STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366024	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sycamore Run Nursing and Rehab Ctr	6180 State Route 83 N Millersburg, OH 44654

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51074 Based on observation, record review and interview, the facility failed to maintain resident dignity when an indwelling urinary catheter drainage bag was not covered. This deficient practice affected one resident (Resident #48) of two reviewed for dignity. The facility census was 89. Findings Include: Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including but not limited to unspecified injury at unspecified level of the cervical spinal cord, type two diabetes mellitus, paraplegia and neuromuscular dysfunction of the bladder. Review of the physician order dated 10/14/24 for Resident #48 revealed 16 French foley catheter with 10 cubic centimeter (cc) balloon to continuous drainage due to neuromuscular dysfunction of the bladder; Catheter care every shift; Change foley catheter as needed for signs and symptoms of infection, obstruction, system compromise dated 09/18/24. Review of the plan of care for Resident #48 dated 11/13/24 revealed an alteration in elimination colostomy, foley catheter, neurogenic bladder, constipation, duodenal ileus. Resident #48 refuses catheter securement device at times. Will be free of complications related to appliance use through target date. Interventions: Foley catheter care every shift and as needed (prn), empty foley catheter bag every shift and prn; Secure foley catheter tubing to prevent accidental dislodgement; Foley catheter bag in place. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 (out of a possible 15 points) indicating moderate cognitive impairment. Resident #48 was assessed to be dependent on staff for toileting, bathing, dressing, bed mobility, required a mechanical lift for transfers and had an indwelling urinary catheter. An observation on 01/13/25 at 9:33 A.M. of Resident #48 revealed the resident was lying in bed and the indwelling urinary catheter drainage bag was hanging on the right side of the bed frame. The catheter drainage bag was uncovered and urine that had collected in the catheter drainage bag was visible from the hallway. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/14/25 at 7:41 A.M. revealed Resident #48 was lying in bed and the indwelling urinary catheter bag was hanging on the bed frame, exposing urine that had collected in the drainage bag and was visible from the hallway. Interview on 01/14/25 at 7:43 A.M. with certified nursing assist (CNA) #28 confirmed the indwelling urinary catheter bag was uncovered and was visible from the hallway.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, interviews and review of the facility Management of Personal Funds form revealed the facility failed to have written authorization to manage Resident #54's funds. This affected one (Resident #54) of five residents reviewed for personal funds. The facility census was 89. Findings include: Review of the medical record revealed Resident #54 was admitted on [DATE] with diagnoses that included vascular dementia, peripheral vascular disease, type II diabetes, and major depressive disorder. Review of the Management of Personal Funds form dated 10/15/24 revealed the form was marked that Resident #54 did not wish to open a personal funds account and he would manage his own funds or have a person or entity other than the facility manage his money while at the facility. Resident #54 agreed to hold the facility harmless for any loss that occurred to their personal money. Lastly, the form was signed by Resident #54. The Medicare 5-day Minimum Data Set assessment dated [DATE] revealed Resident #54 had a brief interview mental status score of seven which indicated severe cognitive impairment. The fourth quarter Trust Statement, dated 11/06/24, revealed a deposit of $746.25 was made into Resident #54's account. Interview with Resident #54 on 01/13/25 at 10:25 A.M. revealed Resident #54 would like a haircut but did not know if he had money to pay for the haircut. Interview on 01/14/25 at 10:58 A.M. with Business Office Manager (BOM) #90 verified Resident #54 had money in an account for a haircut. An additional interview on 01/24/25 at 1:52 P.M. with BOM #90 verified a personal funds account had been opened for Resident #54 but a Management of Personal Funds form had not been signed. Review of the facility Management of Personal Funds form revealed every resident was encouraged to exercise the right of managing his/her financial affairs. However, upon written authorization of a resident, responsible party, or legal guardian, the facility will hold, safeguard, manage and account for the personal funds of the resident deposited with us.

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NAME OF PROVIDER OR SUPPLIER: Sycamore Run Nursing and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 6180 State Route 83 N Millersburg, OH 44654	

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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** 19571 Based on medical record record review, observation, staff interview, and policy review, the facility failed to ensure fall interventions were implemented. This affected two (Resident #10 and Resident #34) of four residents reviewed for accidents. The facility census was 89. Findings include: 1. Review of Resident #34's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and pre-diabetes. Review of the plan of care dated 08/14/23 revealed Resident #34 is at risk for falls. Interventions included: Alarming floor mat beside the bed, taped down with brightly colored tape and a Motion Sensor to the floor while the resident is in the room to alert staff to attempts of unassisted ambulation and transfers. Check function and placement every shift. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not intact. She used a walker for ambulation, and required supervision or touching assistance with eating, oral hygiene and personal hygiene, substantial/maximal assistance for toileting, and shower/bathing. Review of the Physician's Order revealed orders on 11/20/24 Motion Sensor Alarm to floor while resident is in room, to alert staff to attempts of unassisted transfers/ambulation. Check function and placement every shift and on 11/20/24 Alarming floor mat on floor beside bed. Check function and placement every shift. Review of the fall assessment dated [DATE] revealed she was at risk for falls. Observations on 01/13/25 at 2:45 P.M. revealed the motion sensor alarm was observed lying on the dresser. This was verified during interview with Licensed Practical Nurse (LPN) #121 at 2:47 P.M. On 01/14/25 at 1:15 P.M. and 3:35 P.M. observation revealed Resident #34 was seated in the recliner in her room, watching television. The mat to the floor was under the bed and no bright colored tape was observed. On 01/15/25 at 8:32 A.M. observation revealed Resident #34 was sitting up in the recliner with the sensor alarm lying on the bed and in the off position. The mat remained under the bed with no bright colored tape observed. At 8:35 A.M. interview with LPN #72 verified the sensor alarm was off and on the bed and the floor mat was not taped to the floor with brightly colored tape. 34298 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #10 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, heart disease, pulmonary embolism, absence of right leg above the knee, tachycardia, depression, and Raynaud's syndrome. A plan of care dated 01/03/23 revealed Resident #10 was at risk for falls. Interventions included the bed to be in the lowest position, the bed locked, and call light within reach. The quarterly MDS dated [DATE] revealed Resident #10 was cognitively intact. Observation on 01/13/25 at 9:22 A.M., revealed Resident #10 was lying in bed with eyes closed. Resident #10's bed was not in the lowest position. Observation on 01/15/24 at 8:49 A.M. revealed Resident #10 was lying in bed with eyes closed. Resident #10's bed was not in the lowest position Interview on 01/15/24 at 8:57 A.M. Certified Nursing Assistant (CNA) #109 verified Resident #10's bed was not in the lowest position. Review of the Fall Management policy and procedure dated 10/17/16 revealed Each resident will be assessed throughout the course of treatment for different parameters such as; cognition, safety awareness, fall history, mobility, medications, or predisposing health conditions that may contribute to fall risk. An interdisciplinary team will attempt to balance safety needs, resident rights and quality of life issues that will positively impact each resident's situation and reduce the risk of occurrence. Residents who experience a fall will receive prompt medical attention. Immediate needs will be quickly assessed and responded to. A plan will be identified and implemented as necessary to protect the resident and/or others from recurrence.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review and interview, the facility failed to maintain an accurate medical record for Resident #47. This affected one resident (#47) of 16 reviewed. The facility census was 89. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included paralytic syndrome following cerebral infarction bilateral, type two diabetes mellitus, respiratory disorders, obstructive sleep apnea, vascular dementia with behavioral disturbance, cognitive social or emotional deficit following cerebral infarction, dysphagia following cerebral infarction, chronic kidney disease stage three, major depressive disorder, chronic pain syndrome, gout, hypertension, hyperlipidemia, allergic rhinitis, heart disease, fibromyalgia, gastroesophageal reflux disease, polyneuropathy, cluster headache syndrome, insomnia, anxiety disorder, and epididymitis. The comprehensive list of diagnoses in the electronic medical record for Resident #47 did not include psychosis or any other severe mental health diagnoses. Review of the psychiatry notes dated 03/07/24 and 11/07/24 indicated Resident #47 was receiving psychiatric services for cognitive impairment secondary to vascular dementia, insomnia, and psychosis secondary to general medical condition. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/28/24, revealed Resident #47 had no cognitive impairment. The assessment indicated Resident #47 had a diagnosis of non-Alzheimer's dementia and had a cerebrovascular accident/transient ischemic attack/stroke, he did not have diagnoses of schizophrenia, bipolar disorder, psychotic disorder other than schizophrenia, or post-traumatic stress disorder, and the resident had received an antipsychotic medication within the seven day lookback period. The assessment also indicated Resident #47 had delusions and did not have any hallucinations. Review of the physician's orders for January 2025 identified orders for Risperidone tablet 0.25 milligrams (mg) by mouth twice daily to be given with the 0.5 mg tablet to equal 0.75 mg for vascular dementia (ordered 11/06/24) and Risperdal tablet 0.5 mg by mouth twice daily to be given with the 0.25 mg tablet to equal 0.75 mg for vascular dementia (ordered 11/06/24). On 01/14/25 at 11:33 A.M., an interview with the Director of Nursing (DON) verified Resident #47 had an order for Risperidone/Risperdal to treat vascular dementia. A follow-up interview at 2:30 P.M. verified Resident #47 did not have a diagnosis of psychosis in the comprehensive list of diagnoses. On 01/15/25 at 1:06 P.M., an interview with Psychiatric (Psych) Physician #133 confirmed Resident #47 had a diagnosis of psychosis secondary to a general medical condition. He further stated Resident #47 was receiving Risperidone to treat delusions and psychosis not related to dementia behaviors.