

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

Printed: 12/04/2024
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 09/12/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident interview, staff interviews and record review, facility failed to ensure a resident received adequate Activities of Daily Living (ADLs) care. This affected one resident (#27) of one reviewed for personal care. Facility census was 125. Findings include Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included contracture of left hand, monoplegia of left upper extremity, anxiety, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had intact cognition and was dependent on staff for showering and bathing as well as personal hygiene and stated, helper does all of the effort, resident does none of the effort to complete the activity. Review of the plan of care dated 07/29/24 revealed Resident #27 had a self care performance deficit related to contracture of the left hand, impaired mobility and limited range of motion, confusion and non compliance with behaviors with interventions of bathing and showering total dependence of two staff, encourage resident to participate in ADLs to the fullest extent possible, trim and clean finger nails on bath day and as necessary, contracture of left hand to provide skin care every shift and use of palm protector at all times. The care plan revealed resident had a behavioral problem including irritability, mood swings and delusions with interventions to anticipate needs. Review of shower sheets revealed resident did not refuse any showers in 08/2024 or 09/2024. Resident had nail care and hair washed checked off on 08/30/24 and 09/06/24 and documentation of bed baths given with no hair washing or nail care marked on 09/04/24 and 09/10/24. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/09/24 at 11:35 A.M. of Resident #27 revealed long fingernails with about 1/4 inch to 1/2 inch growth from the nail bed. Resident had a black/brownish dirt substance under all nails. Resident revealed a staff member trimmed a hangnail a few days ago, but reported they did not trim or clean her nails at that time. She revealed her nails had looked dirty for a few weeks. Residents left hand had a contracture with a splint in place and nails on her contracted hand were also very long with dirt and grime underneath them. Resident also reported she wanted her hair washed and revealed staff have not provided hygiene and bathing for several weeks. Resident revealed she felt dirty and felt her hair was greasy and matted. Residents hair appeared greasy and was stringy from scalp to the ends and her hair also appeared matted and knotted in the back. When resident lifted her head off the pillow or turned her head from side to side during discussion, her hair stayed in place and had no flow or movement. Observations on 09/10/24 from 9:00 A.M. to 4:45 P.M. revealed residents nails and hair appeared in the same condition as observation on 09/09/24. Observations on 09/11/24 from 8:15 A.M. to 5:45 P.M. revealed residents nails and hair appeared in the same condition as observation on 09/09/24. Observation and interview on 09/12/24 at 8:42 A.M. with Resident #27 revealed residents nails and hair appeared in the same condition as observation on 09/09/24. Resident stated she had not received any shower or bath and had not had hair washing or nail trimming in the past week. Resident nails remained dirty with a black/brown substance and were long 1/4 inch to 1/2 inch growth from the nail bed. Resident stated she wanted to get cleaned up and was agreeable to nail care and shower being performed. Interview and observation on 09/12/24 at 8:48 A.M. Licensed Practical Nurse (LPN) #308 and LPN #354 confirmed Resident #27 had long and dirty nails. They revealed they would provide care shortly. They also acknowledged the resident's hair appeared greasy and stated the resident had an ointment placed on her scalp that can make it look greasy. They confirmed hair should not look matted and knotted and were present when resident stated another unknown staff member told her, her hair looked greasy. LPN's verified resident should have hygiene maintained and stated that she refused showers and care frequently. Facility provided no evidence of refusals since 07/2024. Review of facility policy titled, Activities of Daily Living (ADL Care), dated 08/2024 revealed staff shall ensure residents who were unable to carry out activities of daily living receive the necessary services to maintain good grooming and personal hygiene. These activities include bathing and grooming.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on observation, record review, interviews, and review of facility policy, the facility failed to send one (Resident #39) to an ophthalmologist appointment timely and the facility failed to identify and treat dry, scaly skin for one (Resident #474). This affected two (Resident #39 and Resident #474) of two residents reviewed for appointments and skin care. The facility census was 125. Findings include: 1. Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease with (acute) exacerbation, chronic respiratory failure with hypercapnia, and unspecified conjunctivitis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #39 was independent with eating, required set-up assistance with oral hygiene and personal hygiene, required partial assistance with bed mobility, transfers, and wheelchair mobility, required substantial assistance with dressing, and was dependent on staff assistance with toileting hygiene and bathing. Review also revealed the resident was on an antibiotic when the MDS was completed. Review of the physician orders revealed an order dated 03/08/24 for Erythromycin Ophthalmic Ointment 5 milligrams/gram (mg/gm), instill 1 application in left eye four times a day for unspecified conjunctivitis. Review of the Infection Control Log for March 2024 revealed Resident #39 admitted with order for Erythromycin Ophthalmic Ointment 5 mg/gm, 1 application left eye four times daily. With no culture available. Review of the Pharmacy Review dated 06/02/24 revealed the physician reviewed the pharmacy recommendation on 06/07/24 and advised Erythromycin Ophthalmic Ointment 5 mg/gm, instill 1 application in left eye four times a day for unspecified conjunctivitis to continue until follow up with Retinal Clinic. Review of the Pharmacy Review dated 07/02/24 revealed the physician reviewed the pharmacy recommendation on 07/03/24 and wrote, Patient needs to follow up with ophthalmologist for stop date. Staff Registered Nurse (RN) documented on form, Orders received to continue through 07/15/24 follow up appointment from ophthalmology. Further review of the medical record revealed no documentation showing Resident #39 went to an ophthalmology appointment. Interview on 09/12/24 at 1:17 P.M. with Assistant Director of Nursing #438 confirmed resident continued on the Erythromycin Ophthalmic Ointment 5 mg/gm 1 drop four times daily since admission. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/12/24 at 2:32 P.M. with Social Service Designee #368 confirmed an appointment was scheduled for Resident #39 to see an ophthalmologist on 06/25/24 and the appointment was canceled along with transportation, but the facility is not sure who canceled it or why. Interview also confirmed the facility has not rescheduled another ophthalmologist appointment. 45751 2. Review of medical record for Resident #474 revealed an admitted [DATE] with diagnoses including but not limited to fracture of one rib left side, strain of muscle fascia and tendon of lower back, anxiety, depression, and edema. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. No skin issues were noted. Review of the care plan dated 08/19/24 revealed the resident had the potential for skin impairment related to impaired mobility, incontinence, fragile skin, and non compliance with bathing. Interventions included but not limited to keep skin clean and dry. Use lotion on dry skin. Review of current physician orders revealed no treatment order for dry, scaly skin to lower extremities. Review of skin assessments revealed no mention of dry/scaly skin to bilateral lower extremities. Observation on 09/09/24 at 10:27 A.M. revealed the resident had very dry, scaly skin to bilateral lower extremities. Observation on 09/10/24 at 3:18 P.M. revealed the resident continued to have dry, scaly skin to bilateral lower extremities. Interview on 09/09/24 at 10:24 A.M. with Resident #474 revealed the resident stated that her legs hurt and the resident felt they were swollen. Observation at the time of the interview revealed the residents nurse entered the room and pushed on the residents legs to check for edema. The residents legs did not appear swollen but they were very dry. The nurse stated she would have the Nurse Practitioner look at them today. Interview on 09/11/24 at 3:30 P.M. with Resident #474 revealed the resident stated that her legs continued to hurt and continued to be dry and itchy. Resident #474 denied that any staff had put any lotion on her legs. Observation at the time of the interview revealed the residents legs were dry and scaly. Small red area noted on right lower shin. Interview on 09/11/24 at 3:35 P.M. with Registered Nurse (RN) #365 verified the resident did not have any order for a treatment to dry skin to bilateral lower extremities. RN #365 verified the residents legs were very dry and that the resident was scratching at her skin due to itching. RN #365 stated she would contact the Nurse Practitioner to get an order for a treatment for the residents lower extremities. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Skin Integrity Team (SIT)- Skin Monitoring Process, dated 06/2023 revealed there will be monthly head to toe skin assessments by the skin assessment nurse or other designee.		

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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 staff interview, review of facility fall investigation, and record review, the facility failed to ensure a safe hoyer transfer was completed for one resident (#36) of three reviewed for falls. Facility census was 125. Findings include Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included hypothyroidism, dysphagia, dementia, repeated falls, spinal stenosis and osteoporosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had significant cognitively impairment and required extensive assistance of staff members for mobility and transfers with several activities not completed due to medical condition or safety concerns. Review of the plan of care undated revealed resident had a self care deficit and required total dependence of two staff for transfers, required mechanical lift hoyer with two staff assistance, and assistance with positioning as needed to help maintain proper body alignment. Review of the Fall Investigation dated 08/28/24 revealed the resident was at risk for falls due to a history of multiple falls, osteoporosis, cognitive decline and stated resident had confusion at baseline with poor safety awareness. The investigations stated the State tested Nursing Aide (STNA) informed the nurse of resident being on the ground. When the nurse arrived, resident was lying on the floor on her back in front of the hoyer lift with her legs stretched out in front of her. The hoyer pad was noted to be positioned incorrectly causing the STNA to lower the resident to the floor via hoyer to prevent resident slipping off hoyer pad. The new intervention included education on hoyer lift transfers and positioning of the hoyer pad completed by nurse and therapy. Interview on 09/12/24 at 12:20 P.M. with Assistant Director of Nursing (ADON) #438 revealed Resident #36 was on the chair and the resident was slid to the floor from the chair by STNA #399 using the hoyer pad. ADON stated the resident was never hooked up to the hoyer machine and stated the investigation was misworded. ADON confirmed two staff should complete a hoyer transfer and revealed only one staff was present due to resident falling while she was being prepped for the transfer. ADON #438 revealed the resident went from requiring one person assist to two person assist for chair and bed mobility. ADON #438 verified the resident had no injuries from the incident. Interview on 09/12/24 at 12:28 P.M. with STNA #399 verified she was getting the resident ready for a transfer from the chair to the bed. She confirmed the resident was hooked up to the hoyer lift machine and using the hoyer lift machine went to the ground. She also verified the language in the fall investigation was accurate. She confirmed a second staff member was not present during the transfer of the fall. STNA #399 verified the resident had no injuries resulting from the incident. Review of facility policy titled, Mechanical lifts, dated 12/2018 revealed the facility would use mechanical lifts to promote safety from one resting surface to another. The care plan assessment determines if more than one staff was required. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Fall and Accident Management, dated 06/2019 revealed the facility interventions would be implemented to prevent falls and reduce risk of injuries. After a fall occurs, the nurse shall assess for clues as to what happened and complete an investigation.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review and staff interviews the facility failed to ensure residents did not receive antibiotic for an excessive amount of time. This affected one (Resident #39) out of one resident assessed for antibiotic use. The facility census was 125. Findings include: Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease with (acute) exacerbation, chronic respiratory failure with hypercapnia, and unspecified conjunctivitis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #39 was independent with eating, required set-up assistance with oral hygiene and personal hygiene, required partial assistance with bed mobility, transfers, and wheelchair mobility, required substantial assistance with dressing, and was dependent on staff assistance with toileting hygiene, and bathing. Review also revealed the resident was on an antibiotic when the MDS was completed. Review of the physician orders revealed an order dated 03/08/24 for Erythromycin Ophthalmic Ointment 5 milligrams/gram (mg/gm), instill 1 application in left eye four times a day for unspecified conjunctivitis. Review of the Infection Control Log for March 2024 revealed Resident #39 admitted with order for Erythromycin Ophthalmic Ointment 5 mg/gm, 1 application left eye four times daily. With no culture available. Review of the Infection Control Log for April 2024 revealed Resident #39 not listed on the log. Review of the Infection Control Log for May 2024 revealed Resident #39 not listed on the log. Review of the Infection Control Log for June 2024 revealed Resident #39 not listed on the log. Review of the Pharmacy Review dated 06/02/24 revealed the physician reviewed the pharmacy recommendation on 06/07/24 and advised Erythromycin Ophthalmic Ointment 5 mg/gm, instill 1 application in left eye four times a day for unspecified conjunctivitis to continue until follow up with Retinal Clinic. Review of the Pharmacy Review dated 07/02/24 revealed the physician reviewed the pharmacy recommendation on 07/03/24 and wrote, Patient needs to follow up with ophthalmologist for stop date. Staff Registered Nurse (RN) documented on form, Orders received to continue through 07/15/24 follow up appointment from ophthalmology. Review of the Infection Control Log for July 2024 revealed Resident #39 listed on 07/03/24 for in-house acquired infection for ocular laceration with no culture completed, order for Moxifloxacin 0.5% one drop in left eye four times daily for 7 days, listed as resolved. Review of the Infection Control Log for August 2024 revealed Resident #39 not listed on the log. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed no evidence the resident went to an ophthalmology appointment. Interview on 09/12/24 at 1:17 P.M. with Assistant Director of Nursing #438 confirmed the resident continued on the Erythromycin Ophthalmic Ointment 5 mg/gm 1 drop four daily since admission. Interview on 09/12/24 at 2:32 P.M. with Social Service Designee #368 confirmed an appointment was scheduled for Resident #39 to see an ophthalmologist on 06/25/24 and the appointment was canceled along with transportation, but the facility was not sure who canceled it or why. Interview also confirmed the facility has not rescheduled another ophthalmologist appointment.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, staff interview, and record review, the facility failed to store foods in a sanitary manner. This had the potential to affect 124 residents who received food from the kitchen. The census was 125. Findings Include: Observation on [DATE] at approximately 8:40 A.M. of the dry storage area revealed a bag of lemonade mix, wrapped in plastic wrap, with no label nor date. Observation of the dry storage area revealed a half bag of dry macaroni noodles and a half bag of dry pasta noodles each closed with a twist tie and unwrapped, with no label and no date Interview at the same time as the observations with Chef #394 verified the lemonade mix, dry macaroni, and dry pasta noodles were not labeled nor dated. Observation on [DATE] at approximately 8:45 A.M. of the walk-in cooler revealed five, five-pound containers of yogurt, dated [DATE], and a cart, containing five pans, each containing eight round portions of what appeared to be raw pancakes or dough. The cart of pans was uncovered and not labeled nor dated. Observation of the walk-in cooler revealed pickle chips, stored in a metal bowl and covered loosely with plastic kling wrap, with a use by date [DATE], and loose lettuce leaves stored in a metal bowl and covered loosely with plastic kling wrap, with a use by date [DATE]. Interview at the same time as the observation with Chef #394 verified the five containers of yogurt were expired and the cart of pans of what appeared to be pancakes or dough was not covered, labeled, nor dated. Chef #394 stated she was unsure what was on the pans on the cart. Review of the facility's policy titled, Food Storage, dated ,d+[DATE] revealed all opened food items will be labeled, dated, covered, and discarded within 7 days.		