STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365924	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amherst Manor Nursing Home	175 N Lake Street Amherst, OH 44001

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on record review, staff interview, and policy review, the facility failed to ensure accurate weights were obtained for Resident #34. This affected one resident (#34) of one resident reviewed for nutrition. The facility census 105. Findings include: Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including adenovirus, atrial fibrillation and muscle weakness. Review of Resident #34's most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #34 was severely cognitively impaired and required extensive assistance of one staff person for completing her activities of daily living. Review of the weight record for Resident #34 revealed a documented weight of 126 pounds on 02/13/25 and a weight of 116 pounds on 02/14/25 indicating a weight loss of 7.94 percent (%). Review of both the electronic and hard chart reveled no documented evidence to suggest such a weight change over a 24-hour period noted in Resident #34 chart was present. No evidence of re-weight was noted in either chart. Interview with Registered Dietician (RD) #799 on 03/06/25 at 11:00 AM, verified that Resident #34's weights for 2/13/25 and 2/14/25 were inaccurate and he was unaware of the weight discrepancy. Review of the policy dated 08/01/29 revealed it is the policy of (the facilities corporation) to ensure weight are obtained as ordered and are monitored appropriately. The policy further noted that re-weights will be obtained to verify weights.

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on record review, staff interview, review of Centers for Disease Control (CDC) recommendation and review of manufacturers instructions the facility failed to ensure necessary respiratory equipment was utilized in a manner to provide maximum efficiency and benefit to the resident. The affected one (Resident #77) of two residents identified by the facility as requiring a bilevel positive airway pressure (bipap) machine while sleeping to address sleep apnea and other similar and related conditions. The facility census was 105. Findings include: Review of the medical record for Resident #77 revealed Resident #77 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, obstructive sleep apnea, and type two diabetes. Review of the Minnimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 was cognitively intact and required extensive assistance of one staff person for completing his activities of daily living Review of the current physicians orders for the month of March 2025 revealed Resident #77 required the use of a bipap (a non-invasive ventilation system through which positive airway pressure is delivered and assists with breathing) machine to address Resident #77's diagnosis of sleep apnea (condition in which an individual intermittently stops and starts breathing during sleep). Observation of the Resident #77's room on 03/05/25 at 3:45 P.M. revealed Resident #77's bipap machine was plugged in with a gallon of spring water next to it that was 75% full. An interview on 03/05/25 at 3:45 P.M. with Licensed Practical Nurse (LPN) #479 verified that Resident #77's bipap machine contained spring water rather than distilled water as recommended. Review of the manufacturers instructions dated 04/2020 for the bipap machine utilized by Resident #77 revealed the machine called for water to be added to the machine for humidification. The humidifier assisted with reducing nasal dryness and irritation by adding moisture to the airflow. The instructions included distilled water is recommended. Review of the Centers for Disease Control webpage entitled Preventing Waterborne Germs at Home dated 03/15/24 revealed bipap machines should use distilled or sterilized water in the humidifier.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 38091 Based on observation and staff interview the facility failed to ensure its dumpster area was maintained in a clean and sanitary condition. This had the potential to affect all residents. The facility census was 105. Findings include: Observation of the dumpster area with Dietary Manager (DM) #700 on 03/03/25 between 8:30 A.M. and 8:45 A.M. revealed an industrial sized dumpster and a small approximately one yard deep dumpster next to it. The industrial sized dumpster was approximately 60 percent full with its top lid and side door open. The small dumpster was noted to overflowing with multiple bags of trash piled approximately four feet high. Multiple bags of trash were also noted around the small dumpster on the ground. Interview on 03/03/25 at 8:45 A.M. with DM #700 verified the above findings at the time of observation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38523 Based on observation, interview, policy review, and review of Centers for Disease Control (CDC) recommendations, the facility failed to ensure appropriate hand hygiene was performed during meal tray distribution. This affected nine residents (#2, #13, #16, #38, #71, #73, #74, #90 and #101) out of nine residents observed for dining on the second floor. The facility census was 105. Findings include: Observation on 03/03/25 at 11:27 A.M. revealed Certified Nursing Assistant (CNA) #657 began to distribute meal trays on the second floor. CNA #657 was not observed cleansing her hands before pushing the food cart from the nurse's station area to the first resident's room. CNA #657 went into Resident #2's room and grabbed a used, facility-provided coffee cup, took it out of the room and put it on top of the food cart before she returned to the meal tray cart without having cleansed her hands. CNA #657 then took a meal tray from the food cart and carried it into Resident #2 and put it on Resident #2's bedside table. CNA #657 proceeded to take a meal tray and a cup of coffee into Resident #101's room. CNA #657 removed personal items off the resident's bedside table before placing the meal tray on it. CNA #657 exited the room, was not observed to cleanse her hands, and proceeded to retrieve a meal tray for Resident #74. CNA #657 proceeded into Resident #74's room, placed the tray on the resident's bedside table, before exiting the room. CNA #657 was not observed to cleanse her hands. CNA #657 retrieved Resident #38's meal tray, entered the resident's room, and placed the meal tray down on the resident's bedside table. CNA #657 exited the resident's room, did not cleanse her hand, and returned to the meal cart, where she retrieved Resident #73's tray. She entered Resident #73's room, moved a used coffee cup out of the way, before placing the meal tray on Resident #73's table. CNA #657 exited the room, still did not cleanse her hands, and retrieved the meal tray for Resident #13. CNA #657 entered Resident #13's room, moved personal items off of the resident's bedside table, before placing the tray down. CNA #657 handled a used cup, the resident's television remote, and elevated the resident's head of the bed before uncovering all the food items on the resident's meal tray. CNA #657 proceeded to provide a few bites of the resident's chocolate pudding and pureed vegetable to Resident #13 before exiting the room. CNA #657 did not wash her hands before returning to the meal cart. CNA #657 obtained a meal tray and a cup of coffee and took it to Resident #16's room. After dropping off the tray, she left Resident #16's room, retrieved another meal tray and a cup of hot water, and took it into Resident #90's room without performing hand hygiene. CNA #657 set the tray down, moved a used cup, opened all the residents' containers, and placed a tea bag in the cup of hot water. CNA #657 left the room, did not wash her hands, and proceeded to obtain Resident #71's tray. After providing the tray to Resident #71, CNA #657 opened all containers and moved the bedside table closer to Resident #71, who was sitting in her recliner. After delivering the tray to Resident #71, CNA #657 used alcohol-based hand sanitizer to cleanse her hands for the first time during the observation. An interview on 03/03/25 at 11:37 A.M. with CNA #657 confirmed she did not cleanse her hands between meal tray distribution to the above residents and should have. Review of the facility policy, Infection Control Program dated 10/22 revealed the facility has an infection control program designed to help prevent the development and transmission of disease and infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Disease Control (CDC) website page titled Clinical Safety: Hand Hygiene for Healthcare Workers revised 02/27/24, revealed hand hygiene is important to protect yourself and your patients from deadly germs by cleaning your hands. Hand hygiene refers to handwashing with soap and water or by using an antiseptic hand rub (alcohol-based foam or gel hand sanitizer). Hand hygiene should be completed immediately before touching a patient, after touching a patient or patient's surroundings, and after contact with contaminated surfaces.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. 38091 Based on observation, record review, and staff interview, the facility failed to develop and implement a smoking policy in accordance with federal, state and local laws and regulations in regards to smoking, smoking areas, and smoking safety for both smoking and non-smoking residents and staff. This had the potential to affect all residents. The facility census was 105. Findings include: 1. On 03/05/25 at 10:10 A.M., tour of the facility with Director of Maintenance (DM) #479 noted improperly discarded smoking materials on and around the second-floor patio near the nurse's station. Five cigarette butts were observed on the cement patio around a metal chair and table sitting in the corner near the door. Additionally, numerous cigarette butts were noted in gutter intermixed with leaves and within proximity to the asphalt roof shingles. Interview with the DM #479 verified the above findings at the time of observation. 2. Observation of the front of the building on 03/05/25 at 11:30 A.M. revealed a resident from the facility's attached residential care facility (RCF) was seated in her walker with a friend outside on a common sidewalk. Both the resident and friend were observed smoking and were witnessed discarding their used cigarettes onto the ground. Interview on 03/05/25 at 11:35 A.M. with Receptionist #925 verified the individuals were outside smoking in a non permitted area. 3. Observation on 03/05/25 at 2:00 P.M., during a second tour of the facility with DM #479, five cigarette butts were observed laying on the ground near the main entry to the facility. A no smoking sign was observed posted and clearly visible in the same area. No ashtrays, or metal cans with self-closing covers were observed during the survey. Interview with the DM #479 verified the above findings at the time of observation. Review of the policy entitled Non-smoking Policy dated 03/01/22 revealed smoking is not permitted for anyone, anywhere in the building, and/or on the campus.