STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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** 46195 Based on observation, record review, interview, and review of facility policy, the facility failed to ensure Resident #80 was fed in a dignified manner. This affected one resident (#80) out of 20 residents reviewed for dignity. The facility census was 94. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE] and diagnoses including Alzheimer's disease, Bell's Palsy (a neurological disorder that causes paralysis or weakness on one side of the face), unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, other specified depressive episodes, other idiopathic peripheral autonomic neuropathy (condition that affects the nerves in the hands and feet causing pain, numbness, and weakness), unspecified protein calorie malnutrition, and need for assistance with personal care. Review of annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 was severely impaired cognitively and was dependent on staff for eating. Review of the care plan created on 06/09/23 revealed Resident #80 had an activity daily living (ADL) self-care performance deficit related to severe cognitive and communication deficits related to dementia and was dependent on staff to provide care. Interventions included the resident may require staff participation to eat. Observation on 08/05/24 at 4:58 P.M. revealed State tested Nursing Assistant (STNA) #502 was standing while feeding Resident #80 in the main dining room, who was seated in a Geri chair (geriatric recliner) with her head elevated sitting next to a half circle table. There was a chair observed right behind STNA #502 as she was feeding the resident. Interview on 08/05/24 at 5:01 P.M. with STNA #502 confirmed she had been standing while feeding Resident #80 and stated she couldn't reach the resident's mouth while sitting. STNA #502 then repositioned Resident #80's Geri chair at the time of the interview and was then able to feed and give fluids through a straw to the resident as STNA #502 sat in a chair. Interview on 08/08/24 at 8:54 A.M. with the Speech Language Pathologist confirmed staff should be sitting while feeding residents. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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	Review of facility policy Serving of Food, dated 01/08/14, revealed residents who couldn't feed themselves would be fed with attention to safety, comfort, and dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, record review, interview, and review of facility policy, the facility failed to maintain resident records in a manner that would protect their confidentiality. This affected one resident (Resident #7) of the 94 residents observed for privacy. The facility census was 94. Findings include: Review of the medical record for Resident #7 revealed an admitted [DATE] and a re-entry date of 03/08/24 with diagnoses including type two diabetes mellitus, schizophrenia, recurrent depressive disorder, osteoporosis, hypertension, diverticulitis, unspecified phobia, and unsteadiness on feet. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 07/26/24 revealed Resident #7 had intact cognition. Further review of the MDS revealed Resident #7 required supervision or touching assistance for toileting hygiene, bathing, dressing her lower body and transfers to the toilet or from the toilet. Resident #7 used a walker and required supervision or touching assistance for toileting hygiene, bathing, dressing her lower body, and transfers to the toilet or from a chair/bed to chair. The MDS also revealed Resident #7 was frequently incontinent of urine and always incontinent of stool. Review of the care plan dated 07/26/24 through 10/26/24 revealed Resident #7 had urinary incontinence at least three to four times per day and stool incontinence at least three to four times per week with a tendency to wear more than one brief at a time or place pads or plastic bags inside her briefs increasing her risk for skin breakdown. Interventions included checking Resident #7 for incontinence every two hours and providing perineal care, skin checks with incontinence care assistance, and provision of a toileting program before and after meals, activities, and t bedtime. Further review of the care plan revealed Resident #7 was at risk for impaired function to her bilateral upper and lower extremities and required restorative nursing assistance to prevent further decline in function twice daily, six to seven times a week, for at least 15 minutes a day. Due to her diagnoses of depression and schizophrenia and use of psychotropic medications, the care plan also directs staff to monitor Resident #7 for agitation, changes in mood, mania, paranoia, hallucinations, and any unusual behavioral symptoms. Random observation on 08/08/24 from 9:05 A.M. to 9:37 A.M. of the computer monitor in the 500 hall revealed an open medical record for Resident #7. Further observation revealed the open record contained visible information including the resident's name, medical record, and plan of care tasks. At the time of the observation, no staff were noted in the hallway and one resident, Resident #48, was sitting in the hallway in his wheelchair. During observation of the documentation station/computer monitor in the 500 hallway on 08/08/24 9:11 A.M., State tested Nurse Aide (STNA) #344 was observed in the hallway passing new water cups to the residents while the medical record remained open and visible on Resident #7's plan of care tab. Continued observation of the 500 hallway on 08/08/24 revealed STNA #345 walking past the computer monitor at 9:15 A.M. twice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/08/24 at 9:34 A.M. with Licensed Practical Nurse (LPN) #349 confirmed the screen on the monitor in the 500 hall was opened with some of Resident #7's medical information visible to others who might be nearby in the hallway. She further confirmed staff were to always lock the screen when walking away to keep information private. During the interview, LPN #349 also confirmed she had occasionally come across unlocked screens with visible resident information and when this occurred, she would lock the screen or log the previous employee out and re-educate them on HIPAA (the Health Insurance Portability and Accountability Act) related to protected health information and confidentiality. As the interview concluded at 9:37 A.M., LPN #349 was observed logging the STNA out of the electronic medical record and locking the screen. Interview on 08/08/24 at 9:55 A.M. with Registered Nurse (RN) #310 confirmed resident information should be kept confidential and the screen to the documentation stations in the halls should not be left open to resident information and unattended. Interview on 08/08/24 at 12:40 P.M. with STNA #303 confirmed she left the computer open earlier on this date when she responded to a call-light and that she should have locked the computer screen prior to leaving it unattended. Review of the policy titled Confidentiality of Information dated 03/16/13 revealed the facility was to treat all resident information confidentially and take measures to safeguard all resident records to protect their privacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46195 Based on observation, staff and resident interviews, and review of the Resident Council meeting minutes and facility policy, the facility failed to ensure residents rooms on the 600 hall were homelike as evidenced by the walls being in disrepair. This affected 20 residents (#1, #2, #3, #14, #16, #26, #29, #30, #32, #39, #41, #45, #47, #70 #76, #77, #88, #52, #91, #197) out of the 43 residents who resided on the 600 hall. The facility census was 94. Findings include: Interview on 08/05/24 at 2:41 P.M. with Resident #26 revealed when asked about the black scrape marks and gouges in the wall behind her recliner, the resident stated she hadn't done that to the wall, and it bothered her since she kept thinking there were bugs on the wall. Observation of all the rooms on the 600 hall in the facility on 08/07/24 from 8:10 A.M. to 9:09 A.M. revealed the following concerns: In Resident #45's room, there were six black lines on the wall and one dollar size punctured area to the drywall on the back wall next to recliner. On the right-hand side of the room behind the recliner, there was one dollar coin size, six pencil eraser size, and one nickel size punctured areas to the wall. Interview on 08/07/24 at 8:20 A.M. with Resident #45 revealed it would be nice if the facility would fix the marks on the wall. In Resident #14's room, there were approximately 15 linear gouge marks on right wall behind a recliner, and there was an extra-large white patched area, approximately two feet by two feet, on the back beige colored wall. Interview on 08/07/24 at 8:32 A.M. with Resident #14 revealed if it was up to him, he would have had the wall fixed. He stated he was a painter by trade and liked to make the rooms look beautiful. In Resident #52's room, there were six black lines, approximately six inches long by one fourth inch wide, six dime size puncture areas with no dry wall showing, and one quarter size hole with drywall exposed on the left side wall behind the recliner. Interview on 08/07/24 at 8:46 A.M. with Resident #52 revealed the walls were in that condition when he was admitted , and it was a mess. In Resident #91's room, there were approximately 29 vertical gouge marks, between four and six inches long, with dry wall exposed on the right-side wall behind the recliner. On the back wall next to the recliner, there was one large black mark midway up the wall, approximately 12 inches long by one fourth inch wide, and one gouge in wall, approximately four inches long by one fourth inch wide. Interview on 08/07/24 at 8:44 A.M. with family of Resident #91 revealed if the marks on the wall were in their house, the wall would be fixed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In Resident #88's room, there was one black line, approximately twelve inches long by one fourth inches wide, and four black puncture marks, and numerous vertical gouges in wall with drywall exposed on the right-side wall behind the quilt stand near the corner of the right-side wall and the back wall. Interview on 08/07/24 at 8:52 A.M. with Resident #88 revealed the areas of concern were there when she was admitted , and if she were at home, they would have been fixed. Resident #88 stated if the areas were repaired, it would make her room nicer. In Resident #16's room, there was one fist sized hole, which was completely through the drywall, three vertical gouge marks varying in length from one inch to four inches long by one fourth inches wide, numerous black vertical lines, and approximately fourteen round, approximately the size of pencil top erasers, gouge areas on right hand wall in the right-hand corner of room behind the recliner. On the back wall near the right-hand corner of the room, there was one vertical gouge in wall, approximately six inches long by one fourth inches wide, with white dry wall exposed, one dime size gouge area with white dry wall exposed, and two long vertical black lines In Resident #3's room, there were numerous puncture areas the size of pencil top erasers with white dry wall exposed on left side wall behind recliner. In Resident #1's room, there were four puncture areas the size of pencil top erasers with dry wall showing, and numerous black circular areas and black linear marks taking up an area approximately two feet by one foot on the right-side wall. In Resident #41's room, there were multiple gouge vertical lines and pencil top eraser sized puncture areas with white dry wall exposed on left wall behind recliner. In Resident #2's room, there were three unpainted white circular patched areas, varying in size from three inches by two inches to six inches by three inches, on the left side beige wall behind the glider. On the back wall beside the glider, there were approximately 16 pencil top eraser sized puncture areas with no drywall exposed. In Resident #32's room , there was an approximately 12 inch long by one half inch wide gouge with drywall paper hanging off and white drywall exposed, one crescent shaped gouge with drywall paper hanging off and white drywall exposed, and one unpainted circular white patched area on the beige wall on the back wall by the recliner. On the right-side wall behind the recliner, there was one extra-large, approximately twelve inches wide by nine inches long, unpainted white patched area on the beige colored wall. In Resident #39's room, there was one extra-large unpainted white patch area, approximately one and a half feet wide by nine inches long, on left side beige colored wall mid-way up the wall near the back left hand corner of the room In Resident #30's room , there was an extra-large area, approximately four feet wide by 12 inches tall, full of black lines and small puncture wounds with drywall exposed on left side wall behind the headboard of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In Resident #47's room, there was one, approximately 12-inch-long by one fourth inch wide gouge in wall with white drywall exposed and approximately sixteen black vertical marks on the left side wall behind the recliner. On the back wall next to the recliner, there was one dime size gouge and two large black linear marks. In Resident #77's room, there was one extra-large, approximately nine inch by six inch, white patched area on the right side beige colored wall behind the recliner. In Resident #197's room, there were six linear gouge marks, approximately four to six inches long by one fourth inch wide, causing the white from the drywall to show on the right side wall behind the recliner, and one large, approximately six inch long by one fourth inch wide, gouge causing the white from the drywall to show on the back wall next to the recliner. In Resident #26's room, there were multiple black linear marks on the left side wall behind the recliner. In Resident #76's room, there was a large, approximately six inch by six inch round, white patched area on the beige colored wall on the back wall to the right of the window in the middle of the wall. On the right side wall behind the refrigerator, there were three long gouge marks, approximately three to four inches long by one fourth inch wide. In Resident #29's room, there were two pencil eraser head sized puncture wounds and five round puncture wounds and large black marks down the right-side wall behind the recliner In Resident #70's room, there were approximately over 100 black marks and one dime size gouge in drywall in the middle of the side wall. Environmental tour of the 600 hall rooms on 08/07/24 from 9:12 A.M. to 9:22 A.M. with Maintenance Supervisor #381 confirmed areas of concern and he stated it was a never-ending job with painting and patching walls. He stated he would start to repair the walls and would then get pulled to do other things. Review of Resident Council Meeting minutes from 02/08/24 to 07/18/24 revealed the residents had voiced during the 02/08/24 and 05/15/24 meetings concern over repairs not being addressed in a timely manner. Review of facility policy Housekeeping & Maintenance, dated 09/30/12, revealed it was the responsibility of the facility to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure care plan interventions were implemented as directed for one resident (Resident #5) and failed to ensure comprehensive care plans were developed for two residents (Resident #51 and Resident #67). This affected three residents (Residents #5, #51, and #67) out of 22 residents reviewed for care plans. The facility census was 94. Findings include: 1. Review of the medical record reviewed Resident #5 was admitted on [DATE] with diagnoses including Alzheimer's Disease, systolic congestive heart failure (COPD), and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #5 had moderately impaired cognition, had an impairment to his bilateral upper and lower extremities, and dependent for toileting hygiene and bathing. Further review of the MDS revealed Resident #5 had last received occupational therapy (OT) services from 04/01/24 through 04/23/24 and received passive and active range of motion (ROM), training assistance with walking, and splint/brace assistance seven out of seven days of the look-back period. Review of the care plan dated 05/16/24 revealed Resident #5 was to wear a left arm and wrist splint and a left ankle-foot orthotic (AFO) when out of bed with a goal of risk reduction of worsening contractures of the left upper and lower extremities. Interventions included direction the splint and brace was to be worn when Resident #7 was out of bed and staff were to provide passive ROM (PROM) of the left upper extremity before and after splint removal, assess for discomfort while the splint and brace were worn, and assess and report any skin concerns noted with applying and removing the splint and AFO. Review of the OT evaluation and visit notes from 04/01/24 through 04/23/24 revealed Resident #5 had a new short-term goal added on 04/10/24 to wear the left hand splint daily for at least two to four hours without signs of ill fit or discomfort and a long-term goal to wear and tolerate the left hand splint up to eight hours daily. Further review of the OT notes revealed Resident #5 was able to tolerate wearing the left hand splint four to five hours a day with no discomfort at the time of discharge from OT services. Review of the plan of care tasks from the last 30 days revealed Resident #5 was to wear an AFO to the left leg for walking only and it was to be off when in bed or the recliner. Further review revealed Resident#5 was to wear a left hand/wrist splint when out of bed. Review of the plan of care task revealed both interventions were included on one sign-off form and there was no differentiation as to which splint/brace was applied on Resident #5. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/05/24 at 11:26 A.M. revealed Resident #5 had a contracture of his left hand and wrist limited ROM of his left hand. At the time of the observation, Resident #5 stated he was given a brace for his left hand, it was in the drawer, but nobody told him if he was still supposed to wear it because they stopped putting it on. Observation on 08/06/24 at 2:30 P.M. revealed Resident #5 was in the main hallway in his wheelchair with the left AFO on and no brace on his left arm/hand. Interview on 08/06/24 at 2:39 P.M. with State tested Nurse Aide (STNA) #395 revealed she had no knowledge of brace orders for Resident #5. During the interview, Resident #5 informed STNA #395 he did have a brace and that it was in his drawer. At this time, STNA #395 verified the hand/wrist splint was in the top drawer. Of his bedside dresser. STNA #395 confirmed she did not know how long Resident #5 had the brace or where it came from and added that sometimes residents get braces from therapy, but staff are typically informed and trained on what to do and when to do it if the residents were supposed to wear any braces or splints and she did not believe he was supposed to wear one. A follow-up interview on 08/06/24 at 4:39 P.M. with Resident #5 revealed a staff member came into his room after the surveyor's visit earlier that afternoon, opened his drawer, and removed the hand splint from his drawer, informing him that he never had orders for it and shouldn't have it in his room. Resident #5's daughter, who was present during this interview, stated yes, he does have a hand splint in his top drawer he used to wear all the time when he was up (confirmed she visited every other day and observed Resident #5 with the left hand/wrist splint) until just a few months ago. She also opened the drawer and confirmed the left hand brace was no longer in his room and neither knew who had the splint at that time. Additional observations were as follows: 08/07/24 at 10:10 AM Resident #5 was asleep in his recliner with no left hand splint but was wearing the left AFO. 08/07/24 at 12:25 P.M. Resident #5 was sitting in the main dining hall eating with no his left AFO on and no hand/wrist splint to his left upper extremity. 08/08/24 at 9:11 A.M. Resident #5 was up in his recliner with his left AFO on and no left hand/wrist splint. Interview on 08/07/24 at 3:35 PM with Director of Rehab #505 confirmed Resident #5 was receiving OT services from 04/01/24 through 04/23/24 and that upon discharge from OT, Resident #5 was able to tolerate wearing his left hand/wrist splint for up to four to five hours with no signs of ill-fit or discomfort. At the time of the interview, Director of Rehab #505 confirmed the discharge recommendations did not include the left hand/wrist splint and in a follow-up interview at 4:15 P.M. was unable to determine the reason for not continuing to recommend left hand splinting after discharge, other than Resident #5 not reaching the long-term goal of tolerating the brace for up to eight hours a day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/08/24 at 8:35 A.M. with Restorative Licensed Practical Nurse (LPN) #345 confirmed restorative programs are developed/written by the Assistant Director of Nursing (ADON) and the restorative LPN, the program interventions are placed in the plan of care (POC) tasks, the floor aides carry out the restorative tasks with the restorative nurse providing assistance when needed. During the interview, LPN #345 confirmed the STNAs would know what to do by looking in the medical record and signing off assigned tasks daily. LPN #345 further confirmed the facility was doing a splinting program for Resident #5's left hand in April 2024 but the resident stated it was too bulky and didn't wear it. LPN #345 further confirmed someone removed Resident #5's hand/wrist splint from his room on 08/06/24 and it was found late afternoon on 08/07/24 in the therapy room. LPN #345 confirmed the splint was not supposed to be removed from Resident #5's room. During the interview, LPN #345 confirmed it was the expectation the STNAs applied Resident #5's left hand/wrist splint daily up to four to six hours as tolerated and she was not sure when Resident #5 wore it last. She also confirmed staff applied the left AFO when getting Resident #5 out of bed and it remained in place until he was put in bed at night. Interview with on 08/08/24 at 9:46 A.M. with Registered Nurse (RN) #310 confirmed Resident #5 had a restorative program for a left hand/wrist splint for as long as he could tolerate use, but the resident often refused. At the time of the interview, RN #310 confirmed there are no documented refusals of the left hand/wrist splint in Resident #5's medical record. Review of the policy titled Goals and Objectives, Restorative Services dated 03/16/13, revealed goals and objectives for rehabilitative services were to be developed and outlined in the resident's plan of care. Review of the policy titled Care Planning - Interdisciplinary Team dated 01/21/14 revealed resident care plans were to be based on comprehensive assessment data and were developed by the care planning or interdisciplinary team. Review of the policy titled Comprehensive Care Plans Policy revealed the comprehensive care plan interventions should aid in preventing or reducing declines in the residents' functional status and should enhance the optimal functioning of the resident's by focusing on rehabilitative services. 2. Review of the medical record for Resident #51 revealed she was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, stage three kidney disease, atrial fibrillation, recurrent severe depressive disorder, oropharyngeal phase dysphagia, anxiety disorder, and assistance with personal care. Review of the annual Minimum Data Set (MDS) 3.0 assessment completed on 07/19/24 revealed Resident #51 had moderately impaired cognition and had exhibited no behaviors or rejection of care. Further review of the MDS revealed Resident #51 was on a therapeutic and mechanically altered diet. The assessment revealed no broken or loose-fitting dentures, no broken teeth, and no chewing difficulties. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 07/11/24 revealed Resident #51 was a nutrition risk, was placed on a minced moist diet on 05/28/24 due to complaints with chewing and was updated on 06/26/24 to reflect tooth extractions. Interventions included providing diet and interventions per orders and interdisciplinary team (IDT) and catering to Resident #51's preferences. Further review of the care plan revealed Resident #51 had an activities of daily living (ADL) self-care deficit related to decreased strength, balance and endurance and fluctuations in mood and cognition. Interventions noted Resident #51 was independent with eating after staff assisted with tray set-up and she was able to perform oral care after set-up by staff. Review of the care plan revealed no indication Resident #51 had complete top dentures or what assistance she needed in denture management. Review of the progress noted revealed a Social Services note dated 07/01/24 revealed Resident #51 was exhibiting fixation on her extracted teeth and area from which they were pulled. Further review of this note confirmed Resident #51 did have upper dentures and was accepting of the moist minced diet prior to her tooth extractions and she was to be seen by the dentist for a follow-up exam on 07/09/24. Review of the 360 Care dental progress notes revealed Resident #51 received upper complete dentures and had a dental visit on 08/17/24 for denture insertion, fitting check, and instructions/denture education. Observation and interview on 08/05/24 at 11:37 A.M. revealed Resident #51's dentures falling out as she attempted to speak. Further observation revealed Resident #51 pulled the dentures out of her mouth and wrapped them in a tissue, then proceeded to state her dentures had been falling out a lot because she lost some weight and her face changed after her bottom teeth were pulled, and she could not keep her teeth in to eat or talk and expressed she had been waiting a long time for them to fit correctly, though she was unable to specify how long. During the interview, Resident #51 had teary eyes and covered her mouth with her had as she spoke. At the time of the interview, Resident #51 expressed she was embarrassed and did not want anyone and the surveyor to see what she looked like without her teeth. Interview on 08/08/24 11:20 A.M. with Licensed Practical Nurse (LPN) #349 in 500 confirmed Resident #51 had top dentures but did not know if there were any instructions on her care plan. Observation and Interview on 08/08/24 at 11:25 A.M. with Resident #51 revealed her top dentures were secured as she informed the surveyor the social worker got her some glue for her dentures and she just had to put a few dots of glue on them and now the dentures stay in until she takes them out and cleans them at night. Interview on 08/08/24 at 11:27 A.M. with State tested Nurse Aide (STNA) #345 confirmed she was aware Resident #51 had dentures but did not know what care or assistance she needed for the dentures since she typically did not work that hall and did not usually see care plans regarding dentures. Interview on 08/08/24 at 12:30 P.M. with STNA #303 confirmed Resident #51 had upper dentures that she typically managed on her own, but the STNAs provided assistance of Resident #51 asked. During the interview, STNA #303 confirmed dentures are typically not on the care plan and there were no plan of care (POC) tasks related to dentures to document while on shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/08/24 at 12:40 P.M. with LPN #337 revealed the IDT works on care plans collaboratively but the facility does not always include a plan of care related residents with dentures. Interview on 08/08/24 at 12:45 PM with the Registered Nurse (RN) #310 confirmed the IDT was involved in care planning and if a hearing or chewing/swallowing concern, the resident specific care plan would be entered by the MDS nurse. Interview on 08/08/24 at 12:55 P.M. with the MDS LPN #322 confirmed residents with dentures do not often have care plans related to the dentures, unless they had chewing or swallowing concerns. Interview on 08/08/24 01:18 PM with Social Worker (SW) #422 confirmed there was no care plan related to Resident #51 wearing dentures in the medical record. Review of the Policy titled ADLs dated 06/18/24 revealed each resident would receive assistance daily to meet their needs. Review of the policy titled Care Planning - Interdisciplinary Team dated 01/21/14 revealed resident care plans were to be based on comprehensive assessment data and were developed by the care planning or interdisciplinary team. Review of the policy titled Comprehensive Care Plans Policy revealed the comprehensive care plan interventions should be person-centered an address the resident's medical, nursing, mental, and psychological needs. 3. Review of the medical record for Resident #67 revealed she was admitted to the facility on [DATE]. Diagnoses included peritoneal abscess, adjustment disorder with anxiety, primary hypertension, chronic obstructive pulmonary disease (COPD), muscle weakness, pneumonia, and need for assistance with personal care. Review of the Minimum Data Set (MDS) 3.0 assessment completed on 06/17/24 revealed Resident #67 had moderately impaired cognition, had adequate hearing with the use of hearing aids, and had adequate vision with the use of corrective lenses. Further review of the MDS revealed Resident #67 had an upper and lower mobility impairment of both sides, was dependent for bathing and transfers, and required substantial assistance with personal care. Review of the active care plan in the electronic medical record revealed Resident #67 had a self-care deficit in the performance of activities of daily living (ADLs) and required staff participation in performance of personal hygiene and care. Further review of the care plan revealed Resident #67 had impaired cognition affecting the ability for her to attend to her own needs and general health. During review of the care plan, there were no care plan interventions related to impaired hearing or vision, or Resident #67 requiring the use of corrective lenses or hearing aids. Review of the plan of care tasks revealed no documentation Resident #67 received assistance with corrective lenses or hearing aids. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview of Resident #67 on 08/05/24 at 11:05 A.M. revealed she was in bed with the television on. At the time of the interview, Resident #67 pointed to her right ear several times and stated she could not hear. Resident #67 was not wearing glasses and did not have hearing aids in at the time of the observation and interview. Further observation revealed a sign posed on Resident #67's door directing staff that when Resident #67 uses her hearing aids, staff should take them out, turn them off, and place them back in her drawer once they are finished using them to speak with her. Observation of Resident #67 on 08/06/24 at 2:42 P.M., on 08/07/24 at 7:33 A.M., 10:12 A.M., and 12:6 P.M., and on 08/0824 at 9:06 A.M. revealed no signs Resident #67 was wearing any glasses or hearing aids. Interview on 08/08/24 11:20 A.M. with Licensed Practical Nurse (LPN) #349 in 500 confirmed Resident # 67 had hearing aids but she did not know if she wore them or when. She further confirmed she did not find information on the care plan regarding the hearing aids. Interview on 08/08/24 at 12:30 P.M. with State tested Nurse Aide (STNA) #345 confirmed she helped the assigned STNA get Resident #67 out of bed and observed STNA #303 put a hearing aid in Resident #67's right ear. Further interview with STNA #345 confirmed Resident #67 was supposed to have hearing aides in every day but the resident sometimes would not allow it. Observation at 11:32 A.M. of Resident #67 revealed she was in the dining hall wearing a hearing aide in her right ear. At the time of the observation, Resident #67 stated she was able to hear better and stated she did not have a hearing aide in daily but did not say why. Interview on 08/08/24 at 12:30 P.M. with STNA #303 confirmed Resident #67 had a hearing aid, but only for one ear and she was not sure why. STNA further confirmed there was no plan of care task to document when Resident #67 uses hearing aids, though she did state it was her assumption Resident #67 should wear a hearing aid every day. Interview on 08/08/24 at 12:40 P.M. with LPN #337 revealed the IDT works on care plans collaboratively and hearing aids should all be care planned for. Interview on 08/08/24 at 12:45 P.M. with Registered Nurse (RN) #310 confirmed the IDT is involved in care planning and if a resident had hearing or chewing/swallowing concerns, the care plan would be entered by the MDS nurse. Interview on 08/08/24 at 12:55 P.M. with the MDS LPN #322 confirmed residents with hearing aids should have the hearing aids care planned for. During the interview, LPN #322 was unable to confirm hearing aids were included on Resident #67's care plan. Interview on 08/08/24 01:18 P.M. with Social Worker (SW) #422 confirmed the IDT always want to care plan related to hearing aids. Review of the Policy titled ADLs dated 06/18/24 revealed each resident would receive assistance daily to meet their needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Care Planning - Interdisciplinary Team dated 01/21/14 revealed resident care plans were to be based on comprehensive assessment data and were developed by the care planning or interdisciplinary team. Review of the policy titled Comprehensive Care Plans Policy revealed the comprehensive care plan interventions should be person-centered an address the resident's medical, nursing, mental, and psychological needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 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** 46195 Based on record review, interview, and facility policy, the facility failed to hold an initial care plan meeting in a timely manner for Resident #91. This affected one resident (#91) out of 22 residents reviewed for care plans. The facility census was 94. Findings include: Review of medical record for Resident #91 revealed an admitted [DATE]. The resident was discharged to the hospital on 08/01/24 and returned on 08/04/24. Diagnoses included unspecified sequelae (an after effect) of other nontraumatic intracranial (within the brain) hemorrhage (heavy discharge of blood), essential hypertension (high blood pressure), atherosclerotic heart disease of native coronary artery without angina pectoris (chest pain), obstructive sleep apnea, chronic combined systolic and diastolic (congestive) heart failure, oropharyngeal phase dysphagia (difficulty swallowing), hemiplegia (total or partial paralysis) and hemiparesis (muscular weakness or partial paralysis) following nontraumatic subarachnoid (below the thin membrane of the brain and spinal cord) hemorrhage (heavy discharge of blood) affecting right dominant side. Review of discharge return anticipated/end of PPS (Prospective Payment System) Part A stay Minimum Data Set (MDS) assessment, dated 08/01/24, revealed Resident #91 was moderately impaired cognitively; required supervision or touch assistance with oral and personal hygiene, substantial/maximum assistance for toileting hygiene, and was dependent on staff for shower/bathe self, and transfers. Resident #91 was always incontinent of bowel and bladder and received nutrition and hydration via a feeding tube. Review of the care plan created on 07/11/24 revealed Resident #91 had an activity of daily living (ADL) self care performance deficit related to cerebrovascular accident and significant decline in functional status. Discharge uncertain but would like to be able to return home. Goals included Resident #91 will have current and prior expressed wishes honored as much as possible regarding care through the review date. Interventions included encourage resident to direct care, offer input and make decisions Further review of the medical chart revealed no indication a care conference had been held for Resident #91 since admission on 07/05/24. Interview on 08/05/24 at 9:58 A.M. with family of Resident #91 revealed she had never been invited to a care plan meeting or had not attended a care plan meeting since the resident had been admitted to the facility. Interviews on 08/07/24 at 12:55 P.M. and 1:10 P.M. with Social Worker #422 confirmed a care conference had not been held for Resident #91, but a care conference meeting had been scheduled for 08/13/24. Social Worker #422 stated Resident #91 should have already had a care conference, but the facility was out of compliance since she had to take some time off work and was the only one who scheduled the care conferences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Care Planning-Interdisciplinary Team, dated 01/21/14, revealed the resident, the resident's family and/or the resident's legal representative/guardian or surrogate would be encouraged to participate in the development of and revisions to the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review and interview the facility failed to ensure direct care staff were able to verbalize knowledge of and understanding of Resident #62, #81 and #83's experiences and preferences pertaining to trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization of the residents. This affected three residents (#62, #81 and #82) out of three residents the facility identified as having post traumatic stress disorder (PTSD). The facility census was 94. Findings included: 1. Review of the medical record revealed Resident # 83 was admitted to the facility on [DATE]. Medical diagnoses included spondylosis without myelopathy, anemia, malignancy neoplasm of prostate and depression. Hospice care started 01/15/24. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #83's cognition was intact. Review of the care plan, start date of 07/11/24, revealed Resident #83 reported a history of trauma. Interventions included staff to identify triggering situations and share information with all staff unless resident requested otherwise. If Resident #83 experienced re-traumatization staff would validate feelings, offer emotional support, reassure and provide calming techniques. Resident #83 preferred small groups of three to four people at a time. Interview on 08/06/24 at 4:23 P.M. revealed State tested Nurse Assistant (STNA) #377 was unaware of any PTSD triggers and care planned interventions for trauma for Resident # 83. Interview on 08/06/24 at 4:24 P.M. revealed Licensed Practical Nurse (LPN) #321 was unaware Resident #83 had any triggers related to PTSD and did not know what the care planned interventions were to not cause retraumatization. 2. Resident #81 was admitted to the facility on [DATE]. Medical diagnoses included personal history of adult neglect, delusional disorder, schizophrenia, severe protein malnutrition and schizoaffective disorder. Review of MDS 3.0 annual assessment dated [DATE] revealed Resident #81's cognition was intact. Resident #81 did not reject care. Resident #81 was independent to transfer from bed to chair and to walk ten to fifty feet. Resident #81 needed assistance to bathe, to dress and undress. Review of the care plan with start date of 06/07/24 revealed Resident #81's family reported past history of trauma related to abuse and was concerned of difficulty with staff bathing Resident #81 or performing personal care. Interventions included staff to assist Resident #81 to identify triggers and how to manage and share information with staff unless resident requests otherwise. Resident #81 would be encouraged to verbalize thoughts and feelings when triggered and offer emotional support and calming techniques. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of facility document titled Pre-Admission Review dated 06/12/23 written by previous social worker (PSW) #500 , revealed Resident #81 had trauma and might be uncomfortable with bathing. Review of facility document titled Trauma Checklist dated 01/12/24, written by PSW # 500, revealed Resident #81 had trauma assault and felt helpless and terrified. Interview on 08/06/24 at 6:05 P.M. with Registered Nurse (RN) #354 and Certified Nurse Assistant (CNA) # 315 revealed both were unaware of any PTSD triggers and care planned interventions regarding Resident #81's care. 3. Resident #62 was admitted to the facility on [DATE]. Medical diagnoses included Alzheimer's, legal blindness, bipolar, schizoaffective and anxiety. Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident # 62 had long and short-term memory problems and cognitive skills were severely impaired. No hallucinations or delusions. No verbal or physical behaviors exhibited. No rejection of care. Resident # 62 was dependent on staff to roll left to right in the bed, lie to sit on the side of the bed, sit on the side of the bed and led back. Resident # 62 did not attempt to sit to stand. Resident # 62 was dependent for bed to chair transfers. Did not walk ten feet. Review of the care plan date initiated 01/12/21 revealed Resident # 62 had a history of trauma related to assaults. Interventions included assist Resident # 62 to identify triggering situations and how to manage and share all information with all staff unless resident requests otherwise. If Resident # 62 experienced re-traumatization staff would validate feelings, offer emotional support, reassurance and calming techniques. Resident # 62 would be encouraged to verbalize thoughts and feelings on his terms and when triggered. Resident # 62 would be offered to receive psych services. Resident # 62 would be provided a calm, quiet and safe environment when triggered or experiencing signs or symptoms of traumatization based on preferences. Review of facility document titled Trauma Checklist dated 01/12/22 written by PSW #500 revealed Resident #62 had trauma assault history. Resident #62 felt helpless and terrified according to Resident's #62 family member. Interview on 08/06/24 at 5:57 P.M. with Social Worker #422 revealed the facility would evaluate each resident regarding trauma and triggers prior to admission in the facility. The facility administration would updated the care plans and all care staff were to follow the care plan. Interview on 08/06/24 at 6:00 P.M. revealed LPN #321 was not aware of PTSD triggers or care planned interventions for Resident #62's trauma because the resident was laid back. Interview on 08/08/24 at 10:07 A.M. revealed the Director of Nursing (DON) was not aware of any PTSD triggers and care planned interventions for Resident # 83, #81 and #62. The DON stated she reviewed care plans. Review of facility in-service documentation dated 02/09/24 revealed services in the facility would be delivered within a trauma informed environment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Trauma Informed Care dated 01/05/22 revealed the facility would use evidence-based services for residents to meet their needs. The services would be delivered within a trauma informed environment. Review of facility policy titled Comprehensive Care Plan revised 10/20/22 revealed an individualized comprehensive care plan would include measurable objectives to meet the resident's medical, nursing, mental and psychological needs was developed for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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. 46195 Based on observation, interviews, and review of the facility Spring and Summer 2024 menu, the facility failed to ensure nutritionally equivalent food substitutions were made and provided for Resident #46, #66, #81, #83 and #145. This affected five residents (#46, #66, #81, #83, and #145) out of the 91 residents who the facility identified as receiving meals from the kitchen. The facility identified three residents (#9, #41, and #55) as receiving no meals from the kitchen. The facility census was 94. Findings include: Review of the facility Spring/Summer 2024 menu cycle for day 10 revealed for lunch a chili dog, baked beans, country potatoes, and watermelon was to be served. Observation of tray line on 08/06/24 between 11:38 A.M. to 12:22 P.M. revealed at 12:21 P.M. the facility ran out of baked beans. Dietary Manager (DM) #380 told the dietary staff to use cottage cheese in place of the baked beans for the five residents (#46, #66, #81, #83, and #145) who did not receive the baked beans. After the cottage cheese was placed on those five residents' trays, the food cart was taken to the 200-300 hall by DM #380. Interview on 08/06/24 at 12:30 P.M. with DM #380 revealed when asked why she told the staff to give cottage cheese for the five residents who didn't receive baked beans, DM #380 stated it was a protein, and it was fast. Interview on 08/08/24 at 10:29 A.M. with Dietitian #376 confirmed the baked beans were the starchy vegetable for the lunch meal on 08/06/24 and should have been substituted with another vegetable instead of the cottage cheese.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, observation and interview, the facility did not ensure food at the appropriate consistency for a mechanical soft diet was served to Resident #39. This affected one resident (#39) of four residents reviewed for food and nutrition. The facility identified 23 residents ordered a mechanical soft diet (#1, #3, #6, #13, #15, #17, #30, #24, #28, #32, #39, #43, #47, #48, #50, #65, #66, #68, #75, #77, #81, #83, and #197). The facility census was 94. Findings include: Review of medical record for Resident #39 revealed a readmitted [DATE]. Diagnoses included Alzheimer's disease, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, chronic diastolic (congestive) heart failure, type two diabetes, oropharyngeal phase dysphagia (difficulty swallowing), and generalized anxiety. Review of physician orders for Resident #39 revealed a diet order dated 07/27/24 for a No Added Salt (NAS) No Concentrated Sweets (NCS) mechanical soft, thin (liquid)consistency diet. Review of 08/03/24 quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #39 was severely impaired cognitively, was independent for eating, and was on a mechanically altered diet. Review of modified barium swallow (MBS) study (a special x-ray for evaluation of swallowing), dated 06/12/24, for Resident #39 revealed mild oral dysphagia and mild pharyngeal dysphagia. It was recommended the resident be on a mechanical soft with thin liquids. Review of speech therapy note dated 06/18/24 Resident #39 was being discontinued from therapy on 06/18/24 on a mechanical soft diet with thin liquids. Review of care plan created on 12/02/21 revealed Resident #39 had a potential for a swallowing problem related to history of oropharyngeal dysphagia. Interventions included all staff would be informed of resident's special dietary and safety needs, and diet would be followed as prescribed. Observation on 08/07/24 at 12:47 P.M. of the lunch meal service in the dining room revealed Resident #39 did not like the main entree so an alternate of chicken tenders was brought to her by Dietary Manager #380 who placed three intact, breaded chicken tenders in front of Resident #39. Resident #39 held the intact chicken tender on a fork and proceeded to bite into the chicken tender when the surveyor intervened due to the Resident's diet slip dated 08/07/24 indicated a mechanical soft diet was what the resident should have received at the meal. At the time of the observation, Licensed Practical Nurse (LPN) #429 was present while feeding another resident next to Resident #39 and LPN #429 confirmed Resident #39 required mechanical soft texture and had been served intact, breaded chicken tenders. LPN #429 proceeded to remove the chicken tenders from the resident and took the plate to the kitchen. Resident #39 was next served the appropriate mechanical soft chicken tenders with gravy. Review of Resident #39's diet slip dated Wednesday 08/07/24 revealed the resident was to receive a mechanical soft diet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366129	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gillette Nursing Home	3310 Elm Rd Warren, OH 44483

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/08/24 at 8:54 A.M. with Speech Language Pathologist (SLP) #503 revealed an intact breaded chicken tender was not considered mechanical soft. Interview on 08/08/24 at 10:29 A.M. with Registered Dietitian #376 confirmed the chicken tender should have been cut up prior to giving it to Resident #39 who was on a mechanical soft diet. Review of facility document Mechanical Soft Diet Allowances, dated 10/17/13, revealed soft tenders were allowed if cut up.