for toileting and rolling.</p> <p>Review of Resident #62's most recent care plan revealed he was at risk for impaired skin integrity related to weakness, difficulty ambulating, current wounds, cancer which metastasized, incontinence, cognitive deficits, pain, and depression.</p> <p>Interview with Resident #62 on 07/09/24 at 8:43 A.M. revealed the resident had not been checked nor received a brief change since the night before. He stated he was wet and called for assistance, but did not receive assistance.</p> <p>Interview with Resident #62 on 07/10/24 at 9:18 A.M. revealed he had not been checked or changed for incontinence the previous night. He had been offered to receive morning care at approximately 8:30 A.M., but was eating breakfast and asked staff to return after eating.</p> <p>Review of Resident #62's intervention/tasks for bowel and bladder care revealed on 07/10/24 he was checked at 1:51 P.M. and at 4:26 A.M. it was marked non-applicable.</p> <p>Observation of incontinence care was completed on 07/10/24 at 9:20 A.M. with Licensed Practical Nurse (LPN) #215 and State tested Nurse Aide (STNA) #255. The Administrator and Unit Manager #109 were also present in the room. Resident #62 started with washing his own chest and private area with washcloths provided by staff. There was a strong odor in the room. When the staff rolled the resident to his right side there was a large amount of urine and dark liquid on the resident, and on his bed pad and bottom bed sheet from his thighs up to his neck. The stain was approximately 12 inches wide.</p> <p>Interview with the Administrator on 07/10/24 during the observation revealed Resident #62 did refuse care at times. The Administrator verified the resident had not been changed for a long period of time.</p> <p>Interview with the Director of Nursing (DON) on 07/15/24 at 2:22 P.M. verified Resident #62 failed to be checked and changed for incontinence throughout the night on 07/09/24 to 07/10/24.</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>Review of the facility policy titled, Urinary Continence and Incontinence - Assessment and Management, dated September 2010, revealed incontinence care should be individualized at night in order to maintain comfort and skin integrity, and minimize sleep disruption.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155573.</p>		

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NAME OF PROVIDER OR SUPPLIER  Ayden Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE  4293 Monroe St Toledo, OH 43606	

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on review of the medical record, hospital document review, and staff interview, the facility failed to ensure physician orders and dietitian recommendations were implemented to address weight changes. This affected one (#21) of two residents reviewed for nutrition. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease, type II diabetes mellitus, and nutritional deficiency.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had intact cognition and required setup and clean-up assistance for eating.</p> <p>Review of Resident #21's weight history revealed weights were obtained on 03/05/24, 04/04/24, 04/26/24, 05/02/24, and 06/03/24. No significant weight loss or trend occurred between 03/05/24 and 06/03/24.</p> <p>Review of a nutrition progress note dated 04/16/24 revealed Dietetic Technician (DT) #261 recommended weekly weights for four weeks and a nutritional supplement twice daily due to decreased meal intake putting Resident #21 at risk for malnutrition.</p> <p>Review of a provider note dated 04/22/24 revealed Resident #21 had a decline over the past few days and was no longer able to feed herself. Resident #21 seemed very weak and fatigued and would be sent to the emergency room for a proper workup.</p> <p>Review of a hospital history and physical dated 04/22/24 revealed Resident #21 was admitted to the hospital on 04/22/24 for hyponatremia (low sodium in the blood). Additionally, the record revealed Resident #21 was noted to have hyponatremia and hypokalemia (low potassium in the blood) due to poor oral intake.</p> <p>Review of a progress note dated 04/26/24 revealed Resident #21 returned from the hospital with a significant weight gain, the physician was notified who ordered weekly weights for four weeks.</p> <p>Review of a provider's progress note/readmission assessment after Resident #21's hospitalization, dated 04/30/24, revealed Resident #21 had been fasting for [NAME] and could not eat at proper times.</p> <p>Review of a nutrition progress note dated 06/17/24 revealed a recommendation for Ensure Plus nutrition supplement for Resident #21.</p> <p>Review of the current and discontinued orders for Resident #21 revealed no orders for a nutrition supplement in April 2024, no orders for weekly weights in April 2024, and no order for Ensure Plus or equivalent nutritional supplement in June 2024.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/11/24 at 7:48 A.M. with the Director of Nursing (DON) confirmed the nutrition supplements were not ordered for Resident #21 per the recommendations on 04/16/24 or 06/17/24. Additionally, the DON confirmed the weekly weight orders were not completed as requested by the DT #261 on 04/16/24 or by the physician on 04/26/24.</p> <p>Interview on 07/15/24 at approximately 8:15 A.M. with Corporate Registered Nurse (RN) #260 confirmed recommendations from the consulted dietetic technician should be implemented.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to ensure physician orders for oxygen administration were in place prior to administering oxygen to residents. This affected two (#26 and #33) of two residents reviewed for oxygen administration. The facility census was 67.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses of chronic respiratory failure with hypoxia and asthma.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had intact cognition.</p> <p>Review of the medical record for Resident #26 revealed she discharged to the hospital on 03/17/24 and returned to the facility on [DATE].</p> <p>Review of the physician orders on 07/08/24 at 1:30 P.M. revealed no current order for oxygen via nasal cannula. Further review revealed a physician order dated 06/09/23 and discontinued on 03/17/24 for continuous three liters of oxygen via nasal cannula.</p> <p>Observation on 07/08/24 at 10:52 A.M. revealed Resident #26 was lying in bed wearing a nasal cannula and receiving oxygen at five liters per minute. Continued observation revealed Central Supply Staff #165 entered the room to exchange Resident #26's oxygen tubing and nasal cannula.</p> <p>Interview on 07/08/24 at 10:54 A.M. with Central Supply Staff #165 confirmed Resident #26 was receiving oxygen via nasal cannula at five liters per minute.</p> <p>Review of the electronic medical record and concurrent interview with Licensed Practical Nurse (LPN) #224 on 07/08/24 at 1:32 P.M. confirmed Resident #26 did not have a current physician order for oxygen.</p> <p>Interview on 07/08/24 at approximately 3:00 P.M. with the Director of Nursing (DON) confirmed she updated Resident #26's physician orders to include an order for oxygen at five liters per minute via nasal cannula continuously. The DON stated Resident #26 had always been on oxygen and the order was not resumed after her last hospitalization .</p> <p>Interview on 07/11/24 at 7:48 A.M. with the DON confirmed Resident #26 had no physician order for oxygen administration since her return to the facility on [DATE] until an order was entered on 07/08/24.</p> <p>2. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease and chronic respiratory failure.</p> <p>Review of the comprehensive admission MDS dated [DATE] revealed Resident #33 had intact cognition.</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 provider progress note dated 05/20/24 revealed Resident #33 required oxygen via nasal cannula and was receiving oxygen at the time of the provider's visit.</p> <p>Review of the admission nursing observation dated 05/18/24 revealed Resident #33 received oxygen therapy at three liters per minute via nasal cannula.</p> <p>Review of the physician orders on 07/08/24 at 2:40 P.M. revealed no current order for oxygen administration.</p> <p>Observation of Resident #33 and concurrent interview with LPN #223 on 07/08/24 at 2:42 P.M. confirmed Resident #33 was receiving oxygen via nasal cannula at four liters per minute.</p> <p>Continued interview and concurrent review of the electronic medical record on 07/08/24 at 2:44 P.M. with LPN #223 confirmed Resident #33 did not have a physician order for oxygen administration.</p> <p>Follow-up interview on 07/08/24 at 2:50 P.M. with LPN #223 revealed she called the physician and obtained an order for Resident #33 to receive oxygen at three liters per minute.</p> <p>Interview on 07/11/24 at 7:48 A.M. with the DON confirmed Resident #33 had no physician order for oxygen administration since his admission 05/16/24 until an order was entered on 07/08/24.</p> <p>Review of the policy titled, Oxygen Administration, revised October 2010, revealed a physician's order for oxygen should be verified prior to providing oxygen.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>45751</p> <p>Based on review of personnel files, staff interview, review of the employee handbook, and review of facility policy, the facility failed to ensure state tested nurse aides (STNAs) received twelve hours of training annually and performance reviews were completed at least once every 12 months. This had the potential to affect all 67 residents in the facility. The census was 67.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the personnel file for STNA #113 revealed a hire date of 02/09/23 and had seven hours of annual training.</li> <li>2. Review of the personnel file for STNA #116 revealed a hire date of 08/02/22 and had seven hours of annual training. The personnel file was absent of a performance evaluation.</li> <li>3. Review of the personnel file for STNA #119 revealed a hire date of 02/21/23 and had five hours of annual training. STNA #119 had a performance evaluation completed on 06/17/24.</li> </ol> <p>Interview on 07/11/24 at 2:12 P.M. with Human Resource Director (HRD) #160 verified STNA #113, STNA #116, and STNA #119 did not have the required twelve hours of annual training, and verified STNA #116 and STNA #119 did not have annual performance reviews completed within required timeframes.</p> <p>Review of the Employee Handbook, dated January 2021, revealed the job description forms the bases of each employee's annual performance evaluation to review job performance. Employees will also be evaluated following their introductory/probationary period. An employee that provides direct patient care will be required to have at a minimum an annual skills evaluation and competency check.</p> <p>Review of the policy titled, Nurse Aide In-Service Training Program, revised October 2017, revealed all nurse aide personnel shall participate in regularly scheduled in-service training classes. The annual in-service must be no less than 12 hours per employment year. In addition, the facility will complete a performance review of nurse aides at least every twelve months. In-service training will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31638</p> <p>Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure medications were administered with a physician's order and were available for administration. This affected two (#55 and #175) of six residents reviewed for medications. The census was 67.</p> <p>Findings include:</p> <p>1. Review of Resident #55's medical record revealed an admitted [DATE]. Diagnoses included human immunodeficiency virus (HIV) and bacteremia.</p> <p>Review of Resident #55's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident did not receive as needed pain medication.</p> <p>Review of Resident #55's care plan revealed the resident was at risk for alteration in comfort and was to be administered medications as ordered.</p> <p>Review of Resident #55's nursing progress note dated 02/04/24 revealed the resident complained of leg pain which was rated a seven on a 10-point pain scale with 10 indicating the highest pain level. On examination the leg was red and swollen and the resident was given the pain medication Tylenol.</p> <p>Review of Resident #55's medication administration record (MAR) dated February 2024 revealed there was no documentation of Tylenol being administered.</p> <p>Review of Resident #55's medical records revealed the chart was absent of a physician order for Tylenol.</p> <p>Interview with the Director of Nursing (DON) and Corporate Registered Nurse #260 on 07/15/24 at 1:25 P.M. verified Resident #55 was administered Tylenol without a physician's order.</p> <p>2. Review of Resident #175's medical record revealed an admitted [DATE]. Diagnoses included diabetes mellitus, a cutaneous abscess of the left foot, hyperlipidemia, hypertension, and depression.</p> <p>Review of Resident #175's admission MDS assessment dated [DATE] revealed the resident had a high cognitive function.</p> <p>Review of Resident #175's nursing progress note dated 04/26/24 revealed the resident was alert, oriented, verbally responsive, and could make her needs known. She had a peripherally inserted central catheter (PICC) on her left upper arm and received vancomycin (antibiotic) intravenously. She was also on Flagyl (antibiotic).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #175's admission orders dated 04/27/24 revealed Lisinopril five (5) milligrams (mg) was to be administered by mouth one time a day for hypertension, Zoloft (serotonin reuptake inhibitor) 50 mg was to be administered by mouth one time a day for depression, Synthroid (hormone) 50 micrograms (mcg) was to be administered one time a day for hypothyroidism, Flagyl 500 mg was order to be given by mouth every eight hours for an infection until 05/17/24, and vancomycin intravenous (IV) solution 1000 mg IV was to be administered three times a day for Methicillin resistant Staphylococcus aureus (MRSA).</p> <p>Review of Resident #175's progress note dated 04/27/24 at 4:34 P.M. revealed Flagyl 500 mg was not administered due to the medication not being delivered.</p> <p>Review of Resident #175's progress note dated 04/27/24 at 4:35 P.M. revealed Lisinopril 5 mg and Synthroid 50 mg were not administered because the medications were not delivered.</p> <p>Review of Resident #175's progress note dated 04/27/24 at 9:33 A.M., 2:32 P.M. and 4:35 P.M., and on 04/28/24 at 8:03 A.M. revealed vancomycin IV solution was not administered due to the medication not being delivered.</p> <p>Review of Resident #175's medication administration record (MAR) dated April 2024 revealed the medications failed to be administered on the above dates.</p> <p>Interview with the Director of Nursing (DON) on 07/10/24 at 10:04 A.M. verified Resident #175's medications were not available timely and doses were missed.</p> <p>Review of the facility policy titled, Administering Medications, dated April 2019, revealed medications are administered in accordance with prescriber orders, including required time frame.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154935.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45751</p> <p>Based on medical record review, staff interview, and facility policy the facility failed to ensure pharmacy recommendations were timely reviewed and implemented. This affected two (#14 and #17) of five residents reviewed for unnecessary medications. The facility census was 67.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included type two diabetes mellitus with diabetic neuropathy, atherosclerotic heart disease of native coronary artery, heart failure, major depressive disorder, acquired absence of the right leg above the knee, chronic atrial fibrillation, and essential (primary) hypertension.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact.</p> <p>Review of Resident #14's pharmacy medication regimen review dated 10/22/23 revealed an order clarification request for the anticoagulant Eliquis tablet 2.5 milligram (mg) with instructions to give one tablet by mouth one time a day for atrial fibrillation and to monitor for signs and symptoms of bleeding. The pharmacy recommendations revealed Eliquis was dosed twice daily in all indications including renal dose adjustments and questioned if it was correct and if it should be changed to twice daily. The physician reviewed the recommendation on 12/12/23 and agreed with the recommendation indicating to increase the medication to twice daily. The pharmacy recommendation also addressed a current order for hemorrhoidal cream with instructions to clarify the frequency of the as needed orders.</p> <p>Review of Resident #14's physician order dated 12/29/20 revealed an order for Eliquis tablet 2.5 mg with instructions to give one tablet by mouth one time a day for atrial fibrillation.</p> <p>Review of Resident #14's physician order dated 01/04/24 revealed an order for Eliquis tablet 2.5 mg with instructions to give one tablet by mouth two times a day for atrial fibrillation.</p> <p>Review of Resident #14's physician order dated 10/19/20 revealed an order for hemorrhoidal cream with instructions to apply to rectum topically as needed for hemorrhoids.</p> <p>Review of Resident #14's physician order dated 01/08/24 revealed an order for hemorrhoidal cream with instructions to apply to the rectum topically as needed twice daily as needed.</p> <p>Interview on 07/10/24 at 3:36 P.M. with the Director of Nursing (DON) verified Resident #14's pharmacy recommendation for changes and clarification of physician orders for Eliquis and hemorrhoidal cream were not timely implemented.</p> <p>2. Review of the medical record revealed Resident #17 was admitted on [DATE]. Diagnoses included other sequelae of cerebral infarction, chronic combined systolic and diastolic heart failure, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder recurrent, and schizoaffective disorder.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS assessment dated [DATE] revealed Resident #17 was cognitively intact.</p> <p>Review of Resident #17's medication regimen review dated 06/13/23 revealed a review of an order for the pain medication tramadol 50 mg and recommended to consider adding an order for the pain medication acetaminophen as needed to be used for less severe pain. The physician responded on 07/12/23 and agreed with orders for tramadol 50 mg and recommended to consider adding an order for the pain medication acetaminophen as needed to be used for less severe pain.</p> <p>Review of Resident #17's physician order dated 11/15/23 revealed an order for acetaminophen tablet 325 mg with instructions to give two tablets by mouth every four hours as needed for general discomfort not to exceed three grams in 24 hours from all sources.</p> <p>Review of Resident #17's medical regimen review dated 12/18/23 revealed a gradual dose reduction attempt for the antidepressant duloxetine hydrochloride 30 mg with instructions to give three capsules by mouth one time a day for depression. The pharmacy recommendation asked if a dose deduction could be attempted. There was no physician response. In addition, a gradual dose reduction attempt was recommended for risperidone tablet 0.5 mg with instructions to give one tablet by mouth in the morning for schizoaffective disorder. The pharmacy recommendation asked if a dose reduction could be attempted at this time. There was no physician response</p> <p>Review of Resident #17's physician orders dated 12/23/20 through current revealed an order for duloxetine hydrochloride 30 mg with instructions to give three capsules by mouth one time a day for depression</p> <p>Interview on 07/10/24 at 3:36 P.M. with the Director of Nursing (DON) verified the physician order for the gradual dose reduction of risperidone and the order for acetaminophen were not implemented timely. The DON verified the gradual dose reductions recommended on 12/18/23 did not have a physician response or change in order.</p> <p>Review of a policy for drug regimen review, 2022 edition, revealed the physician provides a written response of the report to the facility within one month after the report is sent.</p> <p>Review of policy for physician services, revised April 2013, revealed physician orders and progress notes shall be maintained in accordance with current regulations and facility policy.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528</b></p> <p>Based on medical record review and staff interview, the facility failed to ensure physician orders for gradual dose reductions of psychotropic medications implemented in a timely manner. This affected one (#17) of five residents reviewed for unnecessary medications. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #17 was admitted on [DATE]. Diagnoses included other sequelae of cerebral infarction, chronic combined systolic and diastolic heart failure, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder recurrent, and schizoaffective disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively intact.</p> <p>Review of Resident #17's medication regimen review dated 06/13/23 revealed a gradual dose reduction for the antipsychotic risperidone tablet 0.5 milligram (mg) with instructions to give one tablet by mouth in the morning for schizoaffective and an order for risperidone one (1) mg tablet give one tablet by mouth at bedtime for schizoaffective disorder. The recommendation questioned if a reduction could be attempted on the medication. The physician responded on 07/12/23 and agreed with a gradual dose reduction writing to decrease the bedtime dose to 0.5 mg.</p> <p>Review of Resident #17's physician order started 12/27/22 and discontinued 11/15/23 revealed an order for risperidone tablet 1 mg at bedtime.</p> <p>Review of Resident #17's physician order dated 11/15/23 revealed an order for risperidone tablet 1 mg with instructions to give 0.5 mg at bedtime.</p> <p>Interview on 07/10/24 at 3:36 P.M. with the Director of Nursing (DON) verified the physician order for the gradual dose reduction of risperidone was not implemented timely.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31638</p> <p>Based on observation, staff interview, and policy review, the facility failed to store medications in a safe and sanitary manner and failed to ensure medications were not able to be used after expiration dates. This had the ability to affect all 67 residents residing in the facility. The facility census was 67.</p> <p>Findings Included:</p> <p>1. Observation of the South hall medication refrigerator on [DATE] at 8:59 A.M. with Licensed Practical Nurse (LPN) #250 revealed the refrigerator contained a brown liquid substance on the bottom shelf. Located on that shelf, soaked in brown liquid, was an expired vial of influenza vaccine. The expiration dated was [DATE].</p> <p>Interview with LPN #250 on [DATE] at 9:04 A.M. verified the refrigerator contained a brown liquid substance and contained expired influenza vaccine.</p> <p>2. Inspection of the North medication storage refrigerator on [DATE] at 9:19 A.M. with LPN #226 revealed a bottle of the neurotransmitter epinephrine was found with an expiration date of [DATE].</p> <p>Interview with LPN #226 on [DATE] at 9:23 A.M. verified the expired epinephrine in the North medication refrigerator.</p> <p>Review of the facility policy titled, Medication Storage in the Facility, dated 2022, revealed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists. Medication storage areas are to be kept clean, well lit, and free of clutter.</p>

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NAME OF PROVIDER OR SUPPLIER  Ayden Healthcare of Toledo		STREET ADDRESS, CITY, STATE, ZIP CODE 4293 Monroe St Toledo, OH 43606	

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45751</p> <p>Based on medical record review and staff interview, the facility failed to ensure consulted wound care specialist laboratory orders were completed. This affected one (#175) of three residents reviewed for wounds. The facility census was 67.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #175 revealed an admitted [DATE] and a discharge date to home on 06/13/24. Diagnoses included type II diabetes mellitus and cutaneous abscess of the left foot.</p> <p>Review of the comprehensive admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #175 had intact cognition and displayed no rejection of care. Resident #175 required substantial /maximal assistance for toileting. Further review revealed Resident #175 had an infection of a diabetic foot ulcer, a surgical wound, and moisture associated skin damage.</p> <p>Review of a consultant wound care physician progress note dated 05/07/24 revealed orders for laboratory testing, complete blood count, basic metabolic panel, c-reactive protein, and vancomycin trough on Mondays and laboratory testing of blood urea nitrogen/creatinine and vancomycin trough on Thursdays.</p> <p>Interview on 07/15/24 at approximately 11:00 A.M. with Corporate Regional Nurse (RN) #260 confirmed the facility did not complete the laboratory tests as ordered by the consultant wound care physician on 05/20/24, 05/27/24, 05/30/24, 06/03/24, 06/06/24, and 06/10/24. Further interview with Corporate RN #260 confirmed consultant physician orders should be implemented.</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>45751</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure the refrigerators at the nurses stations for resident food was kept clean and food labeled and dated. This has the potential to affect all 67 residents residing in the facility. The facility census was 67.</p> <p>Findings include:</p> <p>1. Observation on 07/15/24 at 8:20 A.M. of the refrigerator in the North nurse's station revealed seven sandwiches in plastic wrap not dated and one baggy of lettuce, tomato, meat, and onion that appeared to be watered down with soggy and was not dated. There was also one carton of oat milk that was not labeled or dated.</p> <p>Interview on 07/15/24 at 8:23 A.M. with Unit Manager (UM) #109 verified the seven sandwiches were not dated and the baggy with lettuce, tomato, meat, and onions was not dated. UM #109 stated the food in the resident refrigerators should be dated.</p> <p>2. Observation of the refrigerator in the South nurse's station on 07/15/24 at approximately 8:30 A.M. revealed six sandwiches wrapped in plastic wrap, one bowl of chili, and two take out bags containing Chinese food all undated with no labels to indicate which resident the food belonged to. The freezer portion of the refrigerator had a towel lying in the bottom of the freezer with a brown substance on it. The refrigerator had a foul odor when the door was opened.</p> <p>Interview on 07/15/24 8:31 A.M. with UM #245 verified the six sandwiches were not dated in the South refrigerator for residents and the Chinese food and chili was not labeled or dated. UM #245 verified there was a foul odor coming from the refrigerator.</p> <p>Review of a policy titled, Foods Brought by Family/Visitors, dated October 2017, revealed perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the residents name, the item, and the use by date.</p> <p>44815</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>31638</p> <p>Based on medical record review, resident interview, staff interview, and review of a facility policy, the facility failed to keep accurate medical records. This affected one (#56) of 26 resident's medical records reviewed. The facility census was 67.</p> <p>Findings include:</p> <p>Review of Resident #56's medical record revealed an order dated 06/03/24 for the resident to obtain a Velcro wrist brace/splint to the left wrist/hand for comfort.</p> <p>Interview with Resident #56 on 07/08/24 at 9:56 A.M. revealed she was ordered a brace/splint for her left hand due to arthritis, but it was uncomfortable so she refused to wear the brace. Observation revealed the brace was in a drawer in the bedside table.</p> <p>Interview with Licensed Practical Nurse (LPN) #215 on 07/09/24 at 2:08 P.M. revealed Resident #56 had her splint in place to the left hand. The resident had a gauze bandage on her right hand from surgery. LPN #215 stated she was confused with the surgery bandage and splint, and LPN #215 stated she had been signing off that the splint was in place when it was not including on 07/09/24.</p> <p>Review of Resident #56's treatment administration record (TAR) for July 2024 revealed the Velcro wrist brace/splint to the left wrist/hand was signed off as being in place on on 07/09/24 at rising.</p> <p>Review of the facility policy titled, Charting and Documentation, dated July 2017, revealed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p> <p>44815</p> <p>45751</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure antibiotic stewardship was practiced when treating residents with urinary tract infections (UTIs). This affected three (#12, #18, and #50) of three residents reviewed for UTIs. The facility census was 67.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and morbid obesity.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had intact cognition, was frequently incontinent of bladder, and required partial/moderate assistance for toileting hygiene.</p> <p>Review of the June 2024 medication administration record (MAR) revealed Resident #12 received cephalexin (antibiotic) capsule 500 milligrams (mg) with instructions to give one capsule by mouth three times a day for infection, presumed UTI for seven days until finished. Further review revealed Resident #12 received cephalexin from 06/14/24 through 06/20/24.</p> <p>Review of the urinalysis laboratory result dated 06/18/24 revealed Resident #12 had few bacteria in her urine.</p> <p>Interview on 07/15/24 at 10:26 A.M. with the Director of Nursing (DON) confirmed no culture of the bacteria or sensitivity testing was completed for Resident #12 to determine what type of infectious agent was present or what type of antibiotic was appropriate to treat it. Additionally, the DON confirmed the urine was not collected until four days after the antibiotic treatment started.</p> <p>2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses of rhabdomyolysis and obstructive and reflux uropathy.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #18 had intact cognition, had an indwelling catheter, and required substantial/maximal assistance for toileting hygiene.</p> <p>Review of the urinalysis laboratory results dated [DATE] revealed Resident #18 had few bacteria in his urine.</p> <p>Review of the June 2024 MAR revealed Resident #18 received Keflex (antibiotic) oral capsule 500 mg one capsule by mouth four times daily for UTI for seven days from 06/17/24 through 06/24/24.</p> <p>Interview on 07/15/24 at 10:26 A.M. with the DON confirmed no culture or sensitivity testing was completed to determine what type of infectious agent was present or what type of antibiotic was appropriate to treat Resident #18's UTI.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses of anxiety and fibromyalgia.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 had slightly impaired cognition, was frequently incontinent of bladder and required substantial/maximal assistance for toileting hygiene.</p> <p>Review of the urinalysis laboratory results dated [DATE] revealed Resident #18 had moderate bacteria in her urine.</p> <p>Review of the June 2024 MAR revealed Resident #50 received Keflex oral capsule 500 mg one capsule by mouth four times daily for UTI for 10 days from 06/20/24 through 06/30/24.</p> <p>Interview on 07/15/24 at 10:26 A.M. with the DON revealed no culture or sensitivity testing was completed for Resident #50 to determine what type of infectious agent was present in the urinalysis completed 06/18/24 or what type of antibiotic was appropriate to treat it.</p> <p>Review of an email dated 07/17/24 at 2:21 P.M. from the DON revealed the symptoms indicating a UTI for Resident #12, Resident #18, and Resident #50 were dysuria (pain with urination).</p> <p>The facility could provide no evidence cultures or sensitivity were ordered for Resident #12, Resident #18, or Resident #50 prior to initiating an antibiotic.</p> <p>Review of the policy titled, Infection Prevention and Control Program, dated June 2021, revealed the facility would implement McGeer criteria or the National Healthcare Safety Network (NHSN) criteria when defining infections.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on medical record review, review of immunization records, staff interview, review of policy, and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure residents were offered pneumococcal and influenza vaccinations per CDC recommendations. This affected two (#14 and #30) of five residents reviewed for influenza and pneumococcal vaccinations. The facility census was 67.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included type two diabetes mellitus and heart disease.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact.</p> <p>Interview on 07/15/24 at approximately 9:00 A.M. with the Director of Nursing (DON) revealed the facility could provide no documentation to verify Resident #14 was offered the pneumococcal vaccine.</p> <p>2. Review of the medical record revealed Resident #30 was admitted on [DATE]. Diagnoses included schizophrenia and depression.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #30 was cognitively intact.</p> <p>Review of the medical record revealed Resident #30 last received the influenza vaccine on 10/07/22 and refused the pneumococcal vaccine.</p> <p>Review of the nursing progress note dated 04/18/24 revealed the facility attempted to contact Resident #30's responsible party regarding immunizations needed.</p> <p>Interview on 07/15/24 at approximately 11:00 A.M. with the DON revealed there was no further documented refusals or attempts to provide Resident #30 the influenza or pneumococcal vaccines.</p> <p>Review of the policy titled, Influenza Vaccine, revised October 2019, revealed the influenza vaccine shall be offered to residents between October 1st and March 31st each year.</p> <p>Review of the policy titled, Pneumococcal Vaccine, revised October 2019, revealed all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.</p> <p>Review of the policy titled, Vaccination of Residents, revised 2019, revealed all residents will be offered vaccines that aid in preventing infectious disease. Refusal of vaccines shall be documented in the medical record.</p> <p>(continued on next page)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of CDC guidance titled, Pneumococcal Vaccination: Summary of Who and When to Vaccinate, reviewed 09/22/23 and located at <a href="https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html">https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html</a>, revealed the CDC recommended pneumococcal vaccination for all adults over 65. For adults over 65 who had not previously received any pneumococcal vaccine, the CDC recommended on dose of PCV15 or PCV20. If PCV15 was used, follow up with one dose of PPSV23 at least one year later. For adults 65 or older who previously received a dose of PPSV23, the CDC recommended a follow up dose of PCV15 or PCV20 at least one year after the most recent dose of PPSV23. Lastly, for adults 65 or older who previously received a dose of PCV13, the CDC recommended a follow up dose of PCV20 or PPSV23 at least one year after receiving PCV13.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44815</p> <p>Based on medical record review, review of immunization records, staff interview, review of a policy, and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure COVID-19 vaccinations were offered per CDC recommendations. This affected two (#14 and #30) of five residents reviewed for COVID-19 vaccinations. The facility census was 67.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included type two diabetes mellitus and heart disease.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident #14 was cognitively intact.</p> <p>Review of the immunization record revealed Resident #14 last received the COVID-19 vaccine on 08/11/22.</p> <p>Interview on 07/11/24 at 3:42 P.M. with the Director of Nursing (DON) revealed there was no further documented refusals or attempts to provide Resident #14 the COVID-19 vaccination booster.</p> <p>2. Review of the medical record revealed Resident #30 was admitted on [DATE]. Diagnoses included schizophrenia and depression.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #14 was cognitively intact.</p> <p>Review of the medical record revealed Resident #30 did not have documentation of the COVID-19 vaccine booster.</p> <p>Review of the nursing progress note dated 04/18/24 revealed the facility attempted to contact the responsible party regarding immunizations needed.</p> <p>Interview on 07/11/24 at 3:42 P.M. with the DON revealed there were no further documented refusals or attempts to provide Resident #30 the COVID-19 vaccine booster.</p> <p>Review of the policy titled, Vaccination of Residents, revised 2019, revealed all residents will be offered vaccines that aid in preventing infectious disease. Refusal of vaccines shall be documented in the medical record.</p> <p>Review of CDC guidance titled, Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States, updated 04/04/24 and located at <a href="https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html">https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html</a>, revealed the CDC recommended special situations for people ages 65 and older include to receive one additional dose of any updated (2023-2024 formula) COVID-19 vaccine.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31638</p> <p>Based on observation, staff interview, and policy review, the facility failed to maintain a safe and homelike environment. This had the potential to affect all 67 residents residing in the facility. The facility census was 67.</p> <p>Findings Included:</p> <p>1. Observation on 07/10/24 at 2:28 P.M. revealed water was running out of the fire dampers from the ceiling onto the floor in the South halls of the facility. Buckets and wet floor signs were in place on four of the areas, but three additional areas had water sitting on the floor.</p> <p>Interview with Maintenance Assistant (MA) #162 on 07/10/24 at 2:30 P.M. revealed the rain water was coming down the vents from the duct work. MA #162 also confirmed the fire dampers contained a black substance on them.</p> <p>Interview with Maintenance Supervisor (MS) #163 on 07/10/24 at 3:03 P.M. revealed the water was coming in through the fire dampers from the roof. MS #163 stated she had been caulking them, but it was not containing the issue. MS #163 also stated it was not connected to the heating, ventilating, and air conditioning (HVAC) system.</p> <p>Tour of the facility on 07/11/24 at 1:36 P.M. with MS #163 revealed the the hallway fire dampers contained a black substance outside of room [ROOM NUMBER] and room [ROOM NUMBER].</p> <p>2. Observation of the bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] revealed the wall contained a large portion (approximately 12 inches long by eight (8) inches wide) of wall paper missing with broken drywall exposed.</p> <p>Tour with MS #163 on 07/11/24 at 1:36 P.M. verified the bathroom wall was in need of repair.</p> <p>Review of the facility policy titled, Quality of Life - Homelike Environment, dated May 2017, revealed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect personalized, homelike setting. These characteristics include clean, sanitary, and orderly environment.</p>