Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366088 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Austinburg Nsg and Rehab Ctr | 2026 State Route 45<br>Austinburg, OH 44010 |

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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969<br><br>Based on record review and interview, the facility failed to ensure timely notification of Resident #74's fall to the resident representative. This affected one resident (#74) of one resident reviewed for notification of change. The facility census was 82.<br><br>Findings include:<br><br>Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, cognitive communication deficit, and vascular dementia, moderate, with agitation.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #74 had severely impaired cognition.<br><br>Review of the interdisciplinary team (IDT) progress note dated 01/22/25 at 3:45 P.M. revealed a fall on 01/13/25 was discussed. Resident #74 noted to be confused with agitation and was wandering into other residents' rooms. He was last seen sitting on his bed at 4:00 A.M. As an aide was answering another resident's call light, she heard a male voice coming from a resident room, and upon opening the door Resident #74 was laying on his right side behind the door. He was assisted up and placed in wheelchair and brought to the common area. The physician was notified regarding increased behaviors and medication adjustment made. Medication adjustment effective at this time.<br><br>Review of the progress note dated 01/23/25 at 10:56 A.M. revealed a nurse attempted to contact emergency contact list on Resident #74's face sheet to inform Resident #74's resident representative of resident's fall on 01/13/25, but there was no answer, so a message was left to contact facility.<br><br>Review of the progress note dated 01/23/25 at 11:11 A.M. revealed Resident #74's resident representative returned the call at 11:09 A.M., the fall was reviewed with her and advised of the medication adjustment made after the fall due to his wandering and agitation. She indicated that she was in contact with Resident #74's son who resided in another state and would update him as well.<br><br>Review of the fall investigation dated 01/13/25 revealed the resident representative was notified on 01/23/25 at 11:09 A.M. noted under time of notification.<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 01/29/25 at 3:44 P.M. with Assistant Director of Nursing (ADON) #720 stated the internet was down on 01/13/25 so that was why the fall wasn't documented on that day. ADON #720 verified Resident #74's resident representative was notified on 01/23/25 and stated she was not sure why it took 10 days. ADON #74 stated the expectation for notifications were to be immediately if able.<br><br>Reviewed policy Notification of Change, dated 07/2017 revealed the resident's physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change in condition, potential discharge, room transfer, or death. Under notification, item number eight revealed the resident legal representative or interested family member is notified of a significant change in the resident condition unless the resident has specified otherwise. The legal representative or family member may indicate to the facility specific notification parameters. Should this occur, document and place behind the face sheet in the chart and care plan their preferences. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51067<br><br>Based on record review, interview and review of facility policy, the facility failed to ensure the interdisciplinary team was present as required when care plan conferences were conducted for Resident #24 and Resident #75. This affected two residents (Resident #24 and #75) of two residents reviewed for care planing. The facility census was 82.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including cellulitis of right lower limb, acute respiratory failure with hypoxia, sepsis, hypertensive chronic kidney disease, cognitive communication deficit, methicillin resistant staphylococcus aureus infection, type two diabetes mellitus with diabetic neuropathy, and hypertension.<br><br>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact.<br><br>Review of the facility documents titled Care Conference, dated 10/30/24 and 01/13/25 revealed only Resident #24, Social Services (SS) #823, MDS Registered Nurse (RN) #811 and a therapist were present for the care conference on 10/30/24 and only Resident #24, SS #823 and MDS RN #811 were present for the care conference on 01/13/25 There was no additional information on the form to indicate any other members of the facility interdisciplinary care team took part in the care conferences.<br><br>Interview with Resident #24 on 01/27/25 at 8:59 AM revealed he believed he had not had a care conference with members of the facility care team.<br><br>Interview with SS #823 on 01/29/25 at 3:43 PM verified all members of the health care team at the facility do not attend care conferences for Resident #24 as required. SS #823 stated she sent a schedule out each Friday to the care team and before the scheduled care conferences to inform staff of the upcoming meetings the following week however not all required staff members attend. SS #823 stated her care conference with the residents last approximately 10 minutes and are very informal so the residents possibly misunderstand their care conferences as a general discussion.<br><br>2. Review of the medical record for Resident #75 revealed an admitted [DATE] with diagnoses including acquired absence of right leg below knee, hereditary and idiopathic neuropathy, major depressive disorder and hypertension.<br><br>Review of the MDS 3.0 assessment dated [DATE] revealed Resident #75 had intact cognition.<br><br>Review of the facility documents titled Care Conference, dated 11/21/24 revealed only Resident #75, Social Services (SS) #823, MDS Registered Nurse (RN) #811, a therapist and another nurse were present for the care conference on 11/21/24. There was no additional information on the form to indicate any other members of the facility interdisciplinary care team took part in the care conferences.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with SS #823 on 01/29/25 at 3:43 PM verified all members of the health care team at the facility do not attend care conferences for Resident #75 as required. SS #823 stated she sent a schedule out each Friday to the care team and before the scheduled care conferences to inform staff of the upcoming meetings the following week however not all required staff members attend. SS #823 stated her care conference with the residents last approximately 10 minutes and are very informal so the residents possibly misunderstand their care conferences as a general discussion.<br><br>Review of Resident Assessment Comprehensive Care Plans policy (updated 05/24/2022, reviewed 01/01/25) revealed, an interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. |

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough food/fluids to maintain a resident's health.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195

Based on observations, interviews, medical record review, and review of facility policy, the facility failed to ensure meal intakes were recorded for Residents #13, #18, #65, and #66, failed to ensure weights were obtained and recorded into the medical record for residents #13 and #41 and failed to ensure therapeutic diets were implemented as ordered for Residents #65 and #66 to allow for accurate nutritional assessment and monitoring of nutritional status. This affected five residents (#13, #18, #41, #65, and #66) out of five reviewed for nutrition. The facility census was 82.

Findings include:

1. Review of Resident #66's medical record revealed an admitted [DATE]. Diagnoses included non-displaced fracture of greater trochanter of right femur, Alzheimer's disease, dementia, major depressive disorder, type two diabetes, and dysphagia.

Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 01/15/25, revealed Resident #66 was severely impaired cognitively, dependent on staff for eating, had no significant weight loss over one and six months, and was on a therapeutic diet.

Review of Resident #66's care plan, initiated on 01/15/24, revealed the resident was at risk for malnutrition. Interventions included assistance with meals as needed, diet per doctor's order, medication as ordered and monitor labs as needed.

Review of Resident #66's labs revealed on 08/02/24 potassium (normal range 3.5 to 5.1 millimoles per liter) was low at 3.1 millimoles per liter (mmol/L), on 08/06/24 potassium level was low at 3.3 mmol/L, on 08/09/24 potassium level was low at 3.3 mmol/L, and on 9/03/24 potassium level was 3.7 mmol/L which was within the normal range but was at the lower end of the normal reference range which was 3.5 to 5.1 mmol/L.

Review of physician orders for Resident #66 revealed an order dated 10/03/24 to push high potassium foods, regular diet with extra gravy on tray, sugar substitute, thin liquids with two glasses of punch/juice with meals.

Review of the annual nutritional assessment dated [DATE] and authored by Registered Dietitian (RD) #826 revealed Resident #66 was on a regular diet, extra gravies, high potassium, sugar substitute diet and was consuming 75-100% of meals and ate in her room. Resident #66's weight had triggered a significant weight increase over three months, but weight had been fairly stable over the past month. Resident #66 had recently tested positive for Covid-19 on 01/06/25 and the dietitian indicated she would monitor intakes and make adjustments as needed.

Review of meal intake records in Resident #66's medical record from 01/01/25 to 01/29/25 revealed there were no meal intakes recorded.

Review of Resident #66's lunch meal tray ticket for 01/28/25 revealed Resident #66 was on a regular diet with sugar substitute. Listed under the section titled beverage/equipment on the tray ticket was two glasses of juice, ginger ale and juice water

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 01/28/25 at 12:57 P.M. revealed on Resident #66's lunch meal tray was ginger ale, iced tea, milk, sloppy joes, green beans, and rice crispy treat. At the time of observation, Certified Nursing Assistant (CNA) #513 confirmed there was no juice or juice water on the tray served to the resident.<br><br>Observation on 01/28/25 at 5:40 P.M. of Resident #66's dinner tray revealed one can of ginger ale, one glass of water, one cup of coffee, one bowl of crushed pineapple, and one plate with chicken pot pie and broccoli. At the time of observation, CNA #616 confirmed what was on the meal tray.<br><br>Interview on 01/29/25 at 10:01 A.M. with CNA #513 revealed meal intakes were supposed to be put into the resident's electronic medical record (EMR) but confirmed meal intakes hadn't been put into the EMR due to lack of time. She stated she had most of the intakes in her brain and would tell the nurse if a resident hadn't eaten a meal.<br><br>Interview on 01/29/25 at 10:05 A.M. with CNA #511 confirmed meal intakes were not being documented into the EMR and the reason she hadn't documented meal intakes was she lost track of time.<br><br>Interview on 01/29/25 at 2:31 P.M. with RD #826 revealed for residents on high potassium diet the facility would push high potassium foods by offering banana at breakfast and orange juice at all meals. RD #826 confirmed Resident #66 was to receive high potassium foods and beverages. After RD #826 reviewed Resident #66's meal tray ticket, she confirmed the meal tray ticket did not state to give orange juice at all meals. RD #826 also confirmed there were no meal intake records in the medical record for Resident #66 for the month of January 2025 so for purposes of nutritional assessments and monitoring of the therapeutic diet she would get her information from nursing on how much the resident was eating. RD #826 verified she was not aware Resident #66 was not getting orange juice at all meals.<br><br>Review of facility policy Nutrition Assessment, revised August 2023, revealed nurse aides were to complete food intake and record daily.<br><br>2. Review of Resident #65's medical record revealed a readmitted [DATE]. Diagnoses included displaced interochanteric fracture of left femur, fracture of right forearm, essential hypertension, anxiety disorder, and localized edema.<br><br>Review of the 01/06/25 admission MDS 3.0 assessment, dated 01/06/25, revealed Resident #65 was cognitively intact, required setup or clean up assistance for eating, had no significant weight changes and was on a therapeutic diet.<br><br>Review of the care plan, initiated on 01/06/25, revealed Resident #65 was at nutritional/hydration risk. Interventions included 2000 cubic centimeter (cc) fluid restriction (1080 dietary/920 nursing), diet per doctor's orders, monitor for signs and symptoms of fluid imbalance, monitor labs as needed, and monitor meal intake/record.<br><br>Further review of Resident #65's medical record revealed an admission nursing note dated 12/31/24 indicating the resident was to be on a 2,000 cc fluid restriction due to low sodium levels.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of physician orders revealed an order dated 01/01/25 for a regular, thin liquids diet and an order dated 01/06/25 for 2000 cc/24 hr (hour) fluid restriction (1080 cc dietary and 920 cc nursing)<br><br>Review of Resident #65's recorded meal intakes from 01/01/25 to 01/30/25 revealed there were no recorded meal intakes.<br><br>Review of 01/06/24 initial nutritional assessment authored by RD #826 revealed Resident #65 was on a regular diet, and was consuming 75 to 100 percent of meals. The resident was receiving a 2000 cc fluid restriction due to low sodium levels.<br><br>Review of labs in Resident #65's medical record revealed the last sodium lab level was drawn on 10/21/24 and it was 137 millimoles per liter (mmol/L), which was at the lower end of the normal reference range of 137 to 147 mmol/L.<br><br>Observation on 01/27/25 at 12:46 P.M. revealed on Resident #65's lunch meal tray there was one full bowl of chicken noodle soup which consisted of broth, chicken, and noodles, one eight ounce (240cc) full glass of lemonade, one eight ounce (240 cc) carton of two percent milk and one eight ounce (240 cc) cup of hot chocolate. At the time of observation Certified Nursing Assistant (CNA) #620 confirmed the soup and beverages on the meal tray.<br><br>Observation on 01/28/25 at 1:02 P.M. revealed on Resident #65's lunch tray was one eight ounce (240 cc) cup of hot chocolate, one full eight ounce (240 cc) glass of lemonade, and one eight ounce (240 cc) carton of two percent milk. Sitting on top of her overbed table was a full pitcher of water. At the time of observation, CNA # 511 confirmed the beverages on the meal tray and the full water pitcher.<br><br>Observation on 01/28/25 at 5:44 P.M. revealed on Resident #65's dinner tray was one eight ounce cup (240 cc) of hot chocolate, and one full eight ounce (240 cc) cup of lemonade. There was a full water pitcher on the overbed table. At the time of observation CNA #620 confirmed the beverages on the meal tray and the water pitcher.<br><br>Interview on 01/29/25 at 10:01 A.M. with CNA #513 revealed meal intakes were supposed to be put into the resident's electronic medical record (EMR) but confirmed meal intakes hadn't been put into the EMR due to lack of time. She stated she had most of the intakes in her brain and would tell the nurse if a resident hadn't eaten a meal.<br><br>Interview on 01/29/25 at 10:05 A.M. with CNA #511 confirmed meal intakes were not being documented into the EMR and the reason she hadn't documented meal intakes was she lost track of time. CNA # 511 indicated she normally worked the unit where Resident #65 resided and was unaware of Resident #65 being on a fluid restriction and stated every resident had a water pitcher.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 01/29/25 at 2:25 P.M. with RD # 826 confirmed Resident #65 was on a fluid restriction due to history of having low sodium lab levels. She stated Resident #65 was to receive one eight ounce (240cc) hot beverage and a half of an eight ounce (120cc) glass of juice for each meal for a total of 1080cc/day. She stated the aides should be reading the tray ticket and should be providing what is on the tray ticket. She also indicated that a resident on a fluid restriction was not supposed to have a water pitcher at bedside. She also stated if a resident received soup it would need to be strained. She went on to confirm there were no meal intakes recorded in the medical record for Resident #65 and stated she would get her information from nursing on how much the resident was eating for a meal.<br><br>Review of facility policy Fluid Restrictions/Hydration, revised August 2023, revealed physician orders for fluid restrictions would be followed, and dietary and nursing would determine the amount of fluids to be given with meals and between meals.<br><br>Review of facility policy Nutrition Assessment, revised August 2023, revealed nurse aides were to complete food intake and record daily.<br><br>3. Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included fracture of right humerus, depression, anxiety, fracture of part of scapula, other fracture of second lumbar vertebra, essential hypertension, acute on chronic diastolic (congestive) heart failure, and hyperlipidemia.<br><br>Review of Resident #13's quarterly MDS 3.0 assessment, dated 01/25/25, revealed the resident was cognitively intact, required partial/moderate assistance from staff for eating, had no significant weight changes, and received a therapeutic diet.<br><br>Review of Resident #13's care plan, initiated on 10/25/24 revealed the resident was at nutritional risk related to being status post fracture of femoral head. Interventions included monitor meal intake and record, monitor tolerance of diet texture, make adjustments as needed, offer substitutes if consumes less than 50 percent of meals, and weight every month and or as needed and notify physician of significant change.<br><br>Review of physician orders revealed an order dated 10/19/24 for weekly weights for four weeks following admission once a day on Monday, an order dated 12/09/24 for weekly weights for four weeks once a day on Monday, and an order dated 12/11/24 for Regular No Added Salt thin liquids diet.<br><br>Review of the 10/25/24 initial assessment authored by RD #826 revealed at the time of the assessment the resident was on a regular diet, was eating her meals in her room, and was consuming 50 to 100 percent of meals with setup from staff. The facility diet was providing 2000 to 2200 calories, 85 to 100 grams protein, and greater than 1400 cubic centimeters of fluid (cc) a day, and Resident #13's estimated needs were 1301 to 1550 calories, 57 to 68 grams protein, and 1425 to 1710 cc fluid.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Further review of Resident #13's medical record revealed a progress note dated 12/09/24 and authored by RD #826 indicatng the resident's monthly weight taken on 12/04/24 of 129.6 pounds had shown a significant weight loss for one month and the previous weight may have been in error with the resident reporting her usual weight was 125 pounds. In the progress note it was documented intakes had been good for Resident #13 with 50 to 100 percent of most meals being consumed; however, it was noted later in the progress note that therapy had reported resident was not eating much recently and the resident stated her appetite was fair. The dietitian was going to request a reweight and weekly weights for verification and stabilization to determine the need for further interventions and was going to try adding a mighty shake (nutritional supplement) to increase intakes and stabilize weights.<br><br>Review of meal intakes for November 2024 revealed the only meal intake which was recorded was on 11/19/24 when Resident #13 consumed 51 to 75 percent of the dinner. In December 2024 the only meal intakes recorded was on 12/09/24 when Resident consumed 51 to 75 percent of breakfast and on 12/14/24 when Resident #13 consumed 76 to 100 percent of breakfast. In January 2025 there were no recorded meal intakes.<br><br>Review of weights recorded in Resident #13's medical record revealed a weight of 137.8 pounds (lbs) on 11/14/24, a weight of 129.6 lbs on 12/04/24, a weight of 128.4 lbs on 12/31/24, and a weight of 128.6 lbs on 01/06/25 were the only weights recorded in the medical record. There were no weights recorded on 10/21/24, 10/28/24, 11/04/24, and 11/11/24 for the weekly weights for the order dated 10/19/24 for four weekly weights. Resident #13 had a 5.9 percent weight loss from 137.8 pounds on 11/14/24 to 129.6 pounds on 12/04/24. There were only two weekly weights on 12/16/24 and 12/23/24 out of four ordered for the order dated 12/09/24 for weekly weights for four weeks .<br><br>Interview on 01/29/25 at 10:01 A.M. with CNA #513 revealed meal intakes were supposed to be put into the residents electronic medical record (EMR) but confirmed meal intakes hadn't been put into the EMR due to lack of time. She stated she had most of the intakes in her brain and would tell the nurse if a resident hadn't eaten a meal.<br><br>Interview on 01/29/25 at 10:05 A.M. with CNA #511 confirmed meal intakes were not being documented into the EMR and the reason she hadn't documented meal intakes was she lost track of time.<br><br>Interview on 01/29/25 at 2:51 P.M. with RD #826 revealed weekly weights were put into the medication administration record (MAR) and would auto populate so the nurses would know when a weight was needed. The nurses would then let the aides know who needed weighed and the nurses were to put the weight into the MAR. She confirmed there was no reweight obtained and the Resident #13 was missing weekly weights. Dietitian #826 went on to state no one told her she refused to be weighed. She confirmed the missing meal intakes and stated she got her information on how much a resident ate from nursing.<br><br>51073<br><br>4. Review of the medical record revealed Resident #18 was admitted on [DATE] with diagnoses including cognitive communication deficit, schizoaffective disorder, obsessive-compulsive disorder, generalized anxiety disorder, major depressive disorder, and constipation.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the MDS 3.0 assessment dated [DATE] revealed the resident was alert with minimal recall of current events, a weight of 177 pounds, no known swallowing disorder, and no known weight loss in the last month.<br><br>Review of physician orders dated 12/11/24 revealed Resident #18 was ordered a regular diet with thin liquids, Prostat AWC (protein supplement) 30 cc twice a day, and a Mighty Shake (nutritional supplement) daily at lunch.<br><br>Review of Resident #18's care plan initiated on 12/16/24 identified Resident #18 as a nutrition/hydration risk. Interventions included monitoring meals intake/records and weigh every month and as needed.<br><br>Review of a dietary admission note dated 12/16/24 identified Resident #18 as at risk for malnutrition.<br><br>Review of meal consumption records for December 2025 revealed Resident #18 was eating between 51 to 75 percent of her meals, however, the meal intakes were only recorded on eight of 20 meals reviewed. No meal consumption records were completed from 01/01/25 to 01/27/25.<br><br>An interview on 01/27/25 at 1:10 P.M. with Resident #18's husband revealed Resident #18 required someone to feed her since she was unable to use regular cups or silverware, and she required special equipment if trying to eat by herself. The husband stated he visited her each day to assist her with eating. He stated he did not know if Resident #18 had lost weight. Observation of Resident #18 during the interview revealed she was alert with confusion and unable to answer simple or open-ended questions, so she was not a reliable source of information.<br><br>An interview with Registered Dietician (RD) #826 on 01/28/25 at 11:08 A.M. revealed Resident #18 required adaptive equipment for eating that included built up silverware, scoop late and handled cup. RD #826 stated the resident was at risk of impaired nutritional status due to depression, weakness and constipation, and was consuming between 50 to 75 percent of her meals and supplements.<br><br>An interview on 01/29/25 at 10:56 A.M. with Licensed Practical Nurse (LPN) #804 verified meal intake records for Resident #18 were partially documented during the month of December 2024 and not documented at all from 01/01/25 to 01/29/25.<br><br>A follow up interview on 01/29/25 at 2:59 P.M. with RD #826 revealed there were meal intakes not being recorded for residents by nursing staff, so she got her information on how much a resident ate from nursing.<br><br>51067<br><br>5. Review of the medical record review for Resident #41 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypoxia, severe sepsis without septic shock, hypertension, solitary pulmonary nodule, cerebrovascular disease, type two diabetes mellitus without complications, hyperlipidemia, shortness of breath, constipation, obesity, and chronic atrial fibrillation.<br><br>Review of the MDS 3.0 assessment, dated 12/12/24, revealed Resident #41 was cognitively impaired.<br><br>(continued on next page) |

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| Austinburg Nsg and Rehab Ctr | 2026 State Route 45<br>Austinburg, OH 44010 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #41's physician orders revealed an order dated 01/09/2025 for weekly weights once a day on Mondays to start on 01/13/25 for one month.<br><br>Review of Resident #41's weights for January 2025 revealed no weekly weight was recorded for 01/13/25 and 01/27/25 per the physician order to be weighed weekly on Mondays.<br><br>Observation on 01/29/25 at 11:05 A.M. with RD #826 revealed RD #826 presented a list of weekly weights for January 2025 for residents requiring weekly weights and Resident #41 was not on the weekly weight list. RD #826 stated the list was how the nursing staff identified which residents required weekly weights, in addition to the physician order.<br><br>Interview on 01/29/25 at 11:05 A.M. with RD #826 verified Resident #41 had an order to be weighed weekly on Mondays to start on 01/13/25 and no weekly weights were obtained on 01/13/25 and 01/27/25.<br><br>Review of the facility policy titled Weight and Height Records Policy, revised August 2023, revealed residents would have their weight obtained by certified and licensed staff at monthly intervals unless more frequent monitoring was needed as determined by resident weight record, medical condition, or clinical staff. Weight orders would be placed in the electronic medical record (EMR) if more frequent monitoring was needed than stated in facility policy. Weights would be recorded in EMR when obtained and residents have the right to decline weights and would document refusals of weights not obtained in the EMR as refused, combative, deferred due to condition, or unavailable.<br><br>Review of facility policy Nutrition Assessment, revised August 2023, revealed nurse aides were to complete food intake and record daily. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095<br><br>Based on observation, record review, and interview the facility failed to give medications with an error rate of under five percent. This affected one resident (Resident #435) of two residents reviewed for medication administration. The total census was 82.<br><br>Findings include:<br><br>Record review of Resident #435 revealed he was admitted [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), acute peptic ulcer with hemorrhage, and hypoxemia. He had active orders dated 01/17/25 for one pill of coenzyme Q10 30 milligrams (mg), one pill of vitamin E 268 mg, and one puff of Trelegy Ellipta (a combination inhalation medication for COPD) 200-62.5-25 micrograms. All of these medications were ordered to be given once daily between 7:00 A.M. and 11:00 A.M.<br><br>Observation of medication administration for Resident #435 by Licensed Practical Nurse (LPN) #802 on 01/28/25 at 8:25 A.M. revealed she did not have the correct doses of coenzyme Q10 and vitamin E in the medication cart and held the medications. The Trelegy Ellipta container included specific instructions to swish and spit after administration. When the nurse administered the Trelegy Ellipta, she then exited the room without instructing the resident to swish and spit and the resident was not observed to do so before the nurse left the room.<br><br>Interview with LPN #802 on 01/28/25 at 8:57 A.M. confirmed the above findings.<br><br>Follow-up interview with LPN #802 on 01/28/25 at 11:18 A.M. revealed the coenzyme Q10 and correct vitamin E medications had to be ordered from pharmacy and were expected to arrive the next day, so she marked both medications as held due to not being available.<br><br>The above findings identified three errors out of 28 observed opportunities for medication error, creating a total error rate of 10.7%. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>46195<br><br>Based on observation, interview, record review and review of facility policy the facility did not ensure menu spreadsheets were followed to provide appropriate portion sizes to Resident #26, #40, #43, #55 and #57 who the facility identified as receiving pureed diets. In addition, the facility did not ensure all other residents receiving meals from the kitchen received appropriate portions sizes at meals excluding Resident #441 who received a full liquid diet and Resident #64 who the facility identified as receiving nothing by mouth (NPO). The facility census was 82.<br><br>Findings include:<br><br>1. Review of the facility menu Atrium Living Center Fall/Winter 2024/2025 Menus for week three revealed for dinner on 01/28/25 chicken pot pie, buttered broccoli, pineapple cup, two percent milk and coffee/tea were to be served.<br><br>Review of the facility week three dinner (01/28/25) spread sheet (expanded menu) revealed for the pureed chicken pot pie no specific scoop size listed, but one #16 (two ounce) scoop was to be used for the pureed broccoli. The spreadsheet did not indicate mashed potato was to be served for the puree diets at this meal.<br><br>Review of Chicken Pot Pie Pureed recipe, with a report date of 09/05/24, revealed the chicken pot pie would be prepared as directed in the recipe. Remove portions required from the prepared recipe and add to food processor and process until fine in consistency. Gradually add hot broth while processing and scrape down sides of processor with a rubber spatula and process for 30 seconds. The serving size would be two number eight (four ounce) scoops.<br><br>Review of the facility document titled Resident Listing Report, dated 01/27/24, revealed a list of of all residents in the facility and their diet order. Resident #26, #40, #43, #55 and #57 had diet orders including pureed texture.<br><br>Observations during tray line on 01/28/25 from 4:20 P.M. to 5:24 P.M. revealed the puree entree/meat being served on the dinner tray line was pureed chicken and not chicken pot pie. The serving scoop sizes being provided on the pureed resident meals was one number six (5.3 ounces) scoop of puree chicken, one number eight scoop (four ounces) of mashed potatoes, and one number ten (3.2 ounces) scoop of puree broccoli.<br><br>During the observation on 01/28/25 from 4:20 P.M. to 5:24 P.M. Dietary [NAME] (DC) #700 confirmed the puree meat was pureed chicken with gravy and not chicken pot pie, and the puree diets were receiving one number six scoop of puree chicken, one number eight scoop of mashed potatoes, and one number ten scoop of puree broccoli.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | An interview and record review of the week three dinner spread sheet (01/28/25) was conducted on 01/29/25 at 2:35 P.M. with Registered Dietitian (RD) #826 who verified the spread sheet for the dinner meal on 01/28/25 meal did not clearly specify what the serving size should have been for the pureed chicken pot pie, and she didn't know what the serving size should have been for the pureed chicken pot pie. She confirmed the puree diet should have received a pureed chicken pot pie and broccoli instead of puree chicken, mashed potatoes, and broccoli.<br><br>2. Review of the facility menu Atrium Living Center Fall/Winter 2024-2025 Menus for week three revealed for dinner on 01/28/25 chicken pot pie, buttered broccoli, pineapple cup, two percent milk and coffee/tea were to be served.<br><br>Observations during tray line on 01/28/25 from 4:20 P.M. to 5:24 P.M. revealed residents on a regular diet were being served one number six scoop (5.3 ounces) of chicken pot pie and residents on a mechanical soft diet were being served one number six scoop (5.3 ounces) of chicken pot pie with ground meat.<br><br>Interview on 01/28/25 at 4:49 P.M. with Dietary Supervisor #702 confirmed one number six scoop was being used for both the chicken pot pie and chicken pot pie with ground meat.<br><br>Review of week three dinner (01/28/25) spread sheet (expanded menu) revealed the residents on a regular diet were to receive one eight-ounce ladle of chicken pot pie and residents on a mechanical soft diet were to receive one eight-ounce ladle of chicken pot pie with ground meat.<br><br>An interview and record review of the week three dinner spread sheet (01/28/25) was conducted on 01/29/25 at 2:35 P.M. with RD #826 who verified one eight-ounce ladle was the serving for the chicken pot pie for regular diets and mechanical soft diets and the residents on those diets had received less than what would have been provided with the eight ounce ladle when facility used one number six (5.3 ounces) scoop.<br><br>Review of facility policy Tray and Dining Room Meal Service, revised August 2023, revealed each employee should review the expanded menu at the beginning of their shift. The dietary manager or cook would go over the expanded menu with tray line personnel before starting to serve. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195<br><br>Based on observations, interviews, record reviews, and review of facility policy, the failed to ensure palatable meals were served to Resident #16, #17, #21, #24, #27, #31, #32, #56 and #73. This affected nine residents (#16, #17, #21, #24, #27, #31, #32, #56 and #73) of 21 residents reviewed for food. The facility census was 82.<br><br>Findings include:<br><br>1.Review of facility menu Atrium Living Center Fall/Winter 2024/2025 Menus for week three dinner on 01/28/25 revealed chicken pot pie, buttered broccoli, pineapple cup, two percent milk and coffee/tea was to be served.<br><br>Observation on 01/28/25 at 4:20 P.M. of Dietary [NAME] (DC) #700 taking the temperature of the tray line items using a facility thermometer revealed all items were at a safe temperature with the chicken pot pie at 206 degrees Fahrenheit (F), the broccoli at 179 degrees F, the pineapple at 42 degrees F and an eight-ounce carton of milk at 38.8 degrees F.<br><br>Observations throughout the tray line process on 01/28/25 from 4:20 P.M. to 5:24 P.M. revealed the chicken pot pie for the regular diets had a very thin layer of biscuit on top and some servings of the pot pie for the regular diets had very little biscuit in the portion which was served to the residents. The facility utilized a heat retention system for the food which included a heating unit that heated both the plates and metal pellets. On the stainless steel table next to the range oven behind the steam table was a stack of metal pellets sitting at room temperature instead of being in the heating unit. When the tray line was three fourths of the way completed, Dietary Supervisor (DS) #702 was observed loading the metal pellets into the heating unit leaving a minimal amount of time for the metal pellets to heat up prior to being placed in the thermal plate base on the meal tray to keep the food hot.<br><br>On 01/28/25 at 5:12 P.M. as the last cart for unit three was starting to be loaded a test tray was requested by the state surveyor. The test tray was plated at 5:24 P.M. and placed on the food cart. Also at 5:24 P.M. the state surveyor touched the metal pellets in the heating unit and the pellets were not warm to the touch. At 5:26 P.M. DS #702 wheeled the cart out of the kitchen and the cart arrived on unit three at 5:29 P.M. The first meal tray was passed at 5:30 P.M. and by 5:46 P.M. all the meal trays had been passed. The test tray was then taken off the meal cart at 5:46 P.M. by DS #702 and taken to an overbed table in the hallway. Using a facility thermometer DS #702 took temperatures of the food and beverage items. As DS #702 was taking the temperatures the state surveyor was tasting the items. The coffee was 166 degrees F and tasted warm. The milk was 37 degrees F and tasted cold and not spoiled. The pineapple was 52 degrees F but still tasted cold and was palatable. The chicken pot pie was 124 degrees F and tasted warm and bland. The broccoli was 113 degrees and didn't taste warm and tasted very bland.<br><br>On 01/28/25 at 5:49 P.M. DS #702 tasted the chicken pot pie and broccoli and stated the pot pie tasted a little bland and the broccoli was not hot and had no flavor. DS #702 confirmed she had added the room temperature metal pellets part way through tray line to the heating unit since there was not enough room in the unit to house all the metal pellets for tray line.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Review of the medical record for Resident #32 revealed an admitted d of 06/22/19. Medical diagnoses included chronic pulmonary (lung) disease, major depression, chronic kidney disease and dysphagia.<br><br>Review of Resident #32's physician orders revealed an order dated 01/21/25 for a regular diet with extra gravy on meats and thin liquids.<br><br>Review of the Minimum Data Set (MDS) 3.0 annual assessment, dated 01/10/25, revealed Resident #32's cognition was intact.<br><br>Interview on 01/28/25 at 5:52 P.M. with Resident #32 revealed she didn't think the chicken pot pie tasted good the last time it was served, and she didn't think it tasted good this time<br><br>3. Review of medical record for Resident #21 revealed an admitted [DATE]. Medical diagnoses included chronic pulmonary (lung) disease, hyperlipidemia, hypertension, and vascular dementia.<br><br>Review of Resident #21's physician orders revealed an order dated 12/20/24 for a regular diet thin liquids.<br><br>Review of the MDS 3.0 quarterly assessment, dated 01/28/25, revealed Resident #21's cognition was moderately impaired.<br><br>Interview on 01/28/25 at 5:54 P.M. with Resident #21 revealed the chicken pot pie didn't taste like chicken pot pie, and she got very little biscuit with her serving of pot pie<br><br>4. Review of medical record for Resident #16 revealed an admitted d of 01/24/20. Medical diagnoses included cerebral infarction (stroke), anxiety disorder, major depression, and prediabetes.<br><br>Review of Resident #16's physician order revealed an order dated 08/01/23 for a regular diet thin liquids.<br><br>Review of the MDS 3.0 annual assessment, dated 01/01/25, revealed Resident #16 had mild cognitive impairment.<br><br>Interview on 01/28/25 at 5:59 P.M. with Resident #16 revealed she got very little biscuit with her serving of chicken pot pie, and the pot pie had no flavor<br><br>5. Review of medical record for Resident #73 revealed an admitted [DATE]. Medical diagnoses included atherosclerosis, type two diabetes, hallucinations, and chronic kidney disease.<br><br>Review of a physician order dated 10/01/24 revealed Resident #73 had an order for a regular diet with sugar substitute and thin liquids.<br><br>Review of MDS 3.0 quarterly assessment, dated 12/13/24, revealed Resident #73's cognition was intact. Resident #73 needed supervision while eating and had a significant weight loss that was not physician prescribed.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 01/28/25 at 6:01 P.M. with Resident #73 revealed if that was chicken pot pie, they left out the biscuit and Resident #73 stated the pot pie didn't have much flavor.<br><br>6. Review of medical record for Resident #27 revealed an admitted [DATE]. Medical diagnoses included pneumonia, congestive heart failure (CHF), cerebrovascular disease, and hypertension.<br><br>Review of a physician order dated 01/05/25 revealed Resident #27 had an order for a regular diet with thin liquids.<br><br>Review of the MDS 3.0 admission assessment, dated 01/10/25, revealed Resident #27's cognition was intact.<br><br>Interview on 01/28/25 at 6:02 P.M. with Resident #27 revealed the chicken pot pie was bland.<br><br>7. Observation on 01/28/25 from 10:55 A.M. to 11:10 A.M. revealed DS #702 placed ten portions of green beans into a robo coupe (commercial food processor) to blend until a portion between pudding and mashed potatoes was achieved for a puree consistency. The final product, which was ready to be placed into a square serving pan for tray line for lunch on 01/28/25, had the appropriate puree consistency but was very salty when tasted. DS #702 at the time of observation tasted the final product and stated it was salty because they added salt. Registered Dietitian #826 who was also in the kitchen at the time of observation, also tasted the puree green beans and confirmed the pureed green beans were very salty.<br><br>Review of the green beans pureed recipe, with a report date of 09/05/24, revealed the recipe called for green beans, margarine, and food thickener. The staff were to remove portions from the regular prepared vegetable (drain liquid), add drained vegetables with melted margarine to the food processor and process until smooth in texture; add a food thickener briefly until mixed while scraping sides of bowl; pour into the steamtable pan. There was nothing documented in the recipe indicating salt should have been added.<br><br>8. Interviews conducted with four residents (#17, #24, #31, and #56) during a resident council meeting held with the state surveyors on 01/29/25 at 11:05 A.M. revealed the residents voiced concerns about hot foods not being hot and describing the hot food as served cold and stated food was served bland and at times was too salty. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195<br><br>Based on observations, interviews, and review of facility policy, the facility failed to ensure food was stored, prepared and served under sanitary conditions. This had the potential to affect all residents receiving meals from the kitchen excluding Resident #64 who the facility identified as receiving nothing by mouth (NPO). The facility census was 82.<br><br>Findings include:<br><br>1. Observation of the kitchen on 01/27/25 from 8:11 A.M. to 8:45 A.M. with Dietary Supervisor (DS) #702 revealed the following concerns:<br><br>The large industrial fan located in the corner of the kitchen revealed a build up of dust and debris on the blades and metal guard.<br><br>On the inside top of the microwave used for resident fooods was an accumulation of food particles and dried food splatters.<br><br>In the walk in cooler on the right hand side of the floor under the crates of milk was a moderate amount of a white dried substance resembling milk that had spilled onto the floor. There was one five pound container of cottage cheese which was unopened but had a best by date of 01/06/25. There was half of a factory bag of diced chicken on a shelf and it had been opened and resealed with no date.<br><br>The large industrial food mixer that was sitting on a two-tiered base had dried food splatters and visible build-up of dust and particles of debris on both tiers of the base.<br><br>At the time of observation, DS #702 confirmed the areas of concern.<br><br>Review of facility policy Dietary Sanitary Procedures for Infection Control, revised August 2023, revealed all equipment and counters would be sanitized per department guidelines and refrigerated items opened would be labeled with a use by date.<br><br>2. Observation of the unit refrigerators on 01/27/25 from 8:45 A.M. to 9:00 A.M. with Dietary Supervisor (DS) #702 revealed the following concerns:<br><br>In the refrigerator part of the refrigerator/freezer unit in the unit three nourishment room there was one carton of med pass supplement opened with no lid, one bacon and cheese sandwich wrapped in plastic with no name or date, one gallon pitcher of lemonade dated 01/18/25 with a throw out date of 01/24/25, one eight-ounce factory bag of shredded [NAME] jack cheese one fourth full with a best by date of 01/15/25, one small circular clear storage container with a lid with what looked like mayonnaise with no date or label, and one fast food restaurant bag with a breakfast sandwich with no name or date.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | There was a buildup of debris on the inside top of the microwave sitting on the counter in the unit three nourishment room.<br><br>In the freezer part of the refrigerator/freezer unit in the unit one nourishment room there was one pint of Almost Heaven ice cream with no date or name and one pink colored fast-food drink with whip cream frozen solid with no name or date with a lid which had a circular opening in the lid leaving it open to air.<br><br>In the refrigerator part of the refrigerator/freezer unit in the unit one nourishment room there was one gallon pitcher half full of orange juice with a date of 01/18/25 and a throw out date of 01/24/25, one gallon pitcher full of cranberry juice with a date of 01/19/25 and a throw out date of 01/25/25 and one grocery plastic bag with a storage container with a piece of meat and sweet potatoes with no name or date.<br><br>Interview with DS #702 at the time of observations confirmed areas of concern and stated dietary was responsible for cleaning, stocking, and ensuring nothing was outdated or unlabeled in the unit nourishment rooms. DS #702 confirmed these were storage areas for resident foods on the unit.<br><br>Review of facility policy Foods Brought into Resident Education Material, revised August 2023, revealed food brought in must be stored in an airtight container; items would be labeled with the resident's name and date; and refrigerated cooked food items must be automatically disposed after three days.<br><br>Review of facility policy Dry Goods Storage Guidelines, undated, revealed the storage length for refrigerated juice was five days, and storage length must be followed.<br><br>Review of facility policy Dietary Sanitary Procedures for Infection Control, revised August 2023, revealed all equipment would be sanitized per department guidelines.<br><br>3. Observation on 01/27/25 at 12:29 P.M. revealed Certified Nursing Assistant (CNA) #607 took a meal tray, which had cake uncovered on the tray, out of the covered delivery cart and placed one eight ounce of glass of water uncovered on the tray and walked down the hallway on unit three to a common area to deliver Resident #4's meal tray. At the time of observation, CNA #607 confirmed the cake and beverage were uncovered, and she stated she complained about it all the time.<br><br>Observation on 01/27/25 at 12:34 P.M. revealed CNA #620 took a meal tray, which had cake uncovered on the tray, out of the covered delivery cart and placed one cup of coffee uncovered on the meal tray and walked halfway down the hallway to Resident #22's room. At the time of observation, Resident #22 revealed she always received desserts and beverages in cups uncovered. At the time of observation, CNA #620 confirmed the cake and beverage were uncovered.<br><br>Observation on 01/27/25 at 12:36 P.M. revealed CNA #620 took a meal tray, which had a piece of cake uncovered on the tray, out of the covered delivery cart and placed a cup of coffee and a glass of apple mango juice uncovered on the meal tray and walked halfway down the hallway to deliver the meal to Resident #8. At the time of observation, CNA #620 confirmed cake and beverages were uncovered.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366088 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Austinburg Nsg and Rehab Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 2026 State Route 45 Austinburg, OH 44010 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 01/27/25 at 12:40 P.M. revealed CNA #608 took a meal tray, which had a piece of cake uncovered, out of the covered delivery cart and placed one cup of coffee and a glass of grape juice uncovered onto the meal tray and walked the full hallway and into the unit three common area to deliver Resident #51's meal tray. At the time of observation, CNA #608 confirmed the cake and beverages were uncovered.<br><br>Interview on 01/29/25 at 2:35 P.M. with Dietitian #826 revealed when delivering room trays, the aides were supposed to walk the meal delivery and beverage carts with them so they could stay close to the rooms, and when they delivered the meal trays, they were not supposed to walk extended distances with items uncovered. |