

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365973	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Birchaven Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 Birchaven Lane Findlay, OH 45840	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on record review, observation, staff interview, and policy review, the facility failed to ensure residents were treated with dignity and respect. This affected three (Residents #23, #57, and #64) of three residents reviewed for dignity and respect. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE]. Diagnoses included muscle weakness, need for assistance with personal care, dependence on wheelchair, dysphagia, and cognitive communication deficit.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment revealed the resident was cognitively impaired. The resident required supervision or touching assistance for eating.</p> <p>An observation of the lunch meal on 01/06/25 beginning at approximately 11:30 A.M. revealed residents residing in the nursing facility and the assisted living facility shared the dining room located on the A-B Unit. Resident #23 was seated in the dining room for the lunch meal and was next to a resident who resided in the assisted living facility. Resident #23 and the assisted living resident each had a bedside table in front of them for dining.</p> <p>Continued observation on 01/06/25 at 11:56 A.M. revealed many residents had finished eating and left the dining room. Resident #23 had not yet received their lunch. On 01/06/25 at 12:13 P.M., the assisted living resident received their meal and began feeding himself. On 01/06/25 at 12:27 P.M., the assisted living resident had finished eating their meal and Resident #23 had still not been served. Resident #23 began lifting their hand up to their mouth and motioning as if they were eating.</p> <p>On 01/06/25 at 12:32 P.M., Resident #23 received their meal and began feeding himself.</p> <p>An interview on 01/06/25 with Hospitality Aide #497 confirmed Resident #23 had to wait to eat while many other residents had been served and finished their meals.</p> <p>47057</p> <p>2. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnosis of malignant neoplasm of appendix, cellulitis of right lower limb and atrial fibrillation.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS assessment dated [DATE] for Resident #64 revealed he was cognitively intact.</p> <p>Observation on 01/06/25 at 11:52 A.M. revealed Resident #64 was sitting in the dining room eating lunch with another resident (#198) at the dining room table. Continued observation revealed Clinical Nurse Practitioner (CNP) #399 interrupted Resident #64's lunch and CNP #399 conducted a physical examination and auscultated (listened with stethoscope) Resident #64's lungs and his heart.</p> <p>Review of the progress note written by CNP #399 for Resident #64 dated 01/06/25 revealed the resident was seen and examined while in his wheelchair while in the dining room.</p> <p>3. Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnosis of cellulitis of left lower extremity and neuropathy.</p> <p>Review of the admission MDS dated [DATE] for Resident #57 revealed he was cognitively intact.</p> <p>Observation on 01/06/25 at 11:53 A.M. revealed Resident #57 was sitting in the dining room eating lunch with two other residents (#43 and #67) at the dining table. Continued observation revealed CNP #399 interrupted Resident #57's lunch, he stopped eating, and CNP #399 conducted a physical examination and auscultated Resident #57's lungs and his heart.</p> <p>Review of the progress note written by CNP #399 for Resident #57 dated 01/06/25 revealed the resident was seen and examined while in his wheelchair while in the dining room.</p> <p>Interview on 01/06/25 at 11:57 A.M. with CNP #399 verified she completed a physical examination for both Resident #64 and Resident #57 while in the dining room with other residents seated at the dining room table. Further interview with CNP #399 stated she does not alter her rounding based on the schedule of the residents unless they are out of the building.</p> <p>Interview on 01/08/25 at 4:30 P.M. with the Director of Nursing (DON) stated the facility does not have a policy on dignity but abides by the residents rights.</p> <p>Review of the Residents Rights handbook provided for all residents, dated 2023 revealed a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057</p> <p>Based on observation, staff interview, and review of facility policy, the facility to ensure privacy was maintained when resident medical conditions, treatments, and results of vital signs were discussed. This affected one resident (#57) of one resident reviewed for privacy. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses of cellulitis of left lower extremity and neuropathy.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #57 revealed he was cognitively intact and was being treated for pain.</p> <p>Review of the current physician orders for 01/25 for Resident #57 revealed he was prescribed tramadol 50 milligrams (mg) every 12 hours as needed for pain.</p> <p>Observation on 01/06/25 at 11:53 A.M. revealed Resident #57 was sitting in the dining room eating lunch with two other residents (#43 and #67) at the dining table. Continued observation revealed Clinical Nurse Practitioner (CNP) #399 discussed Resident #57's medical condition of pain, the treatment for the pain with the prescribed tramadol, and vital signs obtained from the nurse earlier in the day.</p> <p>Interview on 01/06/25 at 11:57 A.M. with CNP #399 verified she discussed with Resident #57 his medical condition of pain, his treatment of tramadol, and discussed the results of his vital signs obtained earlier in the day while at the dining room table with other residents seated adjacent to him at the table. Further interview with CNP #399 stated she does not alter her rounding based on the schedule of the residents unless they are out of the building.</p> <p>Review of the facility policy titled, Health Insurance Portability and Accountability Act (HIPPA), dated 12/24, revealed health information is personal and should be kept confidential. Associates must take necessary precautions to reduce the risk of incidentally disclosing Protected Health Information (PHI) to unauthorized individuals.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on medical record review, staff interview, and review of the facility Self-Reported Incident (SRI), the facility failed to ensure staff reported an injury of unknown origin and/or physical abuse to administration. This affected one (Resident #63) of four residents reviewed for abuse. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #63 was admitted to the facility on [DATE]. Diagnoses included dysphagia, need for assistance with personal care, muscle weakness, cognitive communication deficit, and dementia.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #63 was severely cognitively impaired. The resident required assistance from staff for all activities of daily living.</p> <p>Review of the facility SRI dated 08/07/24 and timed 2:40 P.M. revealed Resident #63's family member informed the Assisted Director of Nursing (ADON) that there was a bruise on Resident #63's lower right forearm. Resident #63's family member stated Resident #63 said someone did this to her.</p> <p>Review of the facility investigation revealed Certified Nursing Assistant (CNA) #598 noticed the bruising sometime prior to 6:00 A.M. on 08/07/24. There was no evidence CNA #598 reported the bruising to the nurse on duty or to any other staff on the morning of 08/07/24. In addition, there was no evidence facility management were aware of the bruising until reported by Resident #63's family on the afternoon of 08/07/24.</p> <p>Review of Resident #63's wound evaluation and photographs dated 08/07/24 and timed 2:27 P.M. revealed the resident had new, in-house acquired bruising to their right outer forearm. There were four total bruises, ranging between near the elbow and down onto the hand and near the wrist.</p> <p>An interview on 01/08/25 at 8:06 A.M. with the Director of Nursing (DON) revealed Resident #63's family informed management of Resident #63's bruising during the afternoon on 08/07/24. The DON verified CNA #598 had noticed the bruising prior to 6:00 A.M. on 08/07/24 and there was no evidence it was reported to anyone at that time. The DON verified CNAs were responsible for checking residents for new skin concerns while assisting with the activities of daily living, and should let the nurse on duty know of any new areas including bruising.</p> <p>An interview on 01/09/24 at 3:56 P.M. with the Administrator verified CNA #598 noticed Resident #63's bruising during their shift which occurred from 08/06/24 at 6:00 P.M. through 08/07/24 at 6:00 A.M. The Administrator verified there was no evidence CNA #598 reported the bruising to anyone at the facility until the investigation was initiated due to the bruising being reported by the resident's family. The Administrator also verified the facility had not initiated a SRI until the bruising was reported by the family on the afternoon of 08/07/24.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057</p> <p>Based on medical record review, review of the facility's self-reported incidents, staff interview, and review of the facility policy, the facility failed to complete thorough investigations for injuries of unknown origin. This affected two residents (#98 and #68) of five residents reviewed for injuries of unknown origin. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of Resident #98's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included Alzheimer's disease, major depressive disorder and polyneuropathy.</p> <p>Review of Resident #98's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero indicating Resident #98 was rarely or never understood. Resident #98 displayed no behaviors at the time of the review. Resident #98 was dependent on staff for activities of daily living.</p> <p>Review of the facility's Self-Reported Incident (SRI) completed 06/28/24 revealed Resident #98 was found to have bruising on her legs. Staff were interviewed, other residents were interviewed, and Resident #98 had a skin assessment completed. However, there was no evidence additional residents who resided on Resident #98's hall who were not able to be interviewed had skin assessments completed. A thorough investigation into Resident #98's bruising incident was not completed.</p> <p>Interview on 01/09/24 at 11:38 A.M. with the Administrator and Director of Nursing (DON) verified skin checks had not been completed on any residents other than Resident #98.</p> <p>2. Review of Resident #68's medical record revealed an admitted [DATE]. Diagnoses included major depressive disorder, cognitive communication deficit, muscle weakness, dementia, and need for assistance with personal care.</p> <p>Review of Resident #68 Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating Resident #68 was moderately cognitively impaired. Resident #68 required maximal assistance with activities of daily living. Resident #68 displayed no behaviors during the time of the review.</p> <p>Review of the facility's SRI completed 09/04/24 revealed Resident #68 was found to have new redness and swelling to her right hand. Resident #68 was interviewed and had reported it had been a cyst she had for years, which was not accurate for the newly developed redness and swelling. It was noted Resident #68 was often cooperative with care. Staff were interviewed, other residents were interviewed, and Resident #68 had a skin assessment completed. However, there was no evidence additional residents who resided on Resident #68's hall who were not able to be interviewed had skin assessments completed. A thorough investigation into Resident #68's right hand redness and swelling incident had not been completed.</p> <p>Interview on 01/09/24 at 11:48 A.M. with the Administrator and Director of Nursing (DON) verified skin checks had not been completed on any residents other than Resident #68.</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy titled, Investigation of Injuries of Unknown Origin, revealed the facility would ensure injuries without obvious cause were investigated thoroughly.		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on observation, medical record review, and staff interview, the facility failed to ensure alternative methods of communication were provided in accordance with physician orders. This affected one (Resident #48) of one resident reviewed for alternate methods of communication. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #48 was admitted to the facility on [DATE]. Diagnoses included muscle weakness, dementia, cognitive communication deficit, and chronic kidney disease.</p> <p>Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #48 was cognitively impaired. Resident #48's primary language was Spanish and the resident needed/wanted an interpreter to communicate with a doctor or health care staff.</p> <p>Review of the Nurse Practitioner (NP) notes dated 12/09/24 revealed Resident #48 was examined. During the examination, the resident was awake and alert. Communication was hindered due to the resident only speaking Spanish. The nursing staff reported the resident ambulated independently, required prompting with bathing and dressing, and had a good appetite.</p> <p>Review of the physician visit/orders dated 12/09/24 and timed 2:42 P.M. identified a physician's order for a translator phone.</p> <p>Review of the active physician orders for January 2024 identified an order dated 12/09/24 for a translator phone.</p> <p>An interview on 01/07/25 at 12:13 P.M. with Resident #48's daughter revealed Resident #48's primary language was Spanish and facility staff were unable to fully communicate with the resident. Resident #48's daughter reported the facility posted some common phrases on the walls of the resident's room, but that did not encompass all day-to-day communication. Resident #48's daughter reported no knowledge of a translator phone or an interpreter.</p> <p>An observation on 01/07/25 at 12:20 P.M. of Resident #48's room revealed there was no translator phone or signage posted to instruct staff and/or visitors on how to reach an interpreter.</p> <p>An interview on 01/08/25 at 11:13 A.M. with CNA #551 revealed the staff member provided care to Resident #48 on a regular basis. CNA #551 reported staff attempted to use an application on their personal phones to communicate with Resident #48 but the application did not recognize or pick up Resident #48's voice to be able to interpret what the resident was saying. CNA #551 reported no knowledge of a translator phone or an interpreter that could be utilized.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 01/09/24 at 9:01 A.M. with the Assistant Director of Nursing (ADON) verified Resident #48 did not have a translator phone as ordered. The ADON reported facility staff attempted to utilize an application on their personal phones and there was a tablet with an application that could be utilized. The ADON reported they were unsure of whether the application on the tablet was able to pick up what the resident was saying.</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on medical record review and staff interview, the facility failed to ensure residents were adequately monitored for bowel movements and interventions for constipation were implemented as ordered. This affected one (Resident #42) of one resident reviewed for constipation. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included severe protein-calorie malnutrition, muscle weakness, lack of coordination, and need for assistance with personal care.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact.</p> <p>Review of the plan of care dated 06/17/24 revealed Resident #42 was taking opioid medication with a high risk for adverse consequences. Interventions included monitoring and documenting bowel movements every shift.</p> <p>Review of the plan of care dated 06/17/24 revealed Resident #42 was at risk for constipation related to generalized weakness, deconditioning, imbalance, pain, medication side effects, nausea, vomiting, surgery on digestive system, gluteal abscess, diabetes, and kidney disease. Interventions included administering stool softeners and/or laxatives per physician orders and recording bowel movement patterns each day while describing the amount, color, and consistency.</p> <p>Review of Resident #42's active physician orders for January 2024 identified an order dated 05/28/24 for bowel management per protocol. The resident also had orders dated 08/20/24 for Miralax oral powder, one scoop by mouth as needed daily for constipation, and Colace oral capsule (100 milligrams) by mouth twice daily as needed for constipation.</p> <p>Review of Resident #42's Bowel and Bladder tracking for 12/10/24 through 01/07/25 revealed no documented bowel movements between 12/22/24 and 12/26/24, between 12/26/24 and 12/30/24, or between 01/02/25 and 01/06/25. There was also no documentation regarding the color of bowel movements occurring within this time period.</p> <p>Review of Resident #42's administration records for 12/01/24 through 01/07/24 revealed the Miralax and/or Colace were not administered to the resident during this time period.</p> <p>An interview on 01/08/25 at 7:54 A.M. with the Director of Nursing (DON) verified Resident #42's bowel movement documentation did not include the color of each bowel movement per the plan of care. The DON also verified the facility's protocol was to offer ordered interventions if a resident had gone three days without a bowel movement and there was no evidence Resident #42 was administered medication to initiate a bowel movement.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on observation, staff interview, and medical record review, the facility failed to ensure interventions to prevent aspiration were implemented for residents receiving enteral nutrition (tube feeding). This affected one (Resident #49) of one resident reviewed for tube feeding. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #49 was initially admitted to the facility on [DATE]. Diagnoses included cognitive communication deficit, respiratory failure, chronic kidney disease, pneumonia, unsteadiness on feet, and dysphagia.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #49 was severely cognitively impaired and was rarely or never understood. Resident #49 was dependent on assistance from staff for all activities of daily living.</p> <p>Review of the current plan of care dated 07/30/24 revealed Resident #49 required tube feeding related to dysphagia. Interventions included needing the head of their bed elevated 45 degrees during and thirty minutes after tube feeding.</p> <p>Review of Resident #49's active physician orders for January 2024 identified orders for no food by mouth, and Diabetisource (nutritional supplement) at 70 milliliters per hour continuously via enteral feed.</p> <p>Observation on 01/07/25 at 8:14 A.M. revealed Resident #49 was lying in bed on their back. The resident's tube feed was running with Diabetisource at 70 milliliters per hour. The head of the resident's bed was barely elevated. Continued observation while awaiting staff revealed the head of the bed was still not elevated to 45 degrees as of 01/07/25 at 8:44 A.M.</p> <p>An interview on 01/07/25 at 8:44 A.M. with Certified Nursing Assistant (CNA) #592 verified the head of Resident #49's bed was supposed to be elevated more while their tube feeding was being administered.</p> <p>An observation on 01/07/25 at 8:47 A.M. revealed CNA #592 went into the room of Resident #49 and slightly raised the head of the bed. The head of the bed was still not at 45 degrees and was barely raised.</p> <p>An interview on 01/07/25 at 9:03 A.M. with Licensed Practical Nurse (LPN) #419 verified the head of Resident #49's bed should have been elevated more than it currently was. LPN #419 reported they believed the head of the bed was supposed to be at 30 degrees and that it definitely was not. LPN #419 reported there was no way to determine how many degrees the head of the bed was elevated.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to ensure oxygen was running per the physician's order. This affected one resident (#53) reviewed for oxygen. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnosis of pneumonia.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] for Resident #53 revealed she was cognitively intact and required oxygen therapy.</p> <p>Review of the current physician orders for 01/25 for Resident #53 revealed she was ordered oxygen at two liter per minute per nasal cannula (nc).</p> <p>Observation on 01/06/25 at 1:24 P.M. of Resident #53 revealed her oxygen rate was set at four liter per minute.</p> <p>Observation on 01/06/25 at 3:15 P.M. of Resident #53 revealed her oxygen continued at the set rate of four per minute.</p> <p>Observation on 01/07/25 at 9:47 A.M. of Resident #53 revealed her oxygen continued at the set rate of four per minute.</p> <p>Interview on 01/07/25 at 9:48 A.M. with Registered Nurse (RN) #534 verified the physician order for Resident #53 is for oxygen two liters per minute and verified Resident #53's oxygen was set at four liters per minute.</p> <p>Review of the facility policy titled, Oxygen Administration, revised 10/10, revealed verify there is a physician's order for this procedure and review the physician's order for oxygen administration.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>44454</p> <p>Based on observation, staff interview, review of the menu and review of the dietary spreadsheet, the facility failed to ensure food was served per the facility menu and spreadsheet. This had the potential to affect 29 (#2, #6, #7, #11, #12, #14, #16, #17, #20, #25, #28, #29, #33, #36, #37, #41, #42, #43, #44, #52, #62, #63, #65, #66, #72, #74, #75, #76, and #149) residents who resided on the Cedar and Dogwood units. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the weekly menu revealed the meal for lunch on 01/08/24 was a fried bologna sandwich and a relish plate with ranch dressing and scalloped corn or broccoli cheddar soup with an Italian beef sub.</p> <p>Review of the menu spreadsheet for lunch on 01/08/24 revealed broccoli cheddar soup would be served as a six-ounce portion.</p> <p>Observations on 01/08/24 beginning at approximately 11:30 A.M. of the meal service for the Cedar and Dogwood Unit, revealed Dietary Aide #474 was plating meals. Dietary Aide #474 was observed using a four-ounce ladle to serve the broccoli cheddar soup.</p> <p>Interview on 01/08/24 at 11:50 A.M. with Chef #441 confirmed the broccoli cheddar soup was being served using a four-ounce ladle and should have been served using a six-ounce ladle.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454</p> <p>Based on observation and staff interview, the facility failed to ensure food items stored in unit refrigerators were labeled and dated and further failed to ensure unit refrigerators did not contain expired food items. This had the potential to affect 45 (#1, #2, #5, #6, #7, #8, #9, #11, #12, #14, #16, #17, #19, #20, #22, #23, #25, #28, #29, #33, #36, #37, #41, #42, #43, #44, #45, #47, #48, #51, #52, #54, #55, #59, #61, #62, #63, #65, #66, #72, #74, #75, #76, #148, and #149) who resided on the Birch, Cedar, and Dogwood units. The facility census was 90.</p> <p>Findings include:</p> <p>1. Observation on [DATE] at 11:25 A.M. of the unit refrigerator located on the Birch-hall revealed there was an unlabeled pack of two small sandwiches which stated to use by [DATE].</p> <p>An interview on [DATE] at 11:28 A.M. with Certified Nursing Assistant (CNA) #579 verified the items should have been disposed of.</p> <p>2. Observation on [DATE] at 11:32 A.M. of the refrigerator located near the dining area for the Birch-hall revealed the following:</p> <p>Three unlabeled and undated disposable plastic containers containing various unknown substances.</p> <p>An unlabeled and undated glass jar containing an unknown red substance.</p> <p>An unlabeled glass jar containing an unknown red substance, dated [DATE]th of an unknown year and to use by [DATE]st of an unknown year.</p> <p>A grocery bag containing three unlabeled and undated disposable containers, one of which was leaking.</p> <p>An interview on [DATE] at 11:39 A.M. with Hospitality Aide #497 verified the above findings.</p> <p>3. Observation on [DATE] at 11:43 A.M. of the unit refrigerator located on the Cedar-hall revealed the following:</p> <p>An unlabeled and undated bag containing an unknown frozen substance.</p> <p>An unlabeled and undated bag containing an unknown brown substance.</p> <p>An interview on [DATE] at 11:45 A.M. with Activities Staff Member #501 verified the items should have been disposed of.</p> <p>4. Observation on [DATE] at 11:57 A.M. of the refrigerator located near the dining area for the Cedar and Dogwood halls revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An unlabeled and undated clear-plastic bag containing an unknown food item.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057</p> <p>Based on observations, resident interview, staff interview, review of facility Transmission Based Precautions (TBP) and Enhanced Barrier Precautions (EBP) postings, and review of facility policy, the facility failed to ensure proper infection control practices were implemented related to Coronavirus Disease 2019 (COVID-19) and EBP. This affected six residents (#25, #14, #28, #72, #49, and #82) of eight residents reviewed for TBP and EBP. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included cognitive communication deficit, type II diabetes, dysphagia, end stage renal disease, dependence on renal dialysis, peripheral vascular disease, and heart failure.</p> <p>Review of Resident #25's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of eight indicating Resident #25 was moderately cognitively impaired. Resident #25 required maximal assistance with toilet use, bathing, dressing and moderate assistance with transfer and mobility. Resident #25 displayed verbal behavioral symptoms and rejection of care one to three days during the review period. Resident #25 was on dialysis at the time of the review.</p> <p>Review of Resident #25's care plan revised 01/03/25 revealed supports and interventions for COVID-19. Interventions included placing Resident #25 on strict COVID-19 isolation, keep door closed, wear all appropriate Personal Protective Equipment (PPE), all services to be provided in Resident #25's private room, and observe and assess for possible changes in condition due to COVID-19 positive.</p> <p>Review of Resident #25's physician orders revealed an order dated 01/02/25 with a scheduled end date of 01/12/25 for Resident #14 to be placed on strict COVID-19 isolation. Keep door closed. Wear all appropriate PPE. All services to be provided in resident's private room.</p> <p>Review of Resident #25's scanned documents revealed Resident #25 tested positive for COVID-19 on 01/02/25. It was noted Resident #25 was asymptomatic, but did have some congestion. Resident #25's physician was notified. COVID-19 protocol was added to Resident #25's orders.</p> <p>Observation on 01/06/25 at 9:53 A.M. found Resident #25 was out of the facility for dialysis. Resident #25's room door was open and there were no isolation signs or PPE available in or around Resident #25's room.</p> <p>Observation on 01/06/25 at 1:53 P.M. of Resident #25 found she had returned from dialysis. There continued to be no PPE or signage indicating Resident #25 was on isolation for COVID-19. Medication Aide (MA) #618 was observed assisting Resident #25 with adjusting her bed and sitting on the side of the bed. Certified Nurse Aide (CNA) #616 was observed to be wearing a surgical mask and no other PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/06/25 at 2:07 P.M. with CNA #561 and CNA #592 verified Resident #25 was COVID-19 positive, was on droplet isolation and there was no signage or PPE cart available outside her room. CNA #561 reported there was a lot of COVID-19 going around and the facility ran out of PPE carts. CNA #592 verified when entering Resident #25's room for any reason, full PPE was to be worn including masks, gloves, gowns, and face shields. CNA #592 also verified the face shields were shared and were to be wiped down with bleach wipes after each use. Bleach wipes were located in the storage room behind the nurses station and not on the PPE carts.</p> <p>Interview on 01/06/25 at 2:10 P.M. with Registered Nurse (RN) #509 verified Resident #25 tested positive for COVID on 01/02/25 and an isolation cart should be placed outside her door with a droplet isolation sign and appropriate PPE. All care provided should be done with an N95 mask, gown, gloves, and eye protection.</p> <p>2. Review of Resident #28's medical record revealed an admitted [DATE]. Diagnoses included dysphagia, cognitive communication deficit, type II diabetes, muscle wasting, dementia, osteoarthritis, and cerebral infarction.</p> <p>Review of Resident #28's MDS dated [DATE] revealed a BIMS score of six indicating Resident #28 was severely cognitively impaired. Resident #28 required supervision with toilet use and moderate assistance with bathing. Resident #28 was independent with transfer and mobility. Resident #28 displayed no behaviors during the review period.</p> <p>Review of Resident #28's care plan revised 01/03/25 revealed supports and interventions for COVID-19. Interventions included placing Resident #28 on strict COVID-19 isolation, keep door closed, wear all appropriate PPE, all services to be provided in Resident #28's private room, and observe and assess for possible changes in condition due to COVID-19 positive.</p> <p>Review of Resident #28's physician orders revealed an order dated 01/02/25 with a scheduled end date of 01/12/25 for Resident #28 to be placed on strict COVID-19 isolation. Keep door closed. Wear all appropriate PPE. All services to be provided in resident's private room.</p> <p>Review of Resident #28's scanned documents revealed Resident #28 tested positive for COVID-19 on 01/02/25. Resident #28 was noted to have some congestion, with clear lung sounds. Resident #28's physician was notified.</p> <p>Observation on 01/06/25 at 10:09 A.M. of Resident #28 found the door to her room was open. There was no PPE cart or signage indicating Resident #28 was on droplet isolation precautions. A sign was on the door of the room indicating a resident was on EBP.</p> <p>Observation on 01/06/25 at 11:47 A.M. found a PPE cart with an droplet isolation sign on the cart with instructions for staff to wear N95s, gowns, glove, and eye protection when entering Resident #28's room. Hospitality Aide (HA) #529 was observed at the cart applying a gown, N95, gloves and a face shield prior to delivering Resident #28's and her roommates lunch trays. It was noted there was only one face shield available for use. Coinciding interview with HA #529 verified Resident #28's door was open and Resident #28 was positive for COVID-19.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/06/25 at 11:50 A.M. of HA #529 found she exited Resident #28's COVID-19 isolation room with all her PPE in place. She removed the face shield from her face and placed it back on the cart. No cleaning wipes were found in the cart and HA #529 did not disinfect the face shield after it was used. HA #529 then removed her gown and gloves and folded them up against her. HA #529 walked down the hallway and placed the gowns and gloves in the small trash can by the medication cart. Coinciding interview with HA #529 verified there was no trash can in the room and she had to dispose of her used PPE from the room with COVID-19 positive residents in the trash can in the hallway. HA #529 reported the gowns were one time use but the face shields were shared as there was only one on the cart. HA #529 verified she placed the face shield back on the cart and it had not been disinfected.</p> <p>Interview on 01/06/25 at 2:07 P.M. with CNA #561 and CNA #592 also verified the face shields were shared and were to be wiped down with bleach wipes after each use. Bleach wipes were located in the storage room behind the nurses station and not on the PPE carts.</p> <p>3. Review of Resident #14's medical record revealed an admitted [DATE]. Diagnoses included anorexia, dysphagia, major depressive disorder, osteoarthritis, cognitive communication deficit, and psychosis.</p> <p>Review of Resident #14's MDS dated [DATE] revealed a BIMS score of 15 indicating Resident #14 was cognitively intact. Resident #14 was independent with toilet use, bathing, dressing, transfer and mobility. Resident #14 displayed no behaviors during the review period.</p> <p>Review of Resident #14's care plan revised 01/02/25 revealed supports and interventions for potential for COVID-19. Interventions included placing Resident # 14 on strict COVID-19 isolation, keep door closed, wear all appropriate PPE, all services to be provided in Resident #14's private room, and observe and assess for possible changes in condition due to COVID-19 positive.</p> <p>Review of Resident #14's physician orders revealed an order dated 01/01/25 with a scheduled end date of 01/11/25 for Resident #14 to be placed on strict COVID-19 isolation. Keep door closed. Wear all appropriate PPE. All services to be provided in resident's private room.</p> <p>Review of Resident #14's scanned documents revealed Resident #14 tested positive for COVID-19 on 01/01/25. It was noted Resident #14 reported having a headache, nasal congestion, and sore throat. Resident #14 reported her headache started on Monday 12/30/24. Resident #14's physician was notified.</p> <p>Observation on 01/06/25 at 10:09 A.M. of Resident #14 found the door to her room was open. There was no PPE cart or signage indicating Resident #14 was on droplet isolation precautions. A sign was on the door indicating a resident was on EBP.</p> <p>Observation on 01/06/25 at 11:47 A.M. found a PPE cart with an droplet isolation sign on the cart with instructions to wear N95s, gowns, glove, and eye protection. HA #529 was observed at the cart applying a gown, N95, gloves and a face shield prior to delivering Resident #14 and her roommates lunch trays. It was noted there was only one face shield available for use. Coinciding interview with HA #529 verified Resident #14's door was open and Resident #14 was positive for COVID-19.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/06/25 at 11:50 A.M. of HA #529 found she exited Resident #14's COVID-19 isolation room with all her PPE in place. She removed the face shield from her face and placed it back on the cart. HA #529 did not disinfect the face shield after it was used. HA #529 then removed her gown and gloves and folded them up against her. HA #529 walked down the hallway and placed the gowns and gloves in the small trash can by the medication cart. Coinciding interview with HA #529 verified there was no trash can in the room and she had to dispose of her used PPE in the trash can in the hallway. HA #529 reported the gowns were one time use but the face shields were shared as there was only one on the cart. HA #529 verified she placed the face shield back on the cart and it had not been disinfected.</p> <p>Interview on 01/06/25 at 2:07 P.M. with CNA #561 and CNA #592 also verified the face shields were shared and were to be wiped down with bleach wipes after each use. Bleach wipes were located in the storage room behind the nurses station and not on the PPE carts.</p> <p>Interview on 01/28/24 at 7:52 A.M. with Assistant Director of Nursing (ADON) #533 revealed she was the ADON for the C and D units. ADON #533 verified whenever a staff entered a COVID-19 positive room they were to wear full PPE including N95, gloves, gown, and face shield. ADON #533 reported things changed a lot with COVID-19 regulations, but their current practice was for droplet isolation for all COVID-19 residents including discarding used PPE before exiting the room.</p> <p>4. Review of Resident #72's medical record revealed an admitted [DATE]. Diagnoses included dysphagia, cognitive communication deficit, muscle wasting and atrophy, type II diabetes, obstructive and reflux uropathy, and urinary tract infection.</p> <p>Review of Resident #72's MDS dated [DATE] revealed a BIMS score of 11 indicating Resident #72 was moderately cognitively impaired. Resident #72 was dependent for toilet use and parts of dressing. Resident #72 required maximal assistance with bathing, transfer and mobility. Resident #72 had an indwelling catheter and was frequently incontinent of bowel. Resident #72 displayed wandering behaviors one to three days during the review period.</p> <p>Review of Resident #72's care plan revised 10/25/24 revealed supports and interventions for EBP related to urinary catheter.</p> <p>Observation on 01/06/25 at 9:35 A.M. of Resident #72's room found a posted sign for EBP. The posting indicated everyone must perform handwashing and providers must wear gloves and a gown for high contact resident care activities which included dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting and device care for urinary catheters.</p> <p>Observation on 01/09/25 at 9:30 A.M. of Resident #72 found his catheter care was provided by CNA #631, CNA #546, and CNA #516. Resident #72 was noted to have a sign above his bed indicating to staff Resident #72 was on EBP and gloves along with gowns were required for direct care including catheter care. A sign was also observed on the door of the room and a bin for disposal of used PPE/gowns and gloves was observed in the room. Staff provided catheter care and donned only gloves, no gowns were worn.</p> <p>Interview on 01/09/25 at 9:36 A.M. with CNA #516 verified none of the staff were wearing the appropriate PPE during the care of Resident #72's catheter.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/28/24 at 7:52 A.M. with ADON #533 revealed for residents who were on EBP, PPE was only needed when coming in direct contact with the resident. PPE included wearing gloves and a gown.</p> <p>44454</p> <p>5. Review of the medical record revealed Resident #49 was initially admitted to the facility on [DATE]. Diagnoses included cognitive communication deficit, respiratory failure, chronic kidney disease, pneumonia, unsteadiness on feet, and dysphagia.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #49 was severely cognitively impaired and was rarely or never understood. Resident #49 was dependent on assistance from staff for all activities of daily living.</p> <p>Review of the plan of care dated 07/29/24 revealed Resident #49 required EBP related to chronic wounds and/or indwelling medical devices. Interventions included educating on the importance of hand washing, gowns and gloves to be stored within room, and washing hands before leaving room.</p> <p>Observation on 01/07/25 at 11:23 A.M. revealed signage was posted on Resident #49's door to indicate the resident was on EBP. The signage stated everyone must clean their hands before entering and when leaving the room. Resident #49 was sitting up in a recliner located in their room. CNA #542 was in the room and was wearing a disposable gown and gloves. CNA #542 doffed the gown and gloves and placed them in a bin located in the room. CNA #542 then retrieved a new pair of gloves which were on top of a cart containing PPE and located outside of the room and in the hallway. CNA #542 did not wash or sanitize their hands after doffing and disposing of their gown and gloves, before leaving the room, or before retrieving a new pair of gloves and entering the shared room of Resident #25 and #42.</p> <p>An interview on 01/07/25 at approximately 11:40 A.M. with CNA #542 verified staff were supposed to practice hand hygiene when leaving the rooms of residents on EBP.</p> <p>35031</p> <p>6. Review of the medical record of Resident #82 revealed an admitted [DATE]. Diagnoses included pneumonia, chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, tracheostomy, and gastrostomy.</p> <p>Observation on 01/06/24 at 10:20 A.M. revealed a small sign on the door of Resident #82's door indicating EBP were in place. Resident #82 was observed to have a tracheostomy.</p> <p>Interview on 01/06/24 at 10:20 A.M with Resident #82 and husband revealed the staff have not been wearing any PPE when assisting Resident #82. Resident #82 added she has a percutaneous gastrostomy feeding tube in place as well. The tube is flushed three times a day by nursing staff, and they do not wear any gown or mask, only gloves. Resident #82 stated the staff placed the gowns in the room this morning.</p> <p>Observation on 01/06/24 at 10:57 A.M. revealed Respiratory Therapist (RT) #530 entered the room of Resident #82 without donning any PPE and instructed Resident #82 on the use of an incentive spirometer, a device to increase the lung expansion capacity. The device will generally induce a cough.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview at 11:05 A.M. with RT #530 provided verification of the lack of PPE.</p> <p>Review of the posted signage for Droplet Precautions and instructions for applying PPE revealed everyone must clean their hands, including before entering and when leaving the room. Staff were to make sure their eyes, nose and mouth were fully covered before room entry and were to remove face protection before room exit. PPE was to be applied after hand hygiene and included gown, mask, face shield, and gloves. PPE was to be removed with gowns first, wash hands, remove face shield and clean, mask off wash hands and exit room.</p> <p>Review of the posted signage for Contact Precautions revealed staff were to clean their hands before entering and when leaving the room. Staff were to put on gloves and gowns before entering the room and remove before exiting the room. A sign indicated gowns were to be used with all activities of daily living, dressing changes, and direct contact. Masks were to be used with dressing changes.</p> <p>Review of the posted signage for EBP and instructions for applying PPE revealed everyone must clean their hands, including before entering and when leaving the room. Staff were to wear gloves and a gown for high contact resident care activities which included dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting and device care for urinary catheters.</p> <p>Review of the facility's policy titled, Transmission Based Precautions, dated 04/03/24 from the Center for Disease Control (CDC) revealed residents with known or suspected infections that represent an increased risk for contact transmission. Use of PPE should be used appropriately including gloves and gowns for all interactions that may involve contact with the resident or resident's environment. Donning PPE upon room entry and properly discarding before exiting the room was done to contain pathogens. Droplet precautions for residents known or suspected to be infected with pathogens transmitted by respiratory droplets that were generated by a patient who is coughing, sneezing or talking should be used.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160996.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365973	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Birchaven Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 Birchaven Lane Findlay, OH 45840	
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031</p> <p>Based on record review and staff interview, the facility failed to ensure one resident, #82, received the influenza vaccination after consenting. Furthermore, the facility failed to offer one resident, #149, the information, consent or refusal of the influenza or the pneumococcal vaccine. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record of Resident #82 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, type II diabetes mellitus, anemia, obesity, cerebral infarction, and chronic obstructive pulmonary disease.</p> <p>Review of the facility form titled, Influenza and Pneumococcal Vaccine, revealed Resident #28 indicated acceptance of the influenza vaccine and signed the form on 11/29/24. Further review of the medical record revealed no evidence the vaccine was administered.</p> <p>2. Review of the medical record of Resident #149 revealed an admitted [DATE]. Diagnoses included cystitis, atherosclerotic heart disease, chronic congestive heart failure, long-term use of anticoagulation therapy, hypertension, and chronic obstructive pulmonary disease.</p> <p>Review of the medical record revealed the form titled, Influenza and Pneumococcal Vaccine, was blank.</p> <p>Interview on 01/08/24 at 2:00 P.M. with the Director of Nursing revealed Resident #149 was cognitively impaired and unable to consent and her Power of Attorney has not been in to sign any documents. The DON did admit the facility could have received verbal phone consent and had not.</p> <p>Interview on 01/07/24 at 3:15 P.M. with the Director of Nursing revealed the influenza vaccine is offered October through March. The pneumococcal vaccine is offered upon admission and yearly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365973	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Birchaven Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 Birchaven Lane Findlay, OH 45840	

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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031</p> <p>Based on record review and staff interview, the facility failed to ensure residents received education and provided consent for COVID-19 vaccinations prior to administration or refusal. This affected five resident (#28, #46, #82, #149, and #201) of five residents reviewed for COVID-19 vaccination. The facility census was 90.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the medical record of Resident #28 revealed an admitted [DATE]. Diagnoses included rhabdomyolysis, type II diabetes mellitus, obesity, cerebral infarction, and chronic obstructive pulmonary disease. Review of the medical record revealed no form to indicate Resident #28 was given any information on COVID-19 vaccination nor any consent or refusal of the vaccine. Review of the medical record of Resident #46 revealed an admitted [DATE]. Diagnoses included spinal stenosis, anemia, hyperlipidemia, hypertension, cerebral infarction, and chronic obstructive pulmonary disease. Review of the medical record revealed no form to indicate Resident #46 was given any information on COVID-19 vaccination nor any consent or refusal of the vaccine. Review of the medical record of Resident #82 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, type II diabetes mellitus, anemia, obesity, cerebral infarction, and chronic obstructive pulmonary disease. Review of the medical record revealed no form to indicate Resident #82 was given any information on COVID-19 vaccination nor any consent or refusal of the vaccine. Review of the medical record of Resident #149 revealed an admitted [DATE]. Diagnoses included cystitis, atherosclerotic heart disease, chronic congestive heart failure, long-term use of anticoagulation therapy, hypertension, and chronic obstructive pulmonary disease. Review of the medical record revealed no form to indicate Resident #149 was given any information on COVID-19 vaccination nor any consent or refusal of the vaccine. Review of the medical record of Resident #201 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, hypothyroidism, hypertension, and chronic kidney disease. Review of the medical record revealed no form to indicate Resident #201 was given any information on COVID-19 vaccination nor any consent or refusal of the vaccine. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365973	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Birchaven Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE 15100 Birchaven Lane Findlay, OH 45840	
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/07/24 at 3:15 P.M. with the Director of Nursing revealed the facility does not have a form for refusal or acceptance of the COVID-19 vaccine and the facility does not have a policy for offering the COVID-19 vaccine. The influenza vaccine is offered October through March. The pneumococcal and COVID-19 vaccines is offered anytime.</p>		