STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366037	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bowerston Hills Nursing & Rehabilitation	9076 Cumberland Road Bowerston, OH 44695

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51519 Based on interviews and record reviews the facility failed to ensure Resident #13 was assisted out of bed on the weekends per resident preference. This affected one (Resident #13) of one residents reviewed for resident rights. Findings include: Record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, insomnia, weakness, constipation, and cerebral palsy. Review of the Minimum Data Set (MDS) Assessment completed 02/13/25 revealed a brief interview for mental status score of 12 out of a possible 15, indicating moderate cognitive impairment. Section D for mood and behavior revealed Resident #13 did have little interest or pleasure in doing things, during six days Resident # 3 felt down, depressed, or hopeless, had trouble falling or staying asleep, or sleeping too much, felt tired or had little energy, and moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual. This resulted in a total severity score of 10. Section G of the MDS for activities of daily living (ADL) revealed Resident #13 was an extensive two plus person assist for bed mobility - how the resident moved to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. Total dependence two plus person physical assist for transfer - how the resident moved between surfaces including to or from: bed, chair, wheelchair, standing position. Two plus extensive physical assist for toilet use, how the resident used the toilet room, commode, bedpan, or urinal; transferred on/off toilet; cleansed self after elimination; changed pad; managed ostomy or catheter; and adjusted clothes. Review of Resident #13's care plan completed on 02/13/25 revealed Resident #13 was at risk for decline in ADL function related to cerebral palsy, weakness, and hypertension. Goals included Resident #13 would maintain current range of motion and the residents ADL's would be met. Interventions included to allow time for rest breaks, encourage resident participation while performing Activates of daily living (ADL), notify nursing of any complaints of pain or discomfort, provide necessary adaptive equipment to meet daily needs, staff to anticipate needs and assist as needed, encourage activity during daily care, encourage to attend activities and assist as needed, monitor decline in care and report to clinical staff as needed, and notify therapy of any decline in condition. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's care plan completed on 02/13/25 revealed Resident #13 had potential for activity deficit related to decreased mobility. Interventions and goals included Resident #13 would participate in activities of choice, assist resident to activities as needed, encourage resident to come to group activities, provide resident access to activity calendar, staff to provide one to one as needed. Review of tasks for transferring from bed to chair and from chair to bed revealed Resident #13 did not get out of bed on Saturday 03/15/25, Saturday 03/29/25, Sunday 03/30/25, Saturday 04/05/25, and Sunday 04/06/25. Review of task for bowel movements (BM) revealed Resident #13 on Saturday 03/15/25 had one BM , Saturday 03/29/25 had four BM's, Sunday 03/30/25 had no BM's, Saturday 04/05/25 Resident #13 had no BM's , and Sunday 04/06/25 Resident #13 had one BM. Review of progress notes and resident record revealed no documentation as to why Resident #13 was not transferred out of bed or refusal to get out of bed on Saturday 03/15/25, Saturday 03/29/25, Sunday 03/30/25, Saturday 04/05/25, and Sunday 04/06/25. Interview on 04/07/25 at 10:06 A.M. with Resident #13 stated on the weekends she stayed in bed because the staff don't want to put her in her wheelchair . Resident #13 stated she was unsure why she couldn't get out of bed, but she would like to get into her chair on the weekends. Interview on 04/09/25 at 1:01 P.M. with Certified Nursing Assistant (CNA) #210 revealed Resident #13 required Hoyer assistance to get out of bed. CNA #210 stated Resident #13 had good range of motion (ROM) with her arms. She stated that on the weekends there were two aides and one nurse for all shifts except midnight shift had one CNA. CNA #210 stated, at times, Resident #13 would refuse to get out of bed. She stated that about a month or so ago, the resident was having a lot of loose stools, so she was staying in bed more often. Interview on 04/09/25 at 1:17 P.M. with CNA #76 stated Resident #13 required a hoyer lift to get out of bed. CNA #76 stated if Resident #13 had diarrhea, she would stay in bed. CNA #76 shared that on the weekends, Resident #13 would sometimes choose to stay in bed. Interview on 04/09/25 at 1:26 P.M. with Licensed Practical Nurse (LPN) #19 stated Resident # 13 would refuse to get out of bed on the weekends at times if she didn't like the activities. If Resident #13 was having bowel movements, she would stay in bed because getting in and out of bed with the hoyer lift took a lot of her energy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on review of the medical record, interview, and review of facility policy, the facility failed to ensure the comprehensive care plan for Resident #1 was revised after a fall and change in elopement risk. This affected one resident (Resident #1) of 13 residents with care plans reviewed The facility census was 19. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including parkinsonism, calculus of gall bladder with acute cholecystitis, conversion disorder with seizures or convulsions, altered mental status, glaucoma, chronic hepatitis, unspecified lack of coordination, diffuse traumatic brain injury, and dementia with behavioral disturbances. Review of the annual Minimum Data Set (MDS) 3.0 assessment revealed Resident #1 had severely impaired cognition and exhibited no behaviors, including rejection of care or wandering behaviors. Further review of the MDS revealed Resident #1 had experienced one fall with injury since the previous comprehensive assessment which was completed on 10/08/24. Review of the progress notes revealed the following On 09/19/24 at 9:31 A.M. a nursing note indicated the nurse had updated the physician that Resident #1 was no longer capable of elopement and was incapable of physically getting himself to exit areas. On 11/18/24 at 6:45 A.M. a nursing note revealed Resident #1 sustained an unwitnessed fall in his room and was found on his floor with a puddle of blood noted under his head. The note further revealed that Resident #1 received first aid and was transported by squad to the emergency room for evaluation and treatment. On 11/18/24 at 9:30 A.M., the nursing note revealed Resident #1 returned to the facility with a laceration to the top right side of his head, a skin tear to his right elbow, and scattered bruising to his right side. On 11/19/24 at 9:40 A.M., the nursing note revealed that the laceration to Resident #1's right elbow had steri-strips in place and the right head laceration had required sutures. Review of all progress notes from 11/07/24 through 12/07/24 revealed no concerns related to Resident #1 wandering or at risk for elopement and no evidence of an interdisciplinary team (IDT) meeting to review the fall risk care plan interventions for continued appropriateness or need for revision. Review of the clinical assessments titled Elopement Risk Screen between 09/04/24 and 03/08/25, which included screenings dated 09/04/24, 09/19/24, 12/05/24, and 03/08/25, revealed Resident #1 was no longer at risk for elopement. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 06/18/18 (last reviewed 01/09/25) revealed Resident #1 had a care plan focus related to being at risk for wandering and elopement secondary to dementia, confusion, and a previous traumatic brain injury (TBI). The elopement risk care plan was initiated on 02/22/21 and the last revision was made on 09/19/24. The care plan also revealed Resident #1 was at risk for falls and fall related injury secondary to seizures, glaucoma, weakness, and TBI. Further review of the fall risk care plan revealed the fall Resident #1 sustained on 11/18/24 was not added to the care plan and no new interventions were added after the 11/18/24 fall. However, the resident was moved closer to the nurses' station for closer observation. Review of the fall investigation initiated 11/18/24 revealed a fall incident report, the progress note dated 11/18/24 at 6:14 A.M., and the post fall risk assessment completed on 11/18/24. None of the documents provided included any post-fall follow-up information, such as injuries sustained, or newly added interventions. Interview with the Director of Nursing (DON) on 04/09/25 at 1:30 P.M. confirmed the paperwork she provided was all she had available regarding the investigation into Resident #1's fall on 11/18/24 because the chart had been thinned, and she would have to search in medical records for any additional information surrounding the fall. No additional information had been provided by the end of the survey on 04/10/25. Interview on 04/09/25 at 3:47 P.M. with MDS Coordinator #27 confirmed Resident #1's last elopement risk assessments revealed he no longer was high risk for elopement and that she had not caught up with updating the care plan because she had not seen the assessments. MDS Coordinator #27 further confirmed she did not attend quarterly resident care conferences. Review of the fall policy last revised 11/04/22 revealed the facility was to implement an intervention based off the fall investigation to prevent a similar fall, update the care plan with the new intervention(s), and communicate the new intervention(s) to direct care staff. The policy further revealed the IDT would meet to discuss the fall, review statements, determine the root cause, implement new interventions based on the determined root cause, and the resident's care plan was to be updated immediately upon completion of the fall investigation. Review of the Care Plan Policy and Procedure dated December 2019 revealed the comprehensive care plan was to be updated quarterly and as needed to ensure accuracy and ongoing appropriateness of interventions.

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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** 51519 Based on observation, interview, record review, review of the facility water management plan and policy review the facility failed to ensure infection control measures were implemented during a dressing change. This affected one resident (Resident #4) observed for dressing change during wound care. The facility also failed to follow their written water management plan for Legionella. This had the potential to affect all residents. Findings include: 1. Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure, muscular dystrophy, dysphagia, unspecified protein-calorie malnutrition, anxiety disorder, dependence on ventilator status, major depressive disorder, gastrostomy status, and attention to tracheostomy. Record review revealed an order for enhanced barrier precautions (EBP) ordered on 11/01/24 due to wounds, a tracheostomy, and gastrostomy (feeding) tube. Further review of the physician orders revealed to cleanse the left and right buttock open areas with normal saline, apply collagen and cover with a dry, sterile, dressing (DSD) every evening. Review of the Minimum Data Set (MDS) Assessment completed on 03/01/25 revealed the resident had intact cognition. Observation on 04/09/25 at 10:45 A.M. of a dressing change for Resident #4 revealed the resident was in enhanced barrier precautions. Nurse Practitioner (NP) #888 was wearing a gown and gloves and Licensed Practical Nurse (LPN) #19 was assisting with the dressing change and was also wearing a gown and gloves. NP #888 removed the old dressings for two areas on Resident #4 buttocks. The NP was not observed to remove her gloves or perform hand hygiene NP #888 cleansed the right side wound with saline and gauze and proceeded to cleanse the left wound with gauze and saline without hand hygiene or a glove change. The wounds measured (right and left wound) measure to be 0.1 centimeters (cm) by (x) 0.1 cm each. The left wound with serosanguinous (clear, blood tinged) drainage, the right wound with serous (clear) drainage. No hand hygiene or glove change performed before skin prep and collagen was applied to both wound beds. NP #888 continued to wear the same gloves as when she started the procedure. NP #888 opened border foam dressings and applied one to each wound. No hand hygiene or glove change was completed. Resident #4 was then repositioned in bed and NP #888's moved Resident #4's bedside table while still wearing the gloves that were initially applied upon entrance to the resident's room. Then NP #888 removed the soiled gloves and gown, discarded the items and used alcohol based hand rub for hand hygiene. Interview with NP #888 on 04/09/25 at 11:13 A.M. confirmed hand hygiene and glove changes should have been performed during the dressing change for Resident #4 and she did not perform hand hygiene by washing or using an ABHR. NP #888 confirmed gloves were not changed during the dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy named Hand Hygiene revision date August 2019 revealed hands should be washed with soap and water or an antiseptic agent used before and after providing routine care, after contact with a resident's intact skin, after contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings. Use of gloves include being easily accessible and worn in situations such as changing gloves after removing wound dressing and before placing new dressing. 2. Review of the facility's water management program dated 10/27/24 revealed water temperatures would be gathered weekly at each of the facility's water heaters to ensure water was being maintained at 140 degrees Fahrenheit. Review of the water temperature log with weekly water temperatures checked at each of the facility's six hot water tanks revealed temperature between 100 degrees Fahrenheit and 119 degrees Fahrenheit from 11/07/24 through 03/25/25. Interview on 04/09/25 with Maintenance Director #11 revealed he obtained the weekly temperatures for the water management program from the faucets, not from each of the facility water heaters as directed in the facility water management plan.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51519 Based on interview and record review the facility failed to implement antibiotic stewardship regarding antibiotic use. This affected one (Resident #70) of one resident reviewed for antibiotics. Findings include: Record review revealed Resident # 70 admitted to the facility on [DATE] with diagnoses including dementia, hypertension, benign prostatic hyperplasia without lower urinary tract symptoms, obesity, type 2 diabetes, schizoaffective disorder, auditory hallucinations, cataracts, hypothyroidism, depression, chronic obstructive pulmonary disease. Review of the minimum data set (MDS) completed 04/02/25 revealed the resident had severe cognitive impairment. Review of Resident #70's care plan completed on 04/04/25 revealed the resident is exhibiting signs and symptoms of a urinary tract infection (UTI). Goals included the resident will be free from signs and symptoms of a UTI after completion of antibiotics. Interventions included to administer antibiotic as ordered, encourage resident to increase fluids, monitor for pain and medicate as ordered, monitor for signs of increased risk for falls related to possible confusion, monitor vital signs for increase in temperature, notify physician and family of a change in condition, obtain urine for urinalysis and culture & sensitivity as ordered. Review of Resident #70 electronic medical record revealed a progress note dated 04/02/25 at 12:41 P.M. by Licensed practical nurse (LPN) #98 stating Resident #70 was being sent to the emergency department for evaluation due to low blood pressure, lethargy, and blood-tinged urine, not responding as he normally does, and ambulance is here at this time to transport resident. Review of Resident #70 progress note revealed a note by LPN #98 dated 04/02/25 at 5:50 P.M. stated Resident #70 was admitted to the hospital with a urinary tract infection (UTI). Record review revealed Resident # 70 was sent to the emergency department on 04/02/25 for altered mental status (AMS) by emergency medical services (EMS) from the facility stating over the last few days he had not been eating or drinking and had a decreased mental status, blood was also noted in his urine by nurses, he was hypotensive at 80/60 millimeters of Mercury (mm Hg) (normal blood pressure 120/60 mm Hg), dry mucous membranes, confused upon arrival to the emergency department, urinalysis showed cloudy urine with moderate bacteria. Blood cultures and urine cultures were pending at the time of hospital discharge on 04/03/25. Resident # 70 was discharged from the hospital on 04/03/25 with an order for cefdinir (antibiotic) 300 mg oral capsule give one capsule by mouth twice a day for seven days. Record review revealed an order placed on 04/03/25 for cefdinir oral capsule 300 milligram (MG) give one capsule by mouth two times a day for UTI until 04/11/25. Review of Resident #70 progress note revealed a note by LPN #19 dated 04/03/25 at 5:32 P.M. stating Resident #70 had returned from the hospital. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #70 progress note dated 04/04/25 at 2:59 P.M. stating Resident #70 was being transported to the hospital. Review of Resident #70 progress note dated 04/05/25 at 2:10 P.M. stating Resident #70 returned from the hospital with a diagnosis of altered mental status and UTI. Awaiting pending urine culture and blood cultures. Orders for Keflex were received. Review of Resident #70 progress note dated 04/05/25 at 4:55 P.M. stating Medical Director #737 wished to cancel Keflex (antibiotic) order and continue cefdinir that was already ordered. Record review revealed no evidence of any documentation of receiving blood cultures or urine culture and sensitivity for the hospitalization on [DATE] through 04/03/25 or documentation of hospital discharge, urinalysis or urine culture and sensitivity for the emergency department visit on 04/04/25 through 04/05/25. Record review revealed one attempt by LPN #19 to receive urine culture and sensitivity from the hospital via fax on 04/07/25. Further review of the medical record revealed a fax received from a local hospital dated 04/09/25 at 8:53 A. M. that showed Resident #70's urine culture collected on 04/04/25 and resulted on 04/07/25 showed no bacterial growth. Record review revealed a fax dated 04/09/25 at 11:40 A.M. from the other hospital that indicated Resident #70's urine culture collected 04/02/25 and resulted on 04/04/25, after 36 hours, showed no bacterial growth. Interview on 04/09/25 at 8:17 A.M. revealed licensed practical nurse (LPN) #19 faxed a request for the urine and blood culture results on 04/07/25 but she was unsure if it came in. LPN #19 stated Resident #70 was currently on antibiotics. LPN #19 stated they would like to have the culture results before continuing the antibiotics, but Medical Director #737 wanted to continue the cefdinir. Interview on 04/09/25 at 8:34 A.M. with the director of nursing (DON) revealed no urine or blood culture results had been received from either hospital for Resident #70. Interview on 04/09/25 at 10:05 A.M. with LPN #19 revealed Resident #70 urine culture results were negative and she would call the physician to discontinue the antibiotic.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51519 Based on record review, interview and policy review the facility failed to ensure an influenza vaccination was administered to one (Resident #70) resident per request/signed consents. This affected one (Resident #70) of five residents reviewed for vaccinations. Findings include: Record review revealed Resident # 70 admitted to the facility on [DATE] with diagnoses including dementia, hypertension, obesity, type 2 diabetes, schizoaffective disorder, auditory hallucinations, hypothyroidism, depression, and chronic obstructive pulmonary disease. Further medical record review revealed a signed consent form for the administration of the influenza vaccine signed by Resident #70's appointed representative and dated 03/30/25. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 03 (out of a possible 15) indicating cognitive impairment. Review of Resident #70's March 2025 and April 2025 medication administration record (MAR) and treatment administration record (TAR) revealed no documentation Resident #70 had received the influenza vaccination. Record review revealed no documentation that Resident #70's representative, who gave consent for Resident #70 to receive the influenza vaccine, was notified that the vaccination was not given or not available for administration. Interview on 04/10/25 at 11:05 A.M. with the Director of Nursing (DON) revealed residents are offered vaccinations on admission and will receive them if they consented to administration. The DON shared influenza vaccinations are completed annually, if the facility runs out of vaccinations they will put in an order from the pharmacy and they typically receive the vaccine within two to four business days. The DON stated Resident #70 had not received his influenza vaccine and there was no documentation of Resident #70's representative being notified of this. The DON stated the influenza vaccine was not administered to Resident #70 because the facility ran out of the vaccine and no one at the facility notified her of this. Review of the undated Influenza Policy revealed between October 1st and March 31st or as otherwise indicated per the Centers for Disease Control (CDC) each year, the influenza vaccine shall be offered to residents unless the vaccine is medically contraindicated or the resident has already been immunized. Residents admitted between October 1st and March 31st shall be offered the vaccine within five (5) working days of the resident's admission to the facility. For those who receive the vaccination the date of the vaccination, lot number, expiration date, person administering and the site of the vaccination will be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record.