STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366062	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caprice Health Care Center	9184 Market St North Lima, OH 44452

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** 52011 Based on record review, staff interview, and observations, the facility failed to ensure all residents were treated in a dignified manner. This affected four (Resident #40, Resident #6, Resident #22, Resident #34) of 29 residents that required a mechanical lift for transfers. The facility census was 64. Findings include: Review of Resident #40's clinical record revealed an admitted [DATE] with diagnoses including vascular dementia, hemiplegia, neurogenic bladder, chronic respiratory failure, and calorie malnutrition. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #40 required a mechanical lift for transfers. Review of Resident #6's clinical record revealed an admitted [DATE] and diagnoses including Alzheimer's disease, major depressive disorder, history of falls, and chronic congestive heart failure. Review of Resident #22's clinical record revealed an admitted [DATE] and diagnoses including hemiplegia, kyphosis (abnormally curved spine), contractures of right and left shoulders, left wrist, and left and right knee. Review of Resident #34's clinical record revealed an admitted [DATE] with diagnoses of Alzheimer's disease, major depressive disorder, hypokalemia, and generalized edema. Observation on 04/21/25 at 11:10 A.M. revealed Resident #40 was sleeping in her bed with a mechanical lift pad underneath her. Interview with Certified Nurse Aide (CNA) #833, at the time of the observation, confirmed the lift pad beneath Resident #40. CNA #833 also confirmed that when Resident #40 was returned to bed via a mechanical lift the lift pad was not removed. Observation on 04/21/25 at 11:30 A.M. revealed Resident #6 was in bed with a mechanical lift pad underneath her as she slept. Interview with CNA #833, at the time of the observation, confirmed the lift pad beneath Resident #6. CNA #833 also confirmed that when Resident #6 was returned to bed via a mechanical lift the lift pad was not removed. (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	Observation on 04/22/25 at 9:35 A.M. revealed Resident #22 was in his bed sleeping with a mechanical lift pad underneath him. Interview with Director of Nursing (DON) #819, at the time of the observation, confirmed the lift pad beneath Resident #22. DON #819 said it was not the facility procedure to leave mechanical lift pads underneath residents. Observation on 04/22/25 at 11:25 A.M. revealed Resident #34 was in bed with a mechanical lift pad underneath the resident. Interview with Wound Licensed Practical Nurse (LPN) #891, at the time of the observation, confirmed the lift pad beneath Resident #34. Interview with DON #819 and Wound LPN #891 on 04/23/25 at 12:51 P.M. confirmed the mechanical lift pads were left underneath Resident #40, Resident #6, Resident #22, and Resident #34 when they were placed back into bed after meals. They also indicated leaving the lift pads underneath the residents did not promote the dignity and skin integrity of the residents. Review of the facility's undated Quality of Life- Dignity policy revealed that each resident would be cared for in a manner that promoted and enhanced the quality of life, dignity, and respect.

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F 0695 Level of Harm - Minimal harm or potential for 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** 51526 Based on observations, interviews, record review and facility policy review, the facility failed to ensure respiratory equipment was dated to make certain it was changed at appropriate intervals to decrease the risk of acquired pneumonia or infection. This affected three residents (#26, #27, #127) of six residents reviewed for respiratory care. The facility census was 64. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, dependence on respirator (breathing machine), tracheostomy, quadriplegia, and gastrostomy (feeding tube). Review of Resident #26's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition and altered level of consciousness. Resident #26 was also completely dependent for all activities of daily living (ADL) and hygiene needs. Review of the care plan dated 03/11/25 revealed Resident #26 had respiratory failure, a tracheostomy and was ventilator dependent. Interventions included changing tracheostomy setup per physician orders and as needed per respiratory therapist (RT). Review of Resident #26's physician orders dated 10/19/22 revealed ventilator circuits and all related ventilator, tracheostomy, oxygen setup to be changed per respiratory therapist (RT). Observation on 04/22/25 at 9:23 A.M. revealed Resident #26's ventilator circuit and oxygen tubing was not dated. Interview on 04/22/25 at 9:23 A.M. with RT #881 and Registered Nurse (RN) # 801 verified that ventilator circuit and oxygen tubing was not dated. RT #881 stated ventilator circuits were to be changed every ninety days or as needed. RT #881 also verified that the ventilator circuits were the responsibility of the respiratory therapy department and therapist and the initials of the RT and change date should be labeled on the circuit/humidified water system. 2. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses of acute and chronic respiratory failure with hypercapnia, stenosis of larynx, tracheostomy, and dependence on supplemental oxygen. Review of the MDS 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The functional assessment noted Resident #27 needed moderate assistance with ADLs and hygiene needs. Review of the care plan dated 04/16/25 revealed Resident #27 had impaired air exchange due to acute and chronic respiratory failure and chronic obstructive pulmonary disease. Interventions included maintaining oxygen saturation levels greater than 88 percent, keeping airway patent through tracheostomy, oxygen via tracheostomy mask at 35 percent, and have tracheostomy, oxygen and nebulizers set up and changed per RT. Review of Resident #27's physician orders dated 12/27/23 revealed tracheostomy, oxygen, and nebulizer set would be changed per RT. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/22/25 at 9:36 A.M. revealed Resident #27's tracheostomy collar oxygen set up was not dated. Interview on 04/22/25 at 9:36 A.M. with RT #881 and RN #801 verified the oxygen setup was not dated to ensure it was changed at an appropriate time interval. 3. Review of the medical record for Resident #127 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, tracheostomy, dependence on supplemental oxygen, gastrostomy, anoxic brain damage and seizures. Review of the MDS 3.0 assessment dated [DATE] revealed severe cognition impairment and response to painful stimuli only. Resident #127 had complete dependence for all ADLs and hygiene needs. Review of the care plan dated 04/13/25 revealed Resident #127 had impairment related to anoxic brain injury and had a tracheostomy. Resident #127 was high risk for self-decannulation and/or disconnection from oxygen. Interventions included assessing the need to suction to clear airway, avoidance of respiratory depression medications, closed suction system, and monitoring respiratory status. Tracheostomy, oxygen and nebulizer set up to be changed per RT. Review of Resident #127's physician orders dated 04/11/25 revealed to change tracheostomy per RT every 90 days and as needed, suction via airway as needed and to change the tracheostomy ties twice a week and as needed. Observation on 04/22/25 at 9:43 A.M. revealed Resident #127's trach collar oxygen set up was not dated. Interview on 04/22/25 at 9:43 A.M. with RT #881 and RN #801 verified the trach collar oxygen set up was not dated to ensure it was changed at an appropriate time interval. Review of facility policy titled Respiratory Therapy: Aerosol/Tracheostomy Set up revised on 07/15/21 revealed the oxygen setup required a label or tape on tubing indicating the date and initials of person changing the system. Review of facility polity titled Respiratory Therapy: Oxygen Therapy revised on 7/15/21 revealed that masks, cannulas and tubing should be changed as follows: a. For ventilator and tracheostomy residents: change on admit then every thirty days and again as needed. b. For non-ventilator tracheostomy residents: change on admit then every thirty days as needed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 52011 Based on record review and staff interview, the facility failed to ensure the accuracy of medical records. This affected one of 32 residents whose records were reviewed, Resident #40. Facility census was 64. Findings include: Review of Resident #40's clinical record revealed an admitted [DATE] with diagnoses including vascular dementia, hemiplegia, neurogenic bladder, chronic respiratory failure, and calorie malnutrition. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #40 did not have any unhealed pressure ulcers or injuries. Review of the Nurses Skin/ Wound notes dated 04/10/25 timed 10:05 A.M. revealed Resident #40 was at high risk for impaired skin integrity. Resident #40 required maximum to total assistance for bed mobility. Diagnosis of hemiplegia, incontinent of bowel, and use of Foley (urinary) catheter for neurogenic bladder. Resident #40 had a history of pressure injuries and the use of left resting-hand splint to left hand. Skin integrity was maintained and would continue current preventative care. Review of the Nurse Practitioner visit notes dated 04/22/25 timed 9:37 A.M. revealed documentation indicating Resident #40 had current wounds. Further review of the Nurse Practitioner notes dated 04/18/25, 04/16/25, and 04/15/25 indicated Resident #40 had wounds. Interview with Wound Licensed Practical Nurse #894 on 04/23/25 at 9:45 A.M. revealed Resident #40 did not have any wounds or skin impairment at this time. Interview with Director of Nursing # 819 and Nurse Practitioner #123 on 04/23/25 at 9:49 A.M. verified the Nurse Practitioner notes dated 04/15/25, 04/16/25, 04/18/25, and 04/22/25, were not accurate regarding Resident #40 having wounds; the entries were made in error. Nurse Practitioner #123 indicated because she was in a hurry when documenting she copied and pasted the information from another entry and did not make the necessary revisions to accurately reflect Resident #40's current status.