

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Dayspring of Miami Valley Hlth Care Center & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Dayton Springfield Road Fairborn, OH 45324	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, staff interview, review of the facility policy, and record review, the facility failed to ensure fall interventions were in place for a resident who had a history of falls and was at a fall risk. This affected one (Resident #84) of three residents reviewed for falls. The facility census was 125. Findings include: Review of the medical record for Resident #84 revealed an admitted [DATE]. Diagnoses included senile degeneration of the brain, chronic obstructive pulmonary disease, respiratory failure dementia and cognitive communication deficit. Review of the care plan dated 08/08/24 revealed Resident #84 was at risk for falls with interventions to assist resident as needed, ensure wheelchair was locked and bed was stable prior to transferring, keep floor free of clutter, use tilt dump wheelchair seat, low bed, non-skid socks, encourage to be in common areas, visual cues to bedside (added 10/21/24), and fall mats to bedside (added 10/21/24). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 had significant cognitive impairment and required partial moderate assistance for bed mobility and transfers. Resident #84 had two or more recent falls during the review period. Review of the quarterly fall risk scale dated 09/18/24 revealed Resident #84 three or more falls in previous 90 days and score a 20 on the fall risk assessment indicating increased risk for falls (over 10 was considered at risk) Review of the progress notes dated 10/18/24 revealed Resident #84 had a fall from her bed that was unwitnessed. The facility initiated interventions of fall mats by the bed and visual cues. Review of the fall investigation dated 10/21/24 revealed Resident #84 had a fall on 10/18/24. Resident #84 was found on the floor by staff laying next to her bed with pillow and blanket. New interventions included a visual cue to bedside and fall mats to bedside. Review of the physician orders dated 10/21/24 revealed an order for fall mats to bedside and a second order dated 10/21/24 for visual cues to bedside (for call light reminder). (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/05/24 at 4:53 P.M. revealed Resident #84 was sitting in her wheelchair in her room. A black rug-like object was on resident's floor. There was no fall mat in Resident #84's room. Observation on 11/06/24 at 9:17 A.M. revealed Resident #84 was lying in bed and there was a black rug like object on resident's floor. No fall mats were observed and no visual cues (for call light reminder) were observed to be on resident's half of the room. Observation and interview on 11/06/24 at 9:20 A.M. with State tested Nursing Aide (STNA) #44 revealed facility fall mats were a thick padded mat and pointed to a red one laying on the floor in a nearby resident room. STNA #44 confirmed Resident #84 did not have any fall mats next to her bed and was unsure what the black rug-like object was. She confirmed it did not have any padding on it for softer fall. She also confirmed Resident #84 did not have any visual cues hanging up for reminders to use the call light as per the care plan. Observation and interview on 11/06/24 at 9:29 A.M. with the Director of Nursing (DON) stated she was unsure why Resident #84's fall interventions were not in place. The DON stated at times, Resident #84 was independent with mobility and possibly a fall mat would be a hazard. Observation on 11/06/24 around 1:00 P.M. revealed Resident #84 had newly placed red fall mat identical to the ones identified by STNA #44 previously as well as a newly placed visual cue reminder to use the call light in resident's room. Review of the facility policy titled Fall and Accident Management, dated 06/2019, revealed facility shall identify patients at risk of falls and interventions shall be implemented and evaluated to reduce risk of injuries, falls or other accidents. The facility would work to identify, evaluate and analyze hazards, implement interventions and monitor for effectiveness of interventions when necessary. This deficiency represents non-compliance investigated under Complaint Number OH00159021.		

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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** 44070 Based on observations, staff interview, review of the facility policy, and record review, the facility failed to ensure a resident was served a therapeutic meal as physician ordered. This affected one (Resident #84) of three residents reviewed for therapeutic diets. The facility census was 125. Findings include Review of the medical record for Resident #84 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, malnutrition, and dementia. Review of Resident #84's physician orders dated 06/13/24 revealed an order for finger foods with regular texture. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 had significant cognitive impairment and required supervision or touching assistance from staff with meals. Review of the care plan dated 10/10/24 revealed Resident #84 had a nutritional problem and was at risk for malnutrition. Interventions included to monitor weight and make recommendations, provide/serve diet as ordered, and speech therapy to follow for chewing/swallowing issues. Review of Resident #84's meal ticket for dinner on 11/05/24 revealed she was to receive finger foods with regular texture. According to the meal ticket, Resident #84 was to receive one pot roast sandwich, brown gravy on the side, one baked sweet potato, four ounces of Brussels sprouts, and a two-by-two size slice of caramel applesauce cake. Review of the menu spreadsheet dated 11/05/24 revealed the residents on a finger food diet were to receive pot roast on bread in sandwich form and shall not receive a dinner roll, a sweet potato, Brussels sprouts, and cake. Observation 11/05/24 at 5:51 P.M. revealed Resident #84 had her tray in front of her in the dining room. Resident #84's plate contained chopped/shredded pot roast with gravy poured on top, diced sweet potato and brussels sprouts and no roll. The meat was not in sandwich form. Interview and observation on 11/05/24 at 5:53 P.M. with Regional Kitchen Manager (RKM) #77 confirmed Resident #84 did not receive the meal according to the spreadsheet guidance for specialized/therapeutic diets. He looked up the meal ticket as one was not provided to Resident #84 and confirmed the meal ticket also stated residents diet order for finger foods with regular texture. Interview on 11/05/24 at 5:55 P.M. with Dietician #66 confirmed Resident #84's plate did not match the physician order nor the spreadsheet and was unsure why the resident was not provided the correct texture diet. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discussions on 11/05/24 from 5:50 to 6:00 P.M. with RKM #77 and Dietician #66 with numerous State tested Nursing Aides (STNAs) and nursing staff present revealed no knowledge of why the diet or food options were not provided according to physician order. Both RKM #77 and Dietician #66 searched for the meal ticket and discussed with STNAs and nursing staff with surveyor present without any information provided related to Resident #84's provided meal being different than the ordered meal type. Interview on 11/05/24 at 6:10 P.M. with RKM #77 confirmed the facility made an error and confirmed it was difficult to get young new staff to read the tickets. He confirmed Resident #84's food was chopped and appeared to be mechanically soft texture and not regular and confirmed the resident was not provided a sandwich and no bread for finger food. Review of the facility policy titled Diet Orders and Selective Menu, dated 11/2019, revealed the facility shall provide physician prescribed diet orders. Diet orders shall be entered in the medical record and the menu software and changes by the dietician will be changed in the diet menu. This deficiency represents non-compliance investigated under Complaint Number OH00159360.		