STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365928	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Court House Manor	555 North Glenn Ave Washington Court Hou, OH 43160

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on medical record review, staff interview, physician interview, and hospital record review, the facility failed to provide treatment and care in accordance with professional standards of practice when they failed to monitor Resident #2 who was on Eliquis (an anticoagulant medication) and had a decreasing hemoglobin and did not complete a Physician recommended complete blood count (CBC) lab test. This resulted in harm when Resident #2 had bloody tarry stool and was admitted to the hospital for three days with a hemoglobin lab value (a test to detect anemia with a normal range of 11.5 to 15.4 g/dl) of 4.5 grams per dececiliter (g/dl) upon hospital admission. Resident #2 had to receive three units of packed red blood cells and was found to have a gastric ulcer that required clamping. This affected one (Resident #2) of three residents reviewed on anticoagulant medication. The facility census was 88. Findings include: Record review of Resident #2 revealed an admitted [DATE] with pertinent diagnoses of: morbid obesity, macular degeneration, retinal hemorrhage left eye, vascular dementia with psychotic disturbance, gait abnormalities, major depressive disorder, low back pain, insomnia, type two diabetes mellitus with diabetic polyneuropathy, hypertensive chronic kidney disease, arthropathy, congestive heart failure, gastroesophageal reflux disease, sleep apnea, atrial fibrillation, anemia, functional urinary incontinence, and chronic kidney disease stage four. Review of the 09/30/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #2 is moderately cognitively impaired and uses a wheelchair to aid in mobility. Resident #2 is noted to be taking an anticoagulant medication. Review of Resident #2's plan of care dated 02/10/24 revealed a goal of being free from signs or symptoms of bruising or bleeding with a target date of 11/22/24. The care planned interventions included: Resident is at risk for bleeding/bruising related to platelet aggregated/anticoagulant therapy. Resident will free from signs or symptoms of bruising or bleeding, Contact Physician with any signs or symptoms of bleeding. Labs per order. Medications as ordered. Monitor for signs or symptoms of bruising or bleeding every shift. Review of a Physician Order dated 10/05/24 revealed Eliquis (Apixaban) oral tablet five milligrams (mgs) Give one tablet by mouth two times a day related to paroxysmal atrial fibrillation the order was discontinued on 10/10/24. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365928	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Court House Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 555 North Glenn Ave Washington Court Hou, OH 43160	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a complete blood count (CBC) lab collected on 08/05/24 and reported the same day revealed a low Hemoglobin value of 10.3 g/dl with a normal value of 11.5-15.4 g/dl. Review of a complete blood count lab collected on 08/13/24 and reported the same day revealed a low Hemoglobin value of 7.3 g/dl with a normal value of 11.5-15.4 g/dl. Review of Nurse Practitioner (NP) #15 written Progress note dated 08/14/24 at 11:59 P.M. revealed an acute visit and Resident #2 is a [AGE] year old female who presents today with anemia, diabetes, and hypothyroidism. Resident #2 had a recent CBC result showing hemoglobin of 7.3 and hematocrit of 22.4, indicating anemia. Resident is currently taking ferrous sulfate 325 mg once a day for anemia management. The patient's vital signs include blood pressure of 133/64, heart rate of 70, respirations of 18, Oxygen saturation of 96%, and temperature of 97.7. The healthcare provider plans to increase the ferrous sulfate dose to twice a day, pending the patient's tolerance and absorption, and will continue to monitor CBC levels in one month for effectiveness. The assessment and plan for Iron deficiency anemia was the resident's CBC results indicated iron deficiency anemia with a hemoglobin level of 7.3 and hematocrit of 22.4. The resident is currently on ferrous sulfate 325 mg once a day. Plan: The dose of ferrous sulfate will be increased to twice a day, pending the patient's tolerance and absorption. CBC levels will be monitored in one month to assess the effectiveness of the increased dosage. Review of progress note dated 8/14/24 at 7:00 P.M. revealed Licensed Practical Nurse (LPN) #22 received an order from NP #15 to give iron twice a day due to hemoglobin level from recent labs. Review of Physician order dated 08/14/24 revealed Ferrous sulfate oral Tablet 325 (65 iron) mg give one tablet by mouth two times a day related to anemia. Review of the medical record for 08/14/24 revealed no order was written for a CBC laboratory value to be drawn in a month as per the NP progress notes. Review of Nurse Practitioner (NP) #15 written Progress Note dated 09/19/24 at 11:59 P.M. revealed and acute visit and the reason for the visit: Resident #2 is a [AGE] year-old female, with a history of diabetes mellitus managed with insulin, atrial fibrillation managed with aspirin, and neuropathy managed with gabapentin, seen today for blood glucose concerns. The patient also reports nausea for the past three weeks, which she attributes to food intake. The nausea occurs both before and after eating, leading her to reduce her food intake. She suspects that an ulcer, diagnosed several years ago, may be contributing to her symptoms. She requested Tums yesterday but did not receive them. Additionally, she reports constipation, with no bowel movement in the past 3 days. Review of a nurse note dated 10/06/24 at 6:30 P.M. revealed Resident #2 received milk of magnesium for complaints of stomachache. Resident's stool appeared black although this is normal with the resident. Resident noted to be pale in color. Family and nurse discussed sending her to emergency room . Resident was alert and oriented,blood pressure was 164/48, heart rate 80 beats per minute and respiration rate 16 per minute, Oxygen saturation 92%. Squad arrived and resident left without incident. Review of Emergency Department Provider notes dated 10/07/24 revealed Resident #2 presents on 10/06/24 with complaints of abdominal pain and concern for dark stools. Resident had a critically low hemoglobin of 4.5 g/dl. She received three units of packed red blood cells and is being sent to another hospital. (continued on next page)

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Court House Manor	555 North Glenn Ave Washington Court Hou, OH 43160

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Hospital record dated 10/07/24 revealed Resident #2 transferred in from another hospital due to dark tarry stool and had an esophagogastroduodenoscopy (EGD) procedure done and she had three linear mucosal gastric erosions/ulcerations and one principal area in the fundus with the potential for a visible vessel which was endoclipped to maintain hemostasis. Review of Nurse Practitioner (NP) #15 written Progress Note dated 10/14/24 at 11:59 P.M. revealed Resident #2 is a [AGE] year old female who presents for a post-acute care visit following a recent hospitalization for anemia and a gastrointestinal bleed. The resident was hospitalized last week due to black, tarry stools and was diagnosed with a gastrointestinal bleed. Resident reports during the hospital stay, she had two large ulcers in her stomach that were bleeding and required clamping. Resident's blood count dropped to four, necessitating several blood transfusions. Resident #2 returned to the care facility on 10/10/24 and started on Protonix 40 mg twice a day. A follow-up with a gastrointestinal (GI) doctor is planned. Resident reports feeling better since returning from the hospital but expresses frustration with the care facility staff for not addressing her stomach pain complaints earlier. She mentioned having complained about stomach pain for weeks prior to the hospitalization . Currently, the resident's stomach is a little sore, and they feel the need to have a bowel movement. Interview with the Director of Nursing (DON) on 11/04/24 at 3:52 P.M. verified there was never an order written on 08/14/24 for Resident #2 CBC and a CBC lab was not completed. Telephone Interview with NP #15 on 11/04/24 at 4:14 P.M. revealed the note from 08/14/24 was read to her and she stated she meant for Resident #2 to have a follow up CBC lab done in a month due to the hemoglobin dropping and the increase of the ferrous sulfate medication. NP #15 was unsure of why it was not completed. NP #15 was informed there was not an order written and she stated her intention was for the lab to be drawn and she is not sure if she gave a verbal order for the CBC or wrote the order out. She stated when she comes in the facility she usually writes out the order but sometimes they do not have the slips. NP #15 could not recollect if she wrote a paper order for the CBC or gave a verbal order to the nurse. NP #15 stated the standard of practice would be to draw a CBC lab in a month to monitor the medication change and the hemoglobin level since the resident was on Eliquis and had the hemoglobin decrease. Interview with LPN #22 on 11/04/24 at 4:35 P.M. revealed she worked 08/14/24 and put the order in the electronic record to increase the ferrous sulfate for Resident #2. LPN #22 was unable to recollect whether she received a verbal order from NP #15 or if NP #15 wrote the order. LPN #22 stated she input the order in the electronic medical record as it was prescriber written so it should of been on paper. The Prescriber Order paper order was unable to be located in the medical record and LPN #22 stated she might of marked that in error and it could of been a verbal order. LPN #22 stated NP #15 usually writes her own paper orders and the nurse will put them in the computer. Review of Resident #2's paper medical record on 11/05/24 revealed no evidence of a telephone order being written for ferrous sulfate to be increased, or the CBC lab to be drawn in a month. Interview with Director of Nursing (DON) on 11/05/24 at 12:50 P.M. revealed Resident #2 had two gastric ulcers on 10/06/24 and they clamped them. This deficiency represents non-compliance investigated under Complaint Number OH00158854.

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NAME OF PROVIDER OR SUPPLIER Court House Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 555 North Glenn Ave Washington Court Hou, OH 43160	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on observation, staff interview, and record review the facility failed to complete a pressure ulcer dressing change per physicians orders for Resident #79. This affected one (Resident #79) of three residents reviewed for pressure ulcers. The facility census was 88. Findings include: Record review of Resident #79 revealed an admitted [DATE] with pertinent diagnoses of: sepsis, pressure ulcer of sacral region, hypertension, mood affective disorder, local infection of the skin, major depressive disorder, anemia, acquired absence of left leg below the knee, and infection of amputation stump left lower extremity. Review of the 10/18/24 admission Minimum Data Set (MDS) assessment revealed the resident was cognitively intact and used a wheelchair to aid in mobility. The resident required setup or clean up assistance to roll left and right and was independent for sit to lying. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. The resident was at risk for pressure ulcer. Review of a Physician Order dated 10/18/24 revealed wound care right lateral foot- cleanse with wound cleanser or normal saline. Pat dry. Apply medi-honey, calcium alginate and cover with abdominal pad. Wrap with kerlix. Change three times a week and as needed every day shift every Tuesday, Thursday, Saturday, and as needed. Observation of Resident #79 dressing change on 11/04/24 at 8:35 A.M. revealed Licensed Practical Nurse (LPN) #10 completing the dressing on resident's right lateral foot. LPN #10 used hand sanitizer and put on personal protective equipment including gloves and a gown. LPN #10 gathered her supplies including four by four gauze, wound wash, medi-honey, calcium alginate, abdominal pad, scissors, and kerlix dressing. LPN #10 removed the old dressing from Resident #79 right foot the dressing was dated 10/31/24 and was initialed by LPN #10. Interview with Licensed Practical Nurse #10 on 11/04/24 at 8:49 A.M. verified the wound dressing was dated 10/31/24 and she had initialed it. LPN #10 stated she changed it on Thursday 10/31/24. Review of the treatment administration record on 11/04/24 at 9:15 A.M. revealed the dressing changed was not signed off as being completed on Saturday 11/02/24. Review of the medical record on 11/04/24 at 9:20 A.M. revealed no progress notes related to the wound dressing change not being completed. Interview with Resident #79 on 11/04/24 at 9:40 A.M. revealed he is unsure if his wound dressing was changed on Saturday 11/02/24 and he does not remember refusing the dressing change. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 11/04/24 at 10:25 A.M. verified the dressing change was not completed for Resident #79 on 11/02/24 as per the physician order. The DON spoke with the nurse working Saturday 11/02/24 and she stated Resident #79 refused the dressing change at that time and then she did not go back to see if he wanted it done at a later time or put a note in the medical record or document in the treatment record he refused. The DON stated she would expect the nurse to document the refusal and check back to see if he wanted it done later. This deficiency represents non-compliance investigated under Complaint Number OH00158854 and Complaint Number OH00158671.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on observation, staff interview, and record review the facility failed to to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections when staff did not follow infection control procedures during a dressing change for Resident #79. Facility staff did not follow infection control techniques when they removed Resident #79's soiled dressing and did not change gloves and then cleaned the wound with the soiled gloves. This affected one (Resident #79) of three residents reviewed for pressure ulcers. The facility census was 88. Findings include: Record review of Resident #79 revealed an admitted [DATE] with pertinent diagnoses of: sepsis, pressure ulcer of sacral region, hypertension, mood affective disorder, local infection of the skin, major depressive disorder, anemia, acquired absence of left leg below the knee, and infection of amputation stump left lower extremity. Review of the 10/18/24 admission Minimum Data Set (MDS) assessment revealed the resident was cognitively intact and used a wheelchair to aid in mobility. The resident required setup or clean up assistance to roll left and right and was independent for sit to lying. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. The resident was at risk for pressure ulcer. Review of a Physician Order dated 10/18/24 revealed wound care right lateral foot- cleanse with wound cleanser or normal saline. Pat dry. Apply medi-honey, calcium alginate and cover with abdominal pad. Wrap with kerlix. Change three times a week and as needed every day shift every Tuesday, Thursday, Saturday, and as needed. Observation of Resident #79 dressing change on 11/04/24 at 8:35 A.M. revealed Licensed Practical Nurse (LPN) #10 completing the dressing on resident's right lateral foot. LPN #10 used hand sanitizer and put on personal protective equipment including gloves and a gown. LPN #10 gathered her supplies including four by four gauze, wound wash, medi-honey, calcium alginate, abdominal pad, scissors, and kerlix dressing. LPN #10 removed the soiled dressing from Resident #79 right foot by cutting it off with scissors and she then discarded the dressing in the trash. LPN #10 did not change her soiled gloves. LPN #10 then cleaned the wounds with wound wash and gauze using the same gauze to clean all three wounds. She then removed her gloves and washed her hands and put on clean gloves and dried off the wounds with dry gauze. LPN #10 applied med-honey to the calcium alginate dressing and placed them on the three wounds. She applied the abdominal pad and then wrapped the foot in kerlix and taped the kerlix and dated the wound. Interview with Licensed Practical Nurse #10 on 11/04/24 at 8:49 A.M. verified she did not change her gloves after removing the soiled dressing and then cleaned the wound with soiled gloves. Interview with the Director of Nursing (DON) on 11/04/24 at 10:25 A.M. revealed they do not have a policy for dressing changes but she would expect them to follow the aseptic dressing technique competency form. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided 11/01/19 Skills Competency Checklist- Aseptic Dressing Technique document revealed to perform hand hygiene, don non-sterile gloves, aseptic dressing change field set up. Soiled dressing removed and disposed of in waste bag. Remove gloves, perform hand hygiene, don nonsterile gloves. Cleanse wound per Physicians orders, remove gloves and perform hand hygiene. Perform treatment per Physicians Orders. This deficiency represents non-compliance investigated under Complaint Number OH00158854.