STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mentor Woods Skilled Nursing and Rehabilitation	8881 Schaefer St Mentor, OH 44060

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41526 Based on observation and interview the facility failed to maintain a clean and homelike environment within resident hallways and a shower room. This affected eight residents (#17, #24, #33, #35, #38, #46, #55 and #73) and had the potential to affect all 90 residents residing in the facility. Findings include: 1. Observation on 04/02/24 at 9:05 A.M. revealed two unused incontinence briefs stuffed into the handrail outside the room entrance for Residents #33 and #46; a yellow soiled sock on the floor near the room entrance for Resident #24; and a large Starbucks beverage and Starbucks food package placed within the handrail alongside the soiled linen and trash containers placed next to the room entrance for Resident #55. Observation on 04/02/24 at 12:01 P.M. revealed a consumed and dirty breakfast tray placed on top of a heating unit underneath the handrail next to the room entrance for Residents #17 and #38; two unused incontinence briefs stuffed into the handrail outside the room entrance for Residents #33 and #46; a yellow soiled sock previously on the floor now stuffed into the handrail between the room entrances for Residents #24 and #73; a consumed and dirty breakfast tray placed upon the seat of a wheelchair parked near the room entrance for Resident #35; a consumed and dirty breakfast tray placed on top of the soiled linen and garbage container located next to the room entrance for Resident #55. The large Starbucks beverage and Starbucks food package remained located within the handrail alongside the soiled linen and trash container. Interview on 04/02/24 at 12:07 P.M. with State tested Nursing Assistant (STNA) #284 verified the above observations. STNA #284 indicated the dirty meal trays were from residents who received a late breakfast tray and although it needed to go back to the kitchen, was uncertain of the procedure and had not yet been returned. STNA #284 confirmed the Starbucks beverage and food container were items purchased for her breakfast and being from agency did not know where to keep them, so she kept it near her in the resident care area. 2. Observation on 04/03/24 at 12:41 P.M. revealed the 300-hall shower room had no bag in the trash can, and the trash can was overfilled with trash items spilled over onto the floor which included paper towels, wadded up toilet paper, and a candy wrapper. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/03/24 at 12:43 P.M. with Licensed Practical Nurse (LPN) #238 verified the above findings in the 300-hall shower room. This deficiency represents non-compliance investigated under Complaint Number OH00152036 and Complaint Number OH00152394.

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	366015	A. Building B. Wing	04/19/2024

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on record review, facility policy review and interview, the facility failed to provide comprehensive, individualized and sufficient wound care for Resident #28 and Resident #95. This affected two residents (#28 and #95) of three residents reviewed for non-pressure related wound care. The facility census was 90. Actual harm occurred on 03/21/24 when Resident #28, who was incontinent and admitted for wound care, was directly admitted to the hospital with a foul smelling, pus draining, painful wound and diagnosed with cellulitis/infection due to a lack of monitoring and adequate wound care following the resident's admission on 03/12/24. Findings include: 1. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included polyneuropathy, diabetes mellitus type II, congestive heart failure, hidradenitis suppurativa (chronic skin condition which involve lesions from inflammation and infection of sweat glands), pain in hip, dorsalgia (back pain), cervicalgia (neck pain), acute kidney failure, and sciatica (pain down leg from back). Resident #28 was discharged to the hospital on 03/21/24 and returned to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #28 had no cognitive impairment, was occasionally incontinent of urine and frequently incontinent of bowel. Review of the hospital discharge information dated 03/11/24 revealed Resident #28 was treated for a hidradenitis suppurativa (HS) flare of the buttocks with left hip and buttock pain and received antibiotic treatment and zinc oxide paste (medicated paste that treats or prevents skin irritation like cuts, burns, or diaper rash) to the area. The wound care consultant recommended zinc oxide 20 percent ointment applied three times daily. Review of Resident #28's admission assessment dated [DATE] revealed a wound to the left buttock with no description or treatment documented. A weekly skin review dated 03/12/24 also reflected the left buttock wound with no documented description or treatment. In addition, the baseline care plan indicated open areas to the left buttocks. Review of the nursing progress notes dated 03/12/24 revealed Resident #28 was admitted to the facility for wound care. A message was left with the physician to review the admission, but there was no documented evidence the physician verified the admission orders. Review of the wound nurse practitioner progress note dated 03/14/24 revealed Resident #28's left buttocks HS measured 10.0 centimeters (cm) length by 12.0 cm width and 0.1 cm depth. Treatment was indicated to cleanse with normal saline, apply silver alginate (dressing to facilitate wound healing) to the base of the wound and secure with bordered foam twice daily. The nurse practitioner requested this order on 03/14/24 after examination, but the order was not initiated. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the skilled nursing note dated 03/14/24 indicated Resident #28 had two areas covered by bandages without a location or further information related to the areas. Review of the nursing progress note dated 03/16/24 revealed Resident #28 called emergency services and indicated not feeling well, wanting narcotics and to be taken to the hospital. Emergency services provided transfer but there was no additional documentation related to Resident #28's complaint. Review of the hospital visit summary dated 03/16/24 revealed Resident #28 was treated at the emergency room for a musculoskeletal problem and returned to the facility. Diagnoses included rib pain and muscle strain of chest wall, initial encounter. Orders were given for Robaxin (muscle spasms and pain) 750 milligrams (mg) every six hours as needed up to three days, and Lidocaine four percent patch (relieves minor pain including nerve pain) daily for five days and remove after 12 hours. Review of Resident #28's physician orders dated 03/17/24 revealed a left buttocks treatment to cleanse with normal saline, dry, apply silver alginate and cover with a foam border dressing twice daily and as needed. There were no treatment orders initiated to the left buttocks prior to 03/17/24. Review of Resident #28's physician orders and medication administration record (MAR) for March 2024 revealed the hospital ordered Robaxin and Lidocaine patches were not ordered or made available to Resident #28 until 03/18/24. These orders should have started on 03/16/24 following the residents return from the emergency room . Review of the wound nurse practitioner progress note dated 03/21/24 revealed Resident #28's left buttocks HS had worsened, measuring 4.0 cm length by 24.0 cm width and 0.1 cm depth, and had a malodourous (foul smelling) odor after cleansing was completed. The wound had a heavy amount of seropurulent exudate (yellow to tan colored secretions). There was a high concern for infection and escalation of care to the hospital was recommended. Arrangements were made for hospital transfer. Review of the nursing progress note dated 03/21/24 revealed Resident #28 was direct admitted to the hospital using emergency services. Resident #28 complained of pain and was medicated with Oxycodone, an opioid pain medication. The progress note was void of the location of the pain. Review of the hospital discharge information dated 03/25/24 revealed Resident #28 was admitted for diagnosis of left hip cellulitis. Resident #28 was presented to the hospital with a left hip infection and had a history of HS of the buttock and received treatment for it at the facility. (The buttock and hip were used interchangeably because the area was large and encompassed both the buttock and hip). Resident #28 reported to the hospital staff the dressing was supposed to be changed twice daily but the facility staff were not doing it, indicating four dressing changes in ten days. Resident #28 developed pain in the left buttock which gradually got worse which required an emergency room visit due to difficulty sitting and standing due to the pain. Intravenous (IV) antibiotic treatment was administered, and wound orders were to wash daily with soap and water, cover with Xeroform (non-adherent dressing) and apply Mepilex (absorbent foam dressing). Review of Resident #28's physician orders dated 03/25/24 revealed the left buttocks treatment order was changed to wash daily with soap and water, cover with Xeroform and cover with Mepilex daily at bedtime. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the wound nurse practitioner progress note dated 03/28/24 at 12:59 P.M. indicated the left buttocks HS was a full thickness wound with a mild odor and ordered a new treatment plan to cleanse with normal saline, apply silver alginate to the base of the wound, and secure with an abdominal dressing pad daily. Review of Resident #28's treatment administration records from March 2024 to April 2024 revealed there was no evidence of wound care provided to the left buttock from admission on 03/12/24 until initiated on 03/17/24. The left buttocks wound treatment ordered on 03/17/24 was not signed as completed on 03/19/24 but was signed as completed on 03/22/24 day shift when Resident #28 was no longer in the facility. Additional treatments effective March 2024 including vital signs every shift and laboratory testing were signed as completed on 03/22/24 day shift when Resident #28 was not in the facility. The left buttock wound treatment dated 03/25/24 was administered from 03/25/24 through 04/03/24 and was not changed on 03/28/24 as requested by the wound nurse practitioner. On 04/02/24 at 11:47 A.M. interview with Resident #28 revealed complaints of left hip dressing changes not being completed by facility staff and indicated the dressing was changed four times in the last 11 days which caused an infection. Resident #28 reported trying to talk to the nurses, and no one did anything about it. Pain in the wound area increased so he called emergency services to get help. Then the wound became infected, and Resident #28 was admitted to the hospital. Attempts to observe wound care three times throughout the survey were unsuccessful because Resident #28 refused to allow the surveyor to observe the area. Interview on 04/04/24 at 1:17 P.M. with Director of Nursing (DON) verified the above findings. The DON stated Resident #28's wound was not treated after admission until 03/17/24 but remembered placing a dressing on it on 03/14/24 when Resident #28 complained about treatments not being completed. Despite the complaint, wound treatment orders were not initiated until 03/17/24 when the DON audited the wound notes. The DON notified the physician but did not document it. The DON confirmed Resident #28 contacted emergency services for increased pain and upon return on 03/16/24 was not offered treatment intervention until 03/18/24. The DON indicated a phone call was received at some time by the hospital case manager regarding Resident #28's complaint of no wound care and verified Resident #28 was ultimately admitted with a wound infection. Review of the facility policy, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised April 2018, revealed the staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions, and the physician will order pertinent wound treatments. Review of the facility policy, Pain - Clinical Protocol, revised October 2022, revealed the physician and staff will identify pain, and provide non-pharmacologic and medication interventions to address the pain. 37097 2. Review of the medical record for Resident #95 revealed an admitted [DATE]. Diagnoses included diabetes, neuropathy, cellulitis of the right lower limb, and localized edema. Review of the admission MDS assessment dated [DATE] revealed Resident #95 had intact cognition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of physician orders for April 2024 identified orders to cleanse the left shin with normal saline solution, pad dry, cover with form dressing daily and as needed dated 03/01/24. Review of the Treatment Administration Record (TAR) for March and April 2024 revealed ordered wound care was not completed as ordered on 03/12/24, 03/13/24, 03/19/24, and 03/22/24. Interview on 04/04/24 at 3:56 P.M. the DON verified Resident #95 did not receive wound care on the dates noted. This deficiency represents non-compliance investigated under Complaint Number OH00152133 and Complaint Number OH00152075.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 Based on interview and record review the facility failed to ensure thorough and accurate fall investigations were completed for Residents #5, #94, and #97. This affected three residents (#5, #94, and #97) of four residents reviewed for accidents. The facility census was 90. Findings include: 1. Review of the medical record for Resident #97 revealed a readmitted [DATE]. The resident was discharged to the hospital on 03/12/24. Diagnoses included acute kidney failure, gout, urinary tract infection (UTI), anxiety disorder, diabetes, cirrhosis of liver, fall from chair-subsequent disorder, and ascites. Review of the admission 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 had moderately impaired cognition. Review of the nurse's note dated 03/13/24 at 12:56 A.M. revealed the nurse went to Resident #97's room to take her vital signs for blood pressure medication administration. Resident #97 was found on the floor with her back leaning against her bed. Vital signs included temperature 97.7 degrees Fahrenheit (F), blood pressure 79/36, pulse 85, respirations 20, oxygen saturation 97% on room air, 0/10 pain. No injuries were noted. The resident was assisted back into bed. The resident was to be sent to the emergency room (ER) for further evaluation. The family was notified of the fall and the transfer to the hospital. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) #248 were notified as well. Review of the nurses note dated 03/21/24 at 9:09 P.M. revealed Resident #97's risk factors were reviewed by the interdisciplinary team (IDT) related to the fall that occurred on 03/12/024. The root cause of the fall appeared to be impaired cognition/altered mental status/balance deficit. All care plan interventions were in place at the time of the incident, and the resident did not sustain major injury. All previous/current interventions remain appropriate currently to assist in minimizing resident opportunity for fall and injury. Intervention immediately implemented: assessed for injury/pain, assisted to place of safety. The resident was sent to the hospital for altered mental status. Intervention was reviewed and appeared appropriate. All responsible parties were notified of the incident and agreed with the current intervention and plan of care. Fall Investigation into Resident #97's fall on 03/12/24 at 9:30 P.M. revealed the nurse's description of the incident, which was the same as the nursing progress note. No injuries were noted at this time. Physiological factors included the resident was confused and hypotensive. Situational factors were ambulating without assistance, and the resident did not use the call light. The investigation included the IDT note, nurses progress note, a pain assessment, a therapy referral, and a new fall risk evaluation. There were no witness statements. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/24 at 10:56 A.M. with the family of Resident #97 revealed they had only left the facility about 30 minutes earlier when they got the word the resident had fallen. The nurse found her up against the wall. It was very unclear to them how she could have fallen. She was not talking, not able to transfer, and not able to stand, yet she was found lying up against the wall. The facility called to let us know she had fallen, we said we were on our way. While getting ready, the facility called back and said the resident's blood pressure was low, and she was being sent out in an ambulance. Interview on 04/02/24 at 2:01 P.M. with State tested Nurse Aide (STNA) #211 revealed Resident #97 did not fall. STNA #211 and another STNA were changing her, and the resident was too close to the edge. The resident was placed in a sitting position up against the bed and then one of the STNAs got the nurse. Interview on 04/02/24 at 2:39 P.M. with the DON revealed Resident #97 had a fall and went to the hospital, we were trying to rule out an UTI because her behavior was different. The fall the DON saw documented was during night shift, and the facility had a problem with getting fall witness statements. Interview on 04/04/24 at 9:01 A.M. with the DON revealed there were no witness statements for the fall. The DON stated STNA #211 had an excellent memory and did not doubt his accuracy. Interview on 04/09/24 at 3:33 P.M. verified fall concerns with DON. The DON verified the fall investigation was not thorough and was inaccurate considering STNA #211's interview. The resident had not gotten out of bed and fallen. She was not ambulating without assistance and had not failed to use the call light. 2. Review of the medical record for Resident #5 revealed a readmitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), conduct disorder, cellulitis, and congestive heart failure. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #5 had impaired cognition. Review of the nurse's note date 01/13/24 at 7:11P.M. revealed Resident #5 was noted on the floor lying on the left side close to his bed. The resident denied pain. Resident was assessed. No injuries or skin tears were noted. Neurological checks were initiated, and the resident's vital signs were within normal limits. Review of the Fall Investigation completed 01/13/24 revealed there were no witness statements. The intervention was a perimeter mattress. Observation on 04/04/24 at 12:23 P.M. of Resident #5 revealed there was not a perimeter mattress on the bed. There was no documentation regarding why the intervention of a perimeter mattress was not completed. (continued on next page)

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	366015	A. Building B. Wing	04/19/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/04/24 at 9:01 A.M. with the DON revealed there were no witness statements for the falls. Resident #5 refused to get out of bed for us to put the perimeter mattress on. The facility had a perimeter mattress. The DON verified there was no documentation of the refusal. 3. Review of the medical record for Resident #94 revealed a readmitted [DATE]. Diagnoses included fracture of the left femur, diabetes, falls, dementia with agitation, and bipolar disorder. Review of the Annual MDS assessment dated [DATE] revealed Resident #94 had intact cognition. There were no nursing notes regarding Resident #94's fall on 02/12/24. The Fall Investigation for 02/12/24 revealed the fall description did not have enough detail. The nursing description was that the nurse heard a loud noise, and Resident #94 fell . The resident description was that she was trying to pull her pants down and fell . No neurological checks were implemented with an unwitnessed fall. The predisposing factors were listed as poor lighting and incontinence, but these were not addressed in the intervention. There were no witness statements. Interview on 04/09/24 at 3:28 P.M. all fall concerns were verified with the DON. This deficiency represents non-compliance investigated under Complaint Number OH00152036.

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	366015	A. Building B. Wing	04/19/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, and facility policy review, the facility failed to obtain orders for and provide sufficient urinary catheter related care for Resident #19. This affected one resident (#19) of one resident reviewed for urinary catheters. The facility census was 90. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type II, acute respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side, tracheostomy status, encephalopathy, and chronic kidney disease stage IV, severe. Resident #19 was discharged to the hospital on 02/28/24, re-entered the facility on 03/06/24, was discharged to the hospital on 03/17/24, re-entered the facility on 04/01/24, and was discharged to the hospital on 04/07/24. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was rarely or never understood and had a urinary catheter. Review of Resident #19's physician orders from 01/09/24 to 04/07/24 revealed no evidence of orders to monitor, maintain, or care for the urinary catheter. Review of Resident #19's medication administration records (MARs) and treatment administration records (TARs) for January 2024 to March 2024 revealed no evidence of care provided to monitor, maintain, or care for the urinary catheter. Review of the progress notes from January 2024 to April 2024 revealed Resident #19 had a urinary catheter on 01/11/24. On 02/05/24, two nurses placed a urinary catheter in Resident #19, and it was maintained. The documentation does not indicate when the previous urinary catheter was removed. On 04/02/24, a skilled review note indicated a urinary catheter was maintained. There was no additional documentation related to the urinary catheter. Observation on 04/03/24 at 10:46 A.M. with State tested Nursing Assistant (STNA) #211 of incontinence care for Resident #19 revealed no urinary catheter in place. Interview on 04/09/24 at 1:42 P.M. with Director of Nursing (DON) verified Resident #19 had a urinary catheter for urinary retention and believed it was placed on 02/05/24 but was removed after returning from the hospital on 04/01/24. The DON indicated urinary catheter orders included urinary catheter care every shift, and maintaining, monitoring, irrigating, and changing of the urinary catheter. The DON confirmed there were no urinary catheter related orders in place while Resident #19 had a urinary catheter, and no evidence sufficient urinary catheter care was provided. Review of the facility policy titled Urinary Incontinence - Clinical Protocol, revised April 2018, revealed with a long-term indwelling catheter, staff will monitor for complications such as a symptomatic urinary tract infection, urosepsis, or urethral erosion or pain.

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F 0692 Level of Harm - 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** 37097 Based on observation, interview, record review, and policy review, the facility failed to ensure Resident #62 received nutritional supplements as ordered, failed to develop and implement a comprehensive and effective nutrition program, and failed to obtain re-weights and/or weekly weights when a severe weight loss was noted. This affected one resident (#62) of three residents reviewed for nutrition. The facility census was 90. Actual harm occurred when Resident #62, who weighed 11.0 pounds on 01/04/24, experienced a severe 6.2% weight loss from 01/04/24 to 02/01/24, continued to lose an additional 8.4% from 02/01/24 to 03/01/24, and the weight loss was not addressed until 02/28/24. Resident #62 did not receive nutritional supplements as ordered. Resident #62's weight of 95.4 pounds on 03/01/24 reflected a severe weight loss of 14.5% over 56 days. Findings include: Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included rheumatoid arthritis (RA), diabetes, lupus, emphysema, Bell's palsy, hypertension (HTN), diabetes mellitus (DM), hyperlipidemia (HLD), schizophrenia, hypothyroidism, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had intact cognition. The assessment indicated the resident was 63 inches tall and weighed 111 pounds. Weight loss was marked as no or unknown. Review of the physician's orders for diet and nutritional supplements revealed: Consistent Carbohydrate Diet, Mechanical Soft texture, thin consistency Diet was ordered on 07/13/23. Super Cereal (high calorie, nutritious, and fortified cereal) in the morning with breakfast was ordered on 07/28/23. Boost Glucose Control (supplement) every morning and at bedtime eight (8) ounces (oz) between meals from nursing was ordered 09/27/23 and discontinued on 02/28/24. House Supplement with meals four (4) oz No Sugar Added Health Shake (supplement) three times a day with meals. Document percent consumed was ordered on 02/28/24. Regular diet, Mechanical Soft texture, thin consistency was ordered 02/29/24. Weekly weights for four weeks in the morning every Monday until 04/15/24 was ordered on 03/25/24. Review of weights revealed Resident #62 weighed 104.1 pounds on 02/05/24 (a 6% weight loss in one month). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mentor Woods Skilled Nursing and Rehabilitation	8881 Schaefer St Mentor, OH 44060

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for February 2024 for the Boost Glucose Control every morning and evening 8 oz between meals from nursing revealed morning intake was 0% (per staff, the 0% was when the resident did not receive the supplement) on 02/05/24, 02/06/24,02/ 07/24, 02/08/24, 02/09/24, 02/10/24, 02/11/24, 02/15/24, 02/16/24, 02/19/24, 02/20/24, 02/21/24, 02/22/24, 02/23/24, 02/24/24, 02/24/24, 02/25/24, and 02/26/24. Evening intake was 0% on 01/03/23, 02/04/24, 02/0524, 02/06/24, 02/07/24, 02/08/24, 02/09/24, 02/14/24, 02/15/24, 02/16/24, 02/18/24, 02/19/24, 02/20/24, 02/22/24, 02/24/24, and 02/25/24. Review of the nutrition note dated 02/28/24 at 1:40 P.M. authored by Registered Dietitian (RD) #282 revealed Resident #62 received a regular diet and liquids, mechanical soft meats, and protein. The resident had a pork intolerance. Meal intakes 50-100% consumption which is adequate, accepts fluids well. No skin issues or edema noted at this time per skin assessments. Recommended DC Boost Glucose Control due to corporate formulary update, recommending a four ounce No Sugar Added Health Shake three times daily with meals for 600 calories and 24 grams of protein daily; document percent consumed on the medication administration record (MAR). Continue Super Cereal as ordered. Will monitor upcoming March weight. The physician was notified of the significant weight loss. Review of weights revealed Resident #62 weighed 95.4 pounds on 03/01/24 (an additional 8% weight loss). Review of the medical record revealed no documented evidence a re-weight was obtained. Review of the medical record revealed no re-weight or weekly weight was documented after 03/01/24. Review of the nutritional care plan (initiated 07/13/23), last revised 03/21/24, revealed the resident was at risk for altered nutrition and dehydration related to multiple medical conditions including HTN, RA, lupus, emphysema, DM, HLD, schizophrenia, hypothyroidism, anxiety. The care plan reflected the resident had a pork intolerance and use of a mechanically altered diet. Therapeutic diet (supplement with meals). The resident's March (2024) weight indicated serious weight loss trend and underweight status. The resident was at risk for malnutrition related to serious weight loss and underweight status as evidenced by a body mass index (BMI) less than 18.5 and chronic disease. The interventions included supplements with meals three times a day, super cereal, and weekly weights. Review of the nutrition note dated 03/21/24 authored by RD #282 revealed Resident #62 received No Added Sugar Health Shakes three times daily with meals. Meal intake average 75-100% most meals per intake records. Dietary caters to food preferences and offers Super Cereal in the morning with breakfast. No chewing or swallowing difficulty reported. Weight history reviewed, noted September 2023 to January 2024 weights between 111 - 115 pounds. February weight was 104.1 pounds. Resident #62 remains at risk for altered nutrition and dehydration related to multiple medical conditions including hypertension, rheumatoid arthritis, lupus, emphysema, diabetes mellitus, hyperlipidemia, schizophrenia, hypothyroidism, anxiety, pork intolerance, mechanically altered diet, therapeutic diet (supplement with meals), significant weight loss and underweight status. Resident #62 is at risk for malnutrition related to significant weight loss as evidenced by body mass index less than 18.5, and chronic disease. Requests re-weight to confirm current body weight. Requests weekly weights times four weeks to monitor for trends. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/21/24 a request for diagnosis of at risk for malnutrition form was completed for Resident #62 based on the following criteria: Involuntary loss of 10% or more of usual body weight within six months, or involuntary loss of greater than or 5% or more of usual body weight in one month. BMI less than 18.5 (weight in kilograms divided by the square of height in meters (kg/m2) or greater than 25 kg/m2 and chronic disease. It was signed by the dietitian on 03/21/24 and approved by the physician on 03/21/24. Review of the medical record revealed no physician notes regarding nutrition or weight status in the medical record. Review of the MAR for March 2024 for the No Sugar Added House supplement revealed Resident #62 drank 100% or 0%. The 0% was when the resident did not receive the supplement. Breakfast was 0% on 03/03/24, 03/14/24, 03/15/24, 03/16/24, 03/20/24, 03/24/24, 03/27/24, 03/28/24, and 03/31/24. Lunch was 0% on 03/04/24, 03/14/24, 03/15/24, 03/17/24, 03/20/24, 03/24/24, 03/28/24, 03/29/24, and 03/31/24. Dinner was 0% on 03/02/24, 03/09/24, 03/11/24, 03/13/24, 03/14/24, 03/15/24, 03/20/24, 03/24/24, 03/27/24, 03/28/24, 03/29/24, and 03/31/24. Interview on 04/03/24 at 12:46 P.M. with Resident #62 revealed the resident stated she often didn't receive her sugar free supplement. She thought maybe the facility had been out of the sugar free ones. Observation on 04/03/24 at 12:12 P.M. and 12:46 P.M. of the lunch meal revealed Resident #62 did not have a supplement on her lunch tray. Interview on 04/03/24 at 1:16 P.M. with Dietary Manager, #285 revealed the facility had ginger ale per request. For supplements the facility carried Mighty Shakes, Sugar Free Mighty Shakes, boost pudding for medication administration, and Gelato magic cups. The Sugar Free Mighty Shakes had just come in and might have still been frozen. The Dietary Manager revealed the facility did not have a problem getting supplements. The dietary aide was responsible to place the supplements on the resident meal trays. Interview 04/03/24 at 1:40 PM. RD #282 revealed the RDs run a monthly report on weight loss. When they see weight loss, they try to figure out the cause. If the weight loss was unplanned, the RDs see if the resident was eating. The kitchen could offer extra portions, health shake mighty. The facility carried a protein supplement and a high protein pudding. Interview on 04/04/24 at 3:56 P.M. the Director of Nursing (DON) verified the above dates/meals a nutritional supplement was not received by Resident #62. Review of the MAR for April 2024 for the No Sugar Added House supplement revealed Resident #62 drank 100% or 0%. The 0% was when the resident did not receive the supplement. Breakfast was 0% on 04/15/24. Lunch was 0% on 04/17/24 and dinner was 0% on 04/13/17/24, 04/17/24, and 04/18/24. Interview on 04/19/24/ at 9:27 A.M. with the DON revealed weight loss was followed up on at the weekly risk management meetings. RD #282 sent an email at least weekly regarding resident's nutritional concerns. (continued on next page)

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	366015	A. Building B. Wing	04/19/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/19/24/ a 9:43 A.M. with Licensed Practical Nurse (LPN) /Unit Manager #247 revealed nursing did not notify the RD of weight loss. The RD reviewed weights and contacted the facility. The RD notified the physician of nutritional concerns. The unit manager and the nurses were responsible for making sure weekly weights were completed as ordered. LPN /Unit Manager #247 verified no weights were documented in the medical record for Resident #62 after 03/01/24. Interview on 04/19/24 at 10:58 A.M. with the DON verified no weights were documented in the medical record for Resident #62 after 03/01/24, and there had been no new orders due to the resident's weight loss. Interview on 04/19/24 at 11:12 A.M. with RD #282 revealed nursing did not notify the RD of residents with weight loss, the RD tracked it. The RD verified there was no nutrition note documented until 02/28/24 after the resident's weight loss documented 02/05/24, 23 days earlier. Weight loss residents were normally monitored weekly. The RD stated they might not write a note if there was no new information. RD #282 revealed Resident #62 was originally offered Boost, due to formulary changes made 02/28/24, the only option was to provide the house supplement. RD #282 did not usually recommend an appetite stimulant because she avoided adding additional medication. The physician or nurse practitioner sometimes ordered an appetite stimulant. RD #282 notified the physician of all resident nutritional concerns weekly on one form. Review of the Weight Assessment and Intervention policy, dated 03/2022, revealed residents were weighed upon admission and at intervals established by the interdisciplinary team. Weights were recorded in each unit's weight record chart and in the individual's medical record. Any weight change of 5% or more since the last weight assessment was retaken the next day for confirmation. If the weight was verified, nursing would immediately notify the dietitian in writing. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. This deficiency represents non-compliance investigated under Complaint Number OH00152036.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0695 Level of Harm - 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** 41526 Based on interview and record review, the facility failed to provide sufficient tracheostomy care for Residents #19 and #29. This affected two residents (#19 and #29) of three residents reviewed for tracheostomy care. The facility census was 90. Actual harm occurred on [DATE] and on [DATE] when Resident #19, who was cognitively impaired and was dependent on staff for tracheostomy care, was admitted to the hospital with acute on chronic respiratory failure with hypoxia, recurrent infection, and need for mechanical ventilation. On [DATE] there was concern for mucus plugging prior to the hospital stay which contributed to the respiratory failure. From admission on [DATE] through [DATE], there was no evidence Resident #19 received routine ordered tracheostomy care including administering oxygen, continuous monitoring of oxygenation levels, suctioning, changing the cannula, and cleaning the tracheostomy site outside of when the respiratory therapist was in the facility. Findings include: 1. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type II, acute respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side, tracheostomy status, encephalopathy, and chronic kidney disease stage four, severe. Resident #19 was discharged to the hospital on [DATE], re-entered the facility on [DATE], was discharged to the hospital on [DATE], re-entered the facility on [DATE], and was discharged to the hospital on [DATE]. Review of the admission Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #19 was rarely or never understood. The plan of care dated [DATE] indicated a need for tracheostomy care. Interventions included oxygen as ordered, monitor oxygenation levels as ordered, and suction tracheostomy as ordered. Review of Resident #19's physician orders for tracheostomy care revealed effective from [DATE] to [DATE] to change trach circuit every week and as needed; continuous pulse oximeter monitoring; maintain oxygenation greater or equal to 92 percent; suction as needed to clear secretions; oxygen via humidified trach collar on FIO2 (fraction of inspired oxygen) 28 percent two liters per minute (LPM) continuous; speaking valve as tolerated and maintain oxygenation of 92 percent or greater; and trach tube #6 Shiley every 30 to 45 days per respiratory therapy (RT). Effective from [DATE] to [DATE] were orders to suction via trach as needed and may use saline if needed every two hours, and trach care every shift and as needed. Review of Resident #19's medication administration records (MARs) and treatment administration records (TARs) for [DATE] to [DATE] revealed tracheostomy care every shift and as needed was completed. There was no documented evidence the additional effective tracheostomy care orders were completed. (continued on next page)

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	366015	A. Building B. Wing	04/19/2024

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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 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes from [DATE] to [DATE] revealed Resident #19 received varied tracheostomy care less than daily from a respiratory therapist during a scheduled shift in the facility. The care included tracheostomy care, changing of the cannula, suctioning, monitoring of oxygenation levels and respiratory assessment. The documented dates of completed tracheostomy type care were [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], and [DATE] to [DATE]. There was no documented evidence nursing provided routine ordered tracheostomy care on dates when a respiratory therapist was not working in the facility. On [DATE] at 8:55 P.M. the primary care physician (PCP) examined Resident #19 and indicated coarse lung sounds were present with upper airway secretions observed. On [DATE] at 3:22 P.M. the PCP examined Resident #19 and indicated rhonchi was present with a copious (abundant) amounts of secretions observed. On [DATE] Resident #19 had bloody sputum and was transferred to the hospital for evaluation and treatment. On [DATE], Resident #19 was sent to the hospital after pulse oxygenation decreased to 78 percent and heart rate was decreasing. Suctioning was performed until all secretions were cleared, but the heart rate still decreased. CPR (cardio-pulmonary resuscitation) was started until emergency services arrived. Resident #19's spouse reported to facility staff of Resident #19 being back on a ventilator. Resident #19 returned to the facility on [DATE]. On [DATE], the PCP examined Resident #19 and indicated rhonchi was present. Resident #19 was taken to the hospital for cardiac arrest, but it appeared it was respiratory failure and infection. On [DATE], Resident #19 had low oxygen saturation. Suctioning was performed and the inner cannula was changed but saturation kept decreasing. Staff bagged for ventilation until emergency services arrived. Review of hospital information from [DATE] to [DATE] revealed Resident #19 was previously admitted on [DATE] for tracheal bleeding and pneumonia with tracheal aspirate positive for multiple organisms which required antibiotic treatment. On [DATE], Resident #19 presented to the hospital post cardiac arrest with acute on chronic hypoxic respiratory failure. CPR was started at the facility and upon emergency services arrival had a heart rate in the 20s. Resident #19 was bagged and upon arrival to the hospital had a heart rate in the 80s and was placed on a ventilator. Resident #19 had decreased breath sounds, wheezing and rhonchi (coarse and loud sound in the larger airways). There was concern for mucus plugging prior to hospital arrival that caused the episode, and concern for pneumonia with sputum culture growing mixed bacteria. Antibiotic treatment was provided. Review of Resident #19's MAR and TAR for [DATE] revealed tracheostomy care every shift and as needed was completed. The suction via trach as needed and may use saline if needed every two hours effective from [DATE] to [DATE] was signed as completed on [DATE] at 10:29 A.M. and 3:00 P.M. There was no documented evidence the additional effective tracheostomy care orders were completed. (continued on next page)

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	366015	A. Building B. Wing	04/19/2024

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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 0695 Level of Harm - Actual harm Residents Affected - Few	Review of hospital information dated [DATE] revealed Resident #19 presented to the hospital with hypoxia and respiratory distress. After emergency services suctioned and bagged for ventilation, Resident #19 returned to normal oxygen saturation levels. Resident #19 was unable to respond to questions due to aphasia (difficulty with communication). Diagnoses was acute one chronic respiratory failure with hypoxia due to recurrent aspiration pneumonia, and sepsis. During an interview on [DATE] at 1:52 P.M. with Resident #19's family, the family voiced concerns Resident #19 did not receive adequate tracheostomy care which caused hospital stays and reported the hospital staff indicated Resident #19's trach was filthy. Interview on [DATE] at 9:31 A.M. with the Director of Nursing (DON) indicated Resident #19 was admitted to the hospital on [DATE] due to low pulse oxygenation and possible pneumonia. Interview on [DATE] at 12:22 P.M. with Respiratory Therapist (RT) #281 revealed a lack of routine or adequate suctioning could contribute to infection but was more likely to cause shortness of breath, difficulty breathing or desaturation (decreased oxygenation levels). Interview on [DATE] at 1:42 P.M. with the DON verified the above findings and indicated the respiratory care orders were in place but not visible to the nursing staff so there was no evidence the required care was provided as ordered or outside of when respiratory therapy was present in the facility. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] and re-entry date of [DATE]. Diagnoses included acute respiratory failure with hypoxia, metabolic encephalopathy, tracheostomy status, and dependence on respiratory ventilator status. Review of the quarterly MDS assessment dated [DATE] revealed Resident #29 had no cognitive impairment. The plan of care dated [DATE] indicated a need for tracheostomy care. Interventions included oxygen as ordered, monitor oxygenation levels as ordered, and suction tracheostomy as ordered. Review of the hospital information for facility re-entry on [DATE] indicated Resident #29 had a tracheostomy and collar without mechanical ventilation. Orders included continuous pulse oximetry, oxygen at ten liters per minute and suctioning. Review of Resident #29's active physician orders for tracheostomy care from [DATE] through [DATE] revealed to change trach circuit every week and as needed; change tracheostomy tube every 30 to 45 days and as needed; maintain oxygenation levels greater than 92 percent and respiratory rate less than 30 by continuous pulse oxygenation monitoring every shift; oxygen via humidified trach collar at FIO2 40 percent during daytime hours when respiratory therapy present; suction as needed; and trach care every shift. Review of Resident #29's MARs and TARs for [DATE] to [DATE] revealed no evidence of tracheostomy care orders completed after re-entry to facility on [DATE]. (continued on next page)

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	366015	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes from [DATE] to [DATE] revealed Resident #29 received varied tracheostomy care less than daily from a respiratory therapist during a scheduled shift in the facility. The care included tracheostomy care, changing of the cannula, suctioning, monitoring of oxygenation levels and respiratory assessment. The documented dates of completed tracheostomy type care were [DATE] to [DATE], and [DATE] to [DATE]. There was no documented evidence nursing provided routine ordered tracheostomy care on dates when a respiratory therapist was not working in the facility. Interview on [DATE] at 2:03 P.M. with Resident #29 revealed the resident believed tracheostomy care was provided but was not sure if it was completed or how it was supposed to be. Resident #29 indicated calling staff if help with the tracheostomy was needed. Interview on [DATE] at 2:46 P.M. with RT #281 and Licensed Practical Nurse (LPN) #238 while reviewing the electronic medical records verified there were no visible tracheostomy care orders for Resident #29. LPN #238 stated a reliance on RT #281 to perform tracheostomy related care when in the facility, but there was not anything visible for the nurses to follow or sign as completed when RT #281 was not in the facility. RT #281 stated the tracheostomy care orders must not have been put back in place when Resident #29 re-entered the facility on [DATE]. Interview on [DATE] at 3:30 P.M. with the DON verified the above findings. This deficiency represents non-compliance investigated under Complaint Number OH00152226.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff used appropriate infection control practices by not implementing required enhanced barrier precautions for Residents #19 and #61, appropriately handling soiled linen and paper hand towels for Resident #61, and not performing hand hygiene and using a clean barrier during wound care for Resident #22. This affected three residents (#19, #22 and #61) and had the potential to affect all 90 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included respiratory failure, tracheostomy status, and gastrostomy status. Hospital documentation dated 03/17/24 indicated a positive MRSA (Methicillin-resistant Staphylococcus aureus) which was a recognized MDRO (multidrug-resistant organism). Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included respiratory failure, gastrostomy status and tracheostomy status. Observation on 04/02/24 at 9:45 A.M. revealed Resident #61 was in bed and had a tracheostomy and gastrostomy tube. There were no enhanced barrier precautions (EBP) posted and no PPE (personal protective equipment) available at the room entrance. Observation on 04/02/24 at 9:47 A.M. revealed Resident #19 was in bed and had a tracheostomy. There were no posted EBPs and no PPE available at the room entrance. Observation on 04/02/24 at 12:07 P.M. revealed Licensed Practical Nurse (LPN) #238 at Resident #19's bedside and had completed a dressing change to Resident #19's tracheostomy. There were no posted EBPs and no PPE available at the room entrance. LPN #238 wore gloves and no gown. Observation on 04/03/24 at 10:46 A.M. revealed State tested Nursing Assistant (STNA) #211 performed incontinence care for Resident #19. There were no posted EBPs and no PPE available at the room entrance. STNA #211 wore gloves and no gown. Observation on 04/03/24 at 10:59 A.M. revealed Respiratory Therapist (RT) #281 performed tracheostomy suctioning, cannula cleaning, and dressing change for Resident #61. There were no posted EBP's and no PPE available at the room entrance. RT #281 wore gloves and no gown. Interview on 04/03/24 at 12:26 P.M. with LPN #247 and Director of Nursing (DON) verified Residents #19 and #61 did not have posted EBPs or PPE available at the room entrances. The DON indicated only just receiving the training regarding EBP on 04/01/24 and although knowing the requirement was effective had not yet trained the facility staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

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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 - Many	Review of the facility policy, Enhanced Barrier Precautions, dated August 2022, revealed EBPs are used as an infection prevention and control intervention to reduce the spread of MDROs to residents, and are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. 2. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included respiratory failure, gastrostomy status and tracheostomy status. Observation on 04/03/24 at 10:59 A.M. with RT #281 of tracheostomy care for Resident #61 revealed RT #281 entered the bathroom and performed hand washing. There was a small, soiled towel balled up and placed on the left sink area next to where RT #281 performed hand washing. The towel appeared wet and had a large amount of brown and yellow substance throughout with moist stringy brown mucus visible. Upon completion of hand washing, RT #281 noted there were no towels to dry hands then left the room with the soiled towel still in place on Resident #61's sink. RT #281 returned with a large roll of continuous paper towel used for the dispenser located on the bathroom wall. RT #281 placed the roll of paper towels on the back of the toilet on top of the toilet tank then proceeded to perform hand washing again with the same visibly soiled towel still on the left sink area and used the soiled roll of paper towels for hand drying. Interview at the time of the observation with RT #281 verified the soiled linen was not appropriately handled and needed to be removed. RT #281 removed the soiled linen, returned to Resident #61's bathroom, performed hand washing, and used the soiled roll of paper towel for hand drying. RT #281 proceeded to perform tracheostomy care including suctioning, cleaning of tracheostomy, and changing of the dressing. Multiple glove changes were performed with hand washing as required; however, RT #281 continued to use the soiled roll of paper towel for hand drying during the procedure. An additional interview at the time of the observation with RT #281 verified the roll of paper towel was soiled and used for hand drying during tracheostomy care for Resident #61. Review of the facility policy, Departmental (Environmental Services) - Laundry and Linen, revised January 2014, revealed all soiled linen must be placed directly into a covered laundry hamper which can contain the moisture and place any linen saturated with blood or body fluids into a leak-resistant bag before placing it into the hamper. 3. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included gastrostomy status, tracheostomy status, colostomy status, chronic respiratory failure, hemiplegia, and hemiparesis following cerebral infarction affecting right dominant side, and post procedural complications and disorders of digestive system. The physician orders effective March 2024 indicate an abdominal wound treatment to cleanse with wound cleanser, apply skin preparation, place alginate (wound dressing to promote healing) to the wound base, and cover with a foam dressing daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366015	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mentor Woods Skilled Nursing and Rehabilitation	8881 Schaefer St Mentor, OH 44060

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/04/24 at 11:28 A.M. with LPN #238 of wound care for Resident #22 revealed posted EBP at the room entrance door with PPE. Resident #22 had a tracheostomy and gastrostomy tube in place. LPN #238 donned a gown and gloves after performing hand washing. LPN #238 placed one of Resident #22's bed pillows on top of the lower extremities then prepared the wound supplies by opening a small abdominal dressing pad and spreading it out on top of the bed pillow. LPN #238 opened and placed the following wound supplies on top of the abdominal dressing pad: two cotton tip applicators, several gauze pads, a skin preparation pad, a calcium alginate dressing, and a foam dressing. Due to the number of supplies, it entirely covered the abdominal dressing pad and portions of the calcium alginate dressing and foam dressing exceeded the size of the pad used as a barrier and rested upon Resident #22's pillow. LPN #238 removed the old dressing with a gloved hand, discarded it then performed hand washing. LPN #238 donned a clean pair of gloves and cleansed the wound with wound cleanser from a spray bottle then used the gauze pads with cotton tip applicators to ensure adequate cleansing. LPN #238 removed the soiled gloves and without performing hand washing or hand hygiene, donned another pair of gloves. Using the unwashed gloved hands, LPN #238 with then applied skin preparation followed by the calcium alginate dressing and foam dressing which were contaminated by Resident #22's pillow. Interview at the time of the observation with LPN #238 verified hand washing or hand hygiene was not performed between gloves changes as required, and the confirmed the clean dressing supplies were not placed on top of an adequate barrier upon a disinfected surface. Review of facility policy, Handwashing/Hand hygiene, revised August 2019, revealed to perform handwashing or hand hygiene after removing gloves. This deficiency represents non-compliance investigated under Complaint Number OH00152036 and Complaint Number OH00152394.