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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366195 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to promote an environment that maintained each residents' dignity by serving meal trays with no knives. This affected Residents #20 and #82 and had the potential to affect the remaining 15 residents (#8, #40, #49, #50, #53, #54, #67, #70, #83, #89, #147, #148, #149, #150, and #151) who resided on the 1200 hallway. The facility identified no residents on the 1200 hallway that received nothing by mouth. The facility also failed to ensure Resident #254's urostomy bag was covered with a privacy cover. This affected one resident (#254) of one resident reviewed for catheter care. The facility census was 102.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #20 revealed an admitted [DATE] with medical diagnoses including anemia, type two diabetes mellitus, anxiety disorder, obstructive sleep apnea, chronic pain, muscle weakness, and chronic kidney disease stage three.</p> <p>Review of the physician's orders revealed Resident #20 was ordered a renal carbohydrate-controlled diet, regular texture and thin liquid consistency.</p> <p>Review of Resident #20's care plan dated 01/23/24 revealed the resident required assistance with activities of daily living related to fatigue with an intervention to encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>Review of the most recent Minimum Data Set (MDS) Medicare Five-day assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 was independent with eating and was always continent of bowel and bladder.</p> <p>2. Review of the medical record for Resident #84 revealed an admitted [DATE] with medical diagnoses including osteomyelitis of vertebra lumbar region, adjustment disorder with depressed mood, type two diabetes mellitus, hyperkalemia, end stage renal disease, and general muscle weakness.</p> <p>Review of the physician's orders revealed Resident #84 was ordered a regular diet, regular texture and thin liquid consistency.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #84's care plan dated 01/31/24 revealed the resident required assistance with activities of daily living related to generalized weakness with an intervention to encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>Review of most recent Discharge Return Anticipated MDS assessment dated [DATE] revealed Resident #84 was mildly cognitively impaired. Resident #84 was independent with eating and was always incontinent of bowel and bladder.</p> <p>Interview on 09/09/24 at 1:45 P.M. with Dietary Manager #576 revealed she had ordered silverware since the facility did not have enough and speculated that staff were throwing out the reusable metal silverware.</p> <p>Observation on 09/10/24 at 9:51 A.M. revealed Residents #20 and #82 breakfast tray did not include metal knives or plastic knives and were observed to have to tear their sausage patties and French toast apart with their fingers.</p> <p>Interview on 09/10/24 at 9:51 A.M. with Dietary Manager #576 confirmed they had run out of metal knives and did not have any plastic knives. Dietary Manager #576 stated most of 1200 hall did not get knives.</p> <p>Interview on 09/11/24 at 12:15 P.M. with Dietary Manager #576 stated that the 1200 hall was always the last hallway to receive their meal trays for each meal.</p> <p>Review of the facility policy titled Resident Rights, last revised on 12/16, revealed residents have the right to a dignified existence.</p> <p>3. Review of the medical record for Resident #254 revealed an admitted [DATE]. Diagnoses included anxiety, kidney disease, intestinal obstruction, stomach inflammation, constipation, and neuromuscular dysfunction of bladder.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #254 was cognitively intact. She required supervision for oral and personal hygiene, set up help for eating and substantial assistance with toileting, showering and dressing. She had an ostomy.</p> <p>Review of the care plan dated 09/03/24 revealed Resident #254 had an ostomy. Interventions included keeping the ostomy site clean, free from infection, emptying the device as needed, and providing ostomy care every shift.</p> <p>Review of the physician's orders for September 2024 revealed an order dated 09/06/24 to keep the ostomy tubing straight to drain, keep below the level of the bladder, check placement and function, and keep the urinary drain bag covered.</p> <p>Observation on 09/09/24 at 9:49 A.M. revealed Resident #254 was lying in her bed. Her ostomy bag was laying on the floor, uncovered. Resident #254 revealed there was a black bag attached to her bed where the ostomy bag should have been. Interview at the time of the observation with Licensed Practical Nurse (LPN) #599 confirmed the ostomy bag should be hanging in the black bag and should not be on the floor.</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>47568</p> |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568</p> <p>Based on interview, record review, and facility policy review the facility failed to ensure Resident #60's representative was timely notified after a fall. This affected one resident (#60) of four residents reviewed for falls. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #60 was admitted on [DATE]. Medical diagnoses included cerebral infarction due to thrombosis of right posterior cerebral artery, type two diabetes mellitus with diabetic chronic kidney disease, Bell's palsy, essential primary hypertension, dysphagia, epilepsy, and adjustment disorder with mixed anxiety and depressed mood.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was moderately cognitively impaired. Resident #60 required setup or clean-up assistance with eating, partial to moderate assistance for oral hygiene and upper body dressing, and was dependent on staff for toileting, shower/bathing, lower body dressing, putting on and taking off footwear, and personal hygiene. Resident #60 was always incontinent of bowel and bladder.</p> <p>Review of the care plan dated 11/08/20 revealed Resident #60 was at risk for falls due to deconditioning, decreased mobility, gait and balance problems, neurological disorder. Resident #60 had an actual fall at the facility.</p> <p>Review of the progress note dated 04/08/24 at 6:22 A.M. revealed Resident #60 was found on the floor by a state tested nurse aide (STNA). Resident #60 was assessed with no negative findings and the physician was notified. The nurse documented the family would be notified by next shift. Further review of progress notes revealed no documented evidence Resident #60's representative was notified. A progress note dated 07/06/24 at 5:53 A.M. revealed Resident #60 was found sitting on the floor. There was no documented evidence of representative notification. A progress note dated 09/11/24 at 3:21 A.M. revealed Resident #60 was found on the floor of his room. There was no documented evidence of representative notification.</p> <p>Interview with the Director of Nursing (DON) on 09/17/24 at 10:40 A.M. confirmed there was no documented evidence that the facility staff notified Resident #60's representative of the falls on 04/08/24, 07/06/24, and 09/10/24.</p> <p>Review of the facility policy Change in a Resident's Condition or Status, dated 05/17, revealed unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, record review, interview, and facility policy review the facility failed to maintain a safe, clean, comfortable and homelike environment including clean and sanitary tube feed pumps and poles. This affected three residents (#60, #84, and #197) out of five residents reviewed for tube feed, additionally one resident (#13) was affected out of five residents reviewed for a clean and sanitary environment. The facility census was 102.</p> <p>Findings include:</p> <p>1. Review of Resident #13's medical record revealed and admitted [DATE]. Diagnoses included colon cancer, history of urinary tract infections, congestive heart failure, and dementia.</p> <p>Review of Resident #13's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. She was dependent on staff for toileting hygiene, and personal hygiene. Resident #13 was always incontinent of both bowel and bladder.</p> <p>Observation made on 09/09/24 at 2:59 P.M. of Resident #13's room revealed State tested Nurse Aide (STNA) #525 had thrown a soiled brief, paper incontinence pad, and cloth incontinence pad on the floor while providing incontinence care to the resident.</p> <p>Interview on 09/09/24 at 3:00 P.M. with STNA #525 revealed she confirmed she threw a soiled brief, paper incontinence pad, and cloth incontinence pad on the floor while providing incontinence care for Resident #13 and stated she knew she was not supposed to do this and quickly picked it all up and placed everything in the resident's trash can.</p> <p>2. Review of Resident #60's medical record revealed an admitted [DATE]. Diagnoses included cerebral infarction due to thrombosis of right posterior cerebral artery, flaccid hemiplegia affecting right dominant side, Bell's palsy, dysphagia, and epilepsy.</p> <p>Review of Resident #60's annual MDS assessment dated [DATE] revealed the resident had impaired cognition. Resident #60 required setup or clean-up assistance for eating, partial to moderate assistance with oral hygiene, he was dependent for toileting hygiene, showers, dressing, and personal hygiene. Finally, he required partial to moderate assistance for bed mobility.</p> <p>Review of Resident #60's physician's orders dated September 2024 reveal the resident received enteral feeding of Glucerna 1.5 (nutritional supplement) at 70 milliliters (ml)/hour (hr) continuously.</p> <p>Observation on 09/12/24 at 7:15 A.M. of Resident #60's tube feed pump and pole revealed there was dried tube feed all over the screen, buttons, and the base of the pole. This was verified by STNA #540 at the time of the observation.</p> <p>Observation on 09/16/24 at 7:07 A.M. of Resident #60's tube feed and pole revealed there was still dried tube feed all over the screen, buttons, and the base of the pole. This was verified by Licensed Practical Nurse (LPN) #638 at the time of the observation.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>3. Review of Resident #84's medical record revealed an admitted [DATE]. Diagnoses included pneumonitis due to inhalation of food and vomit, dysphagia, abnormal weight loss, adult failure to thrive, and intestinal malabsorption.</p> <p>Review of Resident #84's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact. Resident #84 required setup or clean-up assistance with eating and was dependent on staff for all other activities of daily living (ADL).</p> <p>Review of Resident #84 physician's orders dated September 2024 revealed the resident was to receive Isosource 1.5 (nutritional supplement) at 45 ml/hr continuous for 12 hours from 4:00 P.M. to 4:00 A.M., and the resident had orders for a regular diet, regular texture, with thin liquids.</p> <p>Observation on 09/12/24 at 7:11 A.M. of Resident #84's tube feed pump and pole revealed there was dried tube feed all over the base of the pole that was hardened. This was verified by STNA # 546 at the time of the observation.</p> <p>Observation on 09/16/24 at 7:05 A.M. of Resident #84's tube feed pump and pole revealed there was still dried tube feed all over the base of the pole hardened. This was verified at time of observation by LPN #638.</p> <p>4. Review of Resident #197's medical record revealed and initial admitted [DATE] with a recent hospital stay from 08/26/24 to 09/08/24. Diagnoses included Alzheimer's disease, adult failure to thrive, hypertension, and dysphagia.</p> <p>Review of Resident #197's discharge MDS assessment dated [DATE] revealed the resident had severely impaired cognition and required setup or clean-up assistance with eating. Upon return from the hospital on 09/08/24, the resident had a feeding tube placed while at the hospital and was to have nothing by mouth.</p> <p>Observation made on 09/12/24 at 6:43 A.M. of Resident #197's tube feed pump revealed there was a copious amount of dried tube feed on the front of the pump, along with what appeared to be Triad cream (a medicated barrier protection cream) on the front of the pump as well.</p> <p>Interview on 09/12/24 at 6:48 A.M. with LPN #603 verified Resident #197's tube feed pump had a copious amount of dried tube feed on the front of the pump, along with what appeared to be Triad cream on the front of the pump as well. She stated there was a cleaning schedule supposed to be completed by the night turn nursing staff, including cleaning the tube feed pumps and poles. She stated make sure you look at the bottoms of the poles too, they are all dirty.</p> <p>Interview on 09/12/24 at 8:00 A.M. with the Director of Nursing (DON) revealed there was no cleaning schedule to her knowledge for the midnight staff to complete nightly.</p> <p>Review of the facility policy titled Quality of Life- Homelike Environment, last revised May 2017, revealed residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff would maintain a clean, sanitary, and orderly environment.</p> <p>44461</p> | | |

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| <p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</p> <p>Based on record review, staff interview, and facility policy review the facility failed to provide written notification of the facility's bed hold policy to the resident or the resident representative. This affected one resident (#197) of four residents reviewed for hospitalization . The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #197 revealed an admitted [DATE] with subsequent hospitalization s from 06/17/24 to 06/19/24 and from 08/26/24 to 09/08/24. Diagnoses included Alzheimer's disease, chronic atrial fibrillation, muscle weakness, type two diabetes mellitus, hypertension, and major depressive disorder.</p> <p>Review of Resident #197's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired.</p> <p>Review of Resident #197's electronic medical record (EMR) profile revealed she had three emergency contacts listed with one designated as number one who was to be contacted with any changes in medical condition or hospitalization s.</p> <p>Interview on 09/16/24 at 11:46 A.M. with Admission Coordinator (AC) #503 revealed she does not give the residents a copy of the bed hold policy prior to going to the hospital because she does not have an office at the facility, she is a liaison at the hospitals in the area and will leave a copy of the letter in the resident's hospital rooms. Once she is notified a resident is at the hospital, she will scan a copy of the letter to facility Social Service Designee (SSD) #632, and they will scan it into the residents EMR. She stated she will mail the letters to the first emergency contact. She does not send them through certified mail; she just mails them out regularly. AC #503 stated she does not document in the EMR regarding delivering or mailing out the bed hold letters.</p> <p>Interview 09/16/24 at 1:41 P.M. with Resident #197's daughter, Emergency Contact (EC) #1 revealed concerns that she had not been notified of the facility bed hold policy, she did not receive a copy of the policy and did not know what a bed hold even was. When asked if she was at the hospital with her mother, and stated yes, and stated no one from the facility approached her there or gave her any documents of the bed hold policy. EC #1 stated her mother is severely impaired and does not even know what day it is or where she is at. She stated no information like this should be discussed or given to her.</p> <p>Review of the facility policy titled Bed-Holds and Returns, last revised in March 2017, revealed under the policy statement, prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review, interview, and facility policy review the facility failed to ensure Resident #252's care plans were comprehensive to include all care needs. This affected one resident (#252) of 35 residents reviewed for comprehensive care plans and had the potential to affect all 102 residents in the facility.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #252 revealed an admitted [DATE]. Diagnoses included hypertension, kidney failure, muscle weakness, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #252 was severely cognitively impaired. She required supervision for oral and personal hygiene, set up help for eating, and substantial assistance with toileting and showering. She was on oxygen.</p> <p>Review of the care plan dated 08/28/24 revealed no evidence Resident #252's care plan addressed the use of oxygen.</p> <p>Interview on 09/12/24 at 11:50 A.M. with the Director of Nursing (DON) confirmed oxygen was not included in Resident #252's comprehensive care plan.</p> <p>Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated December 2016, revealed the care plan would describe all services that assisted the resident in obtaining their highest level of physical, mental, and psychosocial well-being.</p> |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</p> <p>45441</p> <p>Based on record review, interview, and facility policy review the facility failed to ensure care plans were updated to include new interventions and needs. This affected four residents (#22, #60, #81, and #197) of 35 residents reviewed for care plans, and had the potential to affect all 102 residents in the facility.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included panic disorder, depression, alcohol dependence, respiratory failure, and osteoarthritis.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact. She was independent for eating, dressing, toileting, and personal hygiene, and required supervision for showering.</p> <p>Review of the care plan dated 08/16/24 revealed Resident #22 used antipsychotic medications. Interventions included administering medications as ordered, monitoring for side effects, consulting with the pharmacy to consider dosage reductions, and discussing with the physician and family the ongoing need for medications.</p> <p>Review of the physician's orders for August and September 2024 revealed no evidence Resident #22 was taking antipsychotic medications.</p> <p>Interview on 09/12/24 at 12:17 P.M. with the Director of Nursing (DON) confirmed she was aware there were issues with care plans not being updated when diagnoses and resident need changed. She confirmed Resident #22 did not take antipsychotic medications.</p> <p>2. Review of the medical record for Resident #60 revealed an admitted [DATE]. Diagnoses included cerebral infarction due to thrombosis of right posterior cerebral artery, flaccid hemiplegia affecting right dominant side, type two diabetes mellitus with diabetic chronic kidney disease, hyperlipidemia, Bell's palsy, essential primary hypertension, transient ischemic attack and cerebral infarction, dysphagia, chronic kidney disease, and epilepsy.</p> <p>Review of the annual MDS assessment dated [DATE] revealed Resident #60 was moderately cognitively impaired. Resident #60 required setup or clean-up assistance with eating, partial to moderate assistance with oral hygiene and upper body dressing, and was dependent on staff for toileting, shower/bathing, lower body dressing, putting on and taking off footwear and personal hygiene. Resident #60 was always incontinent of bowel and bladder.</p> <p>Review of the facility provided incident and accident log from 09/01/23 to 09/09/24 revealed Resident #60 had fallen on 04/08/24, 06/16/24, 06/20/24, 06/23/24, 07/02/24, 07/03/24 and 07/06/24.</p> <p>(continued on next page)</p> |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the care plan dated 11/08/20 revealed Resident #60 was at risk for falls related to deconditioning, decreased mobility, gait and balance problems, neurological disorder. Resident #60 had an actual fall at the facility. Interventions included to anticipate and meet the resident needs, be sure the resident's call light was within reach, and encourage to use it as needed, bed in the lowest position, bedside floor mats, bolsters to bilateral bed at all times, call before you fall sign in room at all times, educate the resident and family about safety reminders and what to do if a fall occurs, educate the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, identify the cause of falls, initiate medication review to reduce fall risk from medication regime, keep personal items within reach, neurological checks for unwitnessed falls, non-skid footwear each shift, occupational therapy referral, pain evaluation, perimeter overlay to bed at all times, physical therapy to evaluate and treat as ordered, provide safe and secure, clutter free environment, psych follow up as needed, and resident education regarding using the call light for staff assistance with needs. The last time Resident #60's fall care plan was updated was on 07/22/24 to add the intervention that Resident #60 was to be up in wheelchair before breakfast, all other interventions were implemented after falls that occurred prior to 04/08/24. Resident #60's care plan did not accurately reflect Resident #60's fall history with appropriate interventions that were implemented after each fall.</p> <p>Interview on 09/17/24 at 3:45 P.M. with the DON confirmed Resident #60's care plan was not updated with appropriate interventions from falls that occurred on 04/08/24, 06/16/24, 06/20/24, 06/23/24, 07/02/24, 07/03/24 and 07/06/24.</p> <p>3. Review of the medical record for Resident #81 revealed an admitted [DATE]. Diagnoses included compression fracture of the vertebrae, asthma, depression, osteoporosis, dementia, and muscle weakness.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #81 was severely cognitively impaired. She required supervision for personal hygiene, set up help for eating and oral hygiene, and substantial assistance for toileting, showering, and bathing.</p> <p>Review of the physician's orders for September 2024 revealed Resident #81 received a mechanically altered, ground texture diet.</p> <p>Review of the care plan dated 07/01/24 revealed Resident #81 was on a regular diet with regular texture. Interventions included adherence to the prescribed diet and dietary consults as needed.</p> <p>Interview on 09/12/24 at 12:17 P.M. with the DON confirmed Resident #81's care plan did not accurately reflect her current diet orders.</p> <p>4. Review of the medical record for Resident #197 revealed an initial admitted [DATE]. Resident #197 was sent to the emergency room for increase in behaviors on 05/07/24 and returned to the facility on [DATE]. Diagnoses included chronic atrial fibrillation, muscle weakness, type two diabetes mellitus, unsteadiness on feet, osteoarthritis, hypertension, Alzheimer's disease, cognitive communication deficit, and dysphagia.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the discharge MDS assessment dated [DATE] revealed Resident #197 was severely cognitively impaired. Resident #197 required set up or clean up assistance for eating, she was independent with bed mobility, she required supervision or touching assistance with walking, and was dependent on staff for oral hygiene, toileting hygiene, showering, dressing, and personal hygiene.</p> <p>Review of the care plan, initiated on 05/06/24, revealed Resident #197 was at increased risk for falls related to Alzheimer's dementia. Resident #197 had an actual fall at the facility on 05/05/24. Goals included Resident #197 will be free from injury through the review date. Interventions included to anticipate and meet the resident needs, be sure the resident's call light was within reach, and encourage the resident to use it for assistance, educate the resident/family/care givers about safety reminders and what to do if a fall occurs, encourage the resident to participate in activities that promote exercise, physical activity, for strengthening and improved mobility. Additional interventions included staff to identify cause of falls, neurological checks for unwitnessed falls, occupational and physical therapies to evaluate and treat as ordered, staff to encourage the resident to lay down on the couch when she falls asleep in chair. Further review of Resident #197's care plan for falls last revised on 05/08/24, revealed the residents care plan was not updated after each fall, and there was not appropriate fall interventions put in place after each fall.</p> <p>Interview on 09/16/24 at 10:30 A.M. with the DON revealed when asked what fall interventions were put in place after each of Resident #197's falls, she provided a list stating for the fall on 05/05/24 the intervention was for physical therapy (PT) and occupational therapy (OT) to evaluate and treat as necessary; however, this was already in place due to the resident being a new admission. The fall on 05/20/24, staff were to encourage the resident to lay down on couch or bed when falling asleep in the chair; the fall on 06/17/24, the resident was sent to the hospital with no actual fall intervention put in place upon return to the facility. For the fall on 06/27/24, the resident was referred to therapy for strengthening; however, the resident was already in therapy for strengthening, this was not a new intervention, and for the fall on 08/26/24, the resident was sent to the emergency room , with no new intervention put into place upon return to the facility. She confirmed the care plan was not updated after each fall, and proper fall interventions were not in place. Investigations were completed with each fall; however, they did not conclude what the root cause of each fall was.</p> <p>Interview on 09/16/24 at 1:41 P.M. with Resident #197's daughter revealed she had asked facility staff to put in different fall interventions, and none were ever put in place.</p> <p>Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated December 2016, revealed care plans would be revised as information and changes in the residents' need arose and the interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, and at least quarterly in conjunction with the required quarterly MDS assessment.</p> <p>47568</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review, and review of the facility policy the facility failed to ensure Resident #84 received therapy and restorative services to help prevent a decline in activity of daily living (ADL). This affected one resident (#84) out of three residents reviewed for therapy services. The facility census was 102.</p> <p>Findings include:</p> <p>Review of Resident #84's medical record revealed an admitted [DATE] with diagnoses including pneumonitis due to inhalation of food and vomit, dysphagia, pseudobulbar affect, and unspecified macular degeneration. Resident #84 was discharged from hospice services on 06/24/24.</p> <p>Review of Resident #84's care plan initiated on 10/30/23 and revised 11/21/23 included Resident #84 had contractures to bilateral wrists and ankles present on admission to the facility. Encourage participation in ADL. Refer to Physical Therapy (PT) and Occupational Therapy (OT) services for position aids, splints, hand rolls, etcetera (etc.). Assess joints for limitations, swelling, redness or pain, and report to nursing and physician. Interventions included position Resident #84 for comfort, place and monitor use of pillows, rolls, splints and braces to assist with comfort and position; refer Resident #84 to PT and OT services as needed. Resident #84 required assistance with ADL related to limited mobility. Resident #84's ADL status would improve through the review date. Interventions included bilateral lower extremity strengthening and stretching initiated on 07/23/24, and therapy per orders.</p> <p>Review of Resident #84's Significant Change in Status Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #84 was cognitively intact. Resident #84 was dependent for eating, bathing, toileting, personal hygiene, and mobility. Resident #84 did not have complaints of difficulty or pain with swallowing, coughing or choking during meals or when swallowing medications, loss of liquids, solids from mouth when eating or drinking. Resident #84 received 26 to 50 percent of her total calories through tube feeding.</p> <p>Review of Resident #84's PT referral dated 07/03/24 revealed Resident #84 had weakness and contractures and recommendations were lower extremity strengthening and stretching. There was no referral for upper extremity strengthening and stretching.</p> <p>Review of Resident #84's Restorative Care Flow Record for 08/2024 and 09/2024 revealed Restorative Aide (RA) #513 assisted Resident #84 with bilateral lower extremity range of motion (ROM). There was no evidence RA #513 assisted Resident #84 with upper extremity strengthening and stretching.</p> <p>Observation on 09/09/24 at 1:17 P.M. of State tested Nursing Assistant (STNA) #554 revealed she was feeding Resident #84. Resident #84 was alert and oriented, and they were having a nice conversation. STNA #554 finished feeding Resident #84 and walked out of the room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/09/24 at 1:17 P.M. of STNA #554 revealed when asked why Resident #84 required assistance with feeding, STNA #554 stated I asked myself the same question, and STNA #554 asked other staff why Resident #84 needed fed and was told Resident #84 was weak and requested to be fed because she could not hold a fork correctly, and the angle made it hard for her spear food. STNA #554 stated she did not usually work on the long-term care unit and did not know if Resident #84 received therapy services.</p> <p>Interview on 09/11/24 at 2:23 P.M. of Director of Rehab (DOR) #630 revealed Resident #84 could feed herself and only needed set-up help. DOR #630 stated OT had not worked with Resident #84 for awhile, she received hospice services, and when her hospice services were discontinued PT picked her up. When told Resident #84 was fed her meals by the aides, DOR #630 stated Resident #84 was a set-up for meals, and she thought Resident #84 probably liked the attention when she was fed by the staff. DOR #630 stated if the nurses or aides feel a resident needs therapy, they would tell the therapy staff. She did not know Resident #84 was not feeding herself, and nursing did not give a verbal or written referral for therapy. DOR #630 stated Unit Manager (UM) #702 was responsible for the restorative program.</p> <p>Interview on 09/12/24 at 8:06 A.M. of Registered Nurse (RN) #627 revealed Resident #84 was fed by staff because she could not put a spoon to her mouth. RN #627 stated she was not sure if Resident #84 received restorative or therapy services, and she did not put a referral in. RN #627 stated UM #702 was the person to speak to because she was responsible for the restorative program.</p> <p>Observation on 09/12/24 at 8:13 A.M. of Resident #84 revealed STNA #540 was feeding her the breakfast meal. When asked why she needed assistance with feeding, Resident #84 stated she could not hold a fork to feed herself because of the contractures in her hands. Resident #84 held her hands up so the surveyor could see the contractures. Resident #84 said she could hold a sandwich, but the sandwich had to be easy to hold, not like a sloppy joe. Resident #84 stated RA #513 worked with her about every other day, but it was with her legs, and not her hands.</p> <p>Interview on 09/12/24 at 8:16 A.M. of RA #513 revealed she worked with Resident #84 three times a week. RA #513 stated she assisted Resident #84 with ROM for her legs, and Resident #84 completed the ROM exercises with encouragement. RA #513 stated she did nothing with Resident #84's hands, talked to her about using built up spoons to feed herself, but Resident #84 said she could not hold any utensils.</p> <p>Interview on 09/12/24 at 8:33 A.M. of Physical Therapist (PT) #612 revealed she saw Resident #84 feed herself, but the contractures of her hands made it easier for someone to do it for her.</p> <p>Interview on 09/12/24 at 8:36 A.M. of Occupational Therapist (OT) #608 revealed Resident #84 was not on his caseload because she was receiving hospice services. OT #608 stated the last referral he had for Resident #84 was the hospice company wanted to know if she was appropriate for a standard wheelchair. OT #608 indicated he was not aware Resident #84 was not feeding herself and was being fed by staff members. OT #608 stated he was not given a referral for Resident #84 by the nurses or aides, but now that it was brought to his attention, he would evaluate her.</p> <p>(continued on next page)</p> | | |

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| <p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/17/24 at 10:20 A.M. of UM #702 revealed Resident #84 was receiving lower strengthening and stretching starting 07/23/24, but nothing was being done and there was no program for her upper extremities. UM #702 stated Resident #84 wanted hospice services discontinued on 06/24/24, PT worked with her for her lower extremities, but not OT.</p> <p>Review of the facility policy titled Restorative Nursing Services revised 07/2017 included restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (for example physical, occupational or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals may include but were not limited to supporting and assisting the resident in adjusting or adapting to changing abilities, developing, maintaining or strengthening his, her physiological and psychological resources, maintaining his, her dignity, independence and self-esteem, and participating in the development and implementation of his, her plan of care.</p> |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review, and review of facility policy the facility failed to ensure Resident #54 was assisted into bed timely. This affected one resident (#54) out of three residents reviewed for dependent care. The facility census was 102.</p> <p>Findings include:</p> <p>Review of Resident #54's medical record revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypercapnia, type two diabetes mellitus with proliferative diabetic retinopathy without macular edema, and muscle weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 was cognitively intact. Resident #54 was dependent for personal care including toileting hygiene, bathing dressing, sit to stand, and chair, bed-to-chair transfer.</p> <p>Review of the care plan dated 03/15/24 included Resident #54 required assistance with activities of daily living (ADL) related to bariatric diagnosis. Resident #54's ADL status would improve through the review date. Interventions included encourage Resident #54 to use call bell system for assistance.</p> <p>Observation on 09/09/24 at 2:19 P.M. of Resident #54 revealed he was sitting in a wheelchair in his room and his call light was activated. Resident #54 stated his call light had been on for about 30 minutes. Resident #54 stated he activated his call light because he wanted to go to bed and needed a mechanical lift. Further observation revealed his bed did not have sheets on it, and the mattress was bare. Resident #54 stated someone took the sheet off the bed, and they had not replaced them yet.</p> <p>Observation on 09/09/24 at 2:21 P.M. of Unit Manager (UM) #643 entered Resident #54's room and answered his call light. UM #643 told Resident #54 she would tell the state tested nursing assistants (STNAs) he wanted to go to bed and walked out of his room.</p> <p>Observation on 09/09/24 at 2:49 P.M. of Resident #54 revealed he was still sitting in his wheelchair waiting for the STNA's to put him to bed.</p> <p>Interview on 09/09/24 at 2:53 P.M. of STNA's #505 and #557 revealed there was an issue with another aide who was working on the unit and that was why it was taking so long to assist Resident #54 into his bed. STNA #557 stated the other STNA was not answering call lights and other things he should be doing and was sent home by the administration.</p> <p>Observation on 09/09/24 at 2:53 P.M. revealed a call light was activated and STNA #505 entered Resident #54's room to answer the light. STNA #557 stated she had to wait for STNA #505 to return because it took two STNA's to use the mechanical lift to transfer Resident #54 back to bed.</p> <p>Observation on 09/09/24 at 3:38 P.M. of STNA #557 revealed she was in Resident #54's room making his bed. Resident #54 was still sitting in his wheelchair and said he was sitting in his wheelchair too long and really wanted to go to bed no later than 3:00 P.M. today.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Observation on 09/09/24 at 3:42 P.M. revealed STNA #505 returned and assisted STNA #557 with the mechanical lift to transfer Resident #54 to his bed.</p> <p>Review of the facility policy titled Resident Rights, revised 12/2016, included residents had the right to self-determination.</p> |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review, review of the Prehospital Care Report Summary, and review of the facility policy the facility failed to ensure Resident #7 was provided timely and appropriate care and services to properly evaluate and treat a fall, Resident #7 was not administered pain medication for complaints of severe pain after the fall and was not transported to the hospital timely after the fall. This affected one resident (#7) of six residents reviewed for accidents. The facility census was 102.</p> <p>Actual Harm occurred on 06/17/24 at 7:55 P.M. when Resident #7 experienced a fall, voiced severe pain after the fall, did not have pain medication ordered, and the physician was not contacted and notified Resident #7 had a fall and was experiencing severe pain until 06/18/24 at 6:36 A.M., ten hours after the fall. The physician issued an order to send Resident #7 to the hospital for right hip and leg pain post fall. Evaluation at the hospital revealed Resident #7 was non-ambulatory, reported significant tenderness with right leg weight bearing, and significant tenderness to palpation of the right femur and right hip, and was diagnosed with a closed displaced fracture of the right acetabulum the socket of the hip joint, where the head of the femur sits).</p> <p>Findings include:</p> <p>Review of Resident #7's medical record revealed an admitted [DATE] with diagnoses including unspecified injury of the head, displaced associated transverse-posterior fracture of the right acetabulum, type two diabetes mellitus with hyperglycemia, major depressive disorder, and end stage renal dialysis.</p> <p>Review of Resident #7's care plan initiated 02/10/21 and revised on 06/28/24 revealed Resident #7 was at increased risk for falls related to generalized weakness and diabetes mellitus. Resident #7 had an actual fall at the facility and outside the facility. Resident #7 would be free of falls through the review date. Interventions included to anticipate and meet the resident's needs, be sure Resident #7's call light was within reach, and encourage Resident #7 to use it for assistance as needed, and Resident #7 needed prompt response to all requests for assistance.</p> <p>Review of Resident #7's Fall Risk Review dated 04/16/24 revealed Resident #7 was at moderate risk for falls.</p> <p>Review of Resident #7's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #7 was cognitively intact. Resident #7 required partial to moderate assistance for toileting, bathing, lower body dressing, sit to stand and chair, bed-to-chair transfer. Resident #7 was always continent of urine and bowel.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #7's Incident Report dated 06/17/24 at 7:55 P.M. included Resident #7 had an unwitnessed fall, and his pain level was a ten out of ten on a scale of zero to ten, ten being the worst pain. There was no further documentation on 06/17/24. On 06/18/24, documentation included Resident #7 had an unwitnessed fall in his bedroom, Resident #7 stated he was transferring himself from the bed to the chair to go to the bathroom when he lost his balance and fell. Resident #7 denied hitting his head, vital signs were within normal limits (WNL), and he was able to move all extremities. Resident #7 was assisted into his wheelchair by Licensed Practical Nurse (LPN) #704 and State tested Nursing Assistants (STNAs) #542 and #549. Resident #7 had complaints of right leg pain, his pain level was a ten out of ten, and Medical Doctor (MD) #705 was notified. Resident #7 was assessed by the day shift nurse after she received report. Resident #7 was still in bed complaining of right hip pain and stated, I can't get up for dialysis. MD #705 was notified, and a new order was given to send Resident #7 to the hospital emergency room (ER) via 911. The ambulance arrived on 06/18/24 at 6:45 A.M. for transfer. The nurse contacted the ER on [DATE] at 2:55 P.M. and was told Resident #7 was transferred to the main campus with a displaced right hip. MD #705 and Resident #7's son were notified of Resident #7's transfer to the main campus and admission to the hospital.</p> <p>Review of Resident #7's progress notes dated 06/17/24 at 7:55 P.M. through 06/18/24 at 4:24 A.M. did not reveal documented evidence that Resident #7 experienced a fall, had an evaluation for a fall including a pain evaluation, or evidence the physician was notified.</p> <p>Review of Resident #7's Medication Administration Record (MAR) dated 06/17/24 at 7:55 P.M. through 06/18/24 did not reveal documented evidence Resident #7 was administered pain medication, including Tylenol for complaints of right leg pain of ten out of ten on a scale of zero to ten, ten being the worst pain.</p> <p>Review of Resident #7's Neurological Review dated 06/18/24 at 4:24 A.M. and initiated on 06/17/24 at 7:55 P.M. included Resident #7's right lower extremity was weak, and he had pain.</p> <p>Review of Resident #7's Fall Packet dated 06/18/24 included a witness statement written by Licensed Practical Nurse (LPN) #704 revealed on 06/17/24 Resident #7 had an unwitnessed fall in his bedroom. Resident #7 stated he was transferring himself from the bed to a chair to go to the bathroom when he lost his balance and fell. Resident #7 denied hitting his head, vital signs were within normal limit (WNL), and he was able to move all extremities. Resident #7 complained of right leg pain and his pain was a ten out of ten on a scale of zero to ten, ten being the worst pain. The physician was notified. LPN #704 and two STNAs transferred Resident #7 to the wheelchair. STNA #549's witness statement included on 06/17/24 at 7:55 P.M. Resident #7's roommate came to the door of their room and yelled [Resident #7] fell on the floor. STNA #549 stated she told the nurse, and two STNAs and the nurse went into the room to assist Resident #7. The nurse took Resident #7's vital signs and asked him questions. The three of them lifted Resident #7 into his wheelchair.</p> <p>Review of Resident #7's progress notes dated 06/18/24 at 4:29 A.M. included Resident #7 had facial expressions, protective body movements, and vocal complaints of pain. Resident #7 rated his pain as a ten out of ten on a scale of zero to ten, ten being the worst. Resident #7 said he had intermittent, aching pain which was worse with movement in his right lower leg. Non-medication interventions did not provide relief. Resident #7 had no complaints of pain up until he fell. There was no evidence the physician was notified of Resident #7's fall or pain.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #7's physician orders dated 06/18/24 at 5:49 A.M. revealed an order for an x-ray of the right lower extremity, one time only for fall purposes.</p> <p>Review of Resident #7's progress notes dated 06/18/24 at 5:55 A.M. revealed Resident #7's son was notified by phone and would like to be notified about the results of the x-ray.</p> <p>Review of Resident #7's physician orders dated 06/18/24 at 6:36 A.M. revealed send to ER for right hip and leg pain post fall.</p> <p>Review of Resident #7's Prehospital Care Report Summary dated 06/18/24 included a call was received from the facility at 6:32 A.M. and Emergency Medical Services (EMS) were on site at 6:39 A.M. The report stated Resident #7 fell on [DATE] at 8:00 P.M. Upon arrival, Resident #7 was lying supine in his bed, and staff said he fell yesterday and was able to transfer himself from the chair to his bed but now could not transfer from the bed to the chair. Resident #7 stated he was having pain since the fall. Resident #7 was taken by ambulance to the ER and had no new complaints during the transport.</p> <p>Review of Resident #7's Emergency Department (ED) Provider Notes dated 06/18/24 at 2:55 P.M. included Resident #7 had a fall at the facility last night when he was transitioning from his bed to the wheelchair, and he fell on his right hip. Resident #7 has been experiencing pain since his fall. Resident #7 was non-ambulatory and reported significant tenderness with weight bearing on the right leg, and significant tenderness to palpation on right femur and right hip. Resident #7 had a closed nondisplaced fracture of the right acetabulum.</p> <p>Review of Resident #7's progress notes dated 06/18/24 at 2:58 P.M. included after nurse to nurse (report) this A.M., Resident #7 was assessed post fall, and he was still in bed complaining of right hip pain and stating he could not go to hemodialysis. The unit manager (UM) and physician were notified, and orders were obtained to send Resident #7 to the local hospital ER to be evaluated. Resident #7 exited the facility at 6:54 A.M. via a stretcher. The ER was contacted, and Resident #7 was transported to the local hospital main campus with a displaced right hip.</p> <p>Observation on 09/10/24 at 3:09 P.M. of Resident #7 revealed he was sitting in a wheelchair in his room and his roommate (Resident #12) was sitting in a wheelchair next to him. When asked if he had any concerns, Resident #7 stated he broke his hip and had been paying for it ever since. Resident #7 stated his knees were no good and gave out, and no one was helping him the day he fell (06/17/24). Resident #7 indicated he stood up and was trying to transfer himself to his wheelchair that was by his bed, his knee gave out and he fell, landing directly on his knees. Resident #7 stated he did not have his call light on because he thought he could get up and walk by himself, he did not think he was wearing shoes or socks but could not remember for sure. Resident #7 stated he felt a lot of pain in his knees and right leg when he fell. Resident #7 stated it hurt so much because he fell on the hard floor. Resident #12 stated he yelled for help, and when the nurse and aides arrived, he told them Resident #7 needed an ambulance right away, but they would not call an ambulance, and did not call an ambulance until the next day. Resident #7 stated on 06/17/24 he fell around bedtime, which was about 7:00 P.M. or 8:00 P.M., and he was pissed off because he laid in bed all night, his leg hurt like hell, and the ambulance was not called until the next morning.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/10/24 at 4:15 P.M. of the Director of Nursing (DON) revealed when a resident had a fall a nurse assessed the resident, and the resident was not to be moved or touched until the nurse arrived. Vital signs including neuro checks should be documented in the nurse's notes, but neuro checks were documented on paper and were not uploaded into the electronic record. The nurse should check for range of motion, internal or external rotation, length of leg, skin redness, discoloration, pain and this should also be documented in the nurse's notes or on the incident report. The DON stated if the resident had pain, it should be documented where the pain was and how bad it was. If a resident was having pain such as in the hip, neck, back staff should not move the resident and call 911. The DON confirmed 911 was not called when Resident #7 fell on [DATE] at 7:55 P.M. and Resident #7 reported pain at a ten out of a ten.</p> <p>Interview on 09/11/24 at 9:45 A.M. of LPN #704 revealed she was administering medications to the residents, and while she was doing the med pass STNA #549 told her Resident #7 fell and was on the floor. LPN #704 stated Resident #12 yelled out to tell them that Resident #7 fell , and when she found Resident #7 on the floor, she took his vital signs, he said his right leg was bothering him, and he was trying to go to the bathroom when he fell . LPN #704 stated two STNAs assisted her, and they helped the resident into his wheelchair, where he sat for at least two hours. LPN #704 stated Resident #7 did not have physician orders for pain medication, but she gave Tylenol to Resident #7 because the facility had standing orders to give Tylenol if needed for pain. The LPN stated she was busy that night and forgot to put the orders in his medical record. LPN #704 stated she documented she administered Tylenol and notified the physician, but the physician never responded, and on 06/18/24, in the morning, Resident #7 was still complaining of leg pain. LPN #704 indicated she called the on-call physician and received an order for an x-ray of Resident #7's right leg, but the day shift nurse arrived and said to just send the resident to the hospital via 911. LPN #704 stated Resident #7 said he had pain in his right leg, but it was not a ten anymore, and she checked him throughout the night but forgot to document she checked him and what his pain level was. In the morning, the STNA said Resident #7 did not want to get out of bed due to pain in his right leg. LPN #704 stated she wrote a note in the secure message system that Resident #7 had a fall, had bilateral bruising on his knees, and he complained of a pain level of ten out of ten on a zero to ten pain scale, ten being the worst, and he did not have pain medication ordered. LPN #704 stated she text the physician, but could not remember which physician, the physician never responded back, and she did not try again.</p> <p>Interview on 09/11/24 at 2:37 P.M. of the DON revealed she did not know all the details of Resident #7's fall, just what was written in the nurse's notes. The DON stated LPN #704 no longer worked at the facility. The DON stated she did not think MD #705 called back until 06/18/24 in the morning, did not know why MD #705 did not respond to the notification, and Resident #7 was sent to the ER. The DON confirmed LPN #704 did not place orders in Resident #7's medical record for Tylenol, and did not document she gave the Tylenol either. The DON confirmed Resident #7's pain was a rated a ten out of a ten which was pretty severe pain, and LPN #704 did not obtain orders for pain medication or administer pain medication. When Registered Nurse (RN) #627 arrived for work on 06/18/24 at 6:00 A.M. she contacted Medical Doctor (MD) #705 and received orders to send Resident #7 to the ER via 911.</p> <p>Interview on 09/12/24 at 8:01 A.M. of RN #627 revealed Resident #7 experienced a fall on 06/17/24 and when she arrived for work on 06/18/24 at 6:00 A.M. Resident #7 stated he was having hip pain, his pain was a ten out of ten and he could not go to dialysis because of the pain. RN #627 stated Resident #7's facial expressions looked like he was in pain. RN #627 indicated she notified MD #705, and he gave orders to send Resident #7 to the ER via 911.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review, and review of the facility policy the facility failed to ensure individualized care planned interventions were developed and followed to prevent Resident #32 and Resident #1 from developing in-house pressure ulcers and failed to ensure the pressure ulcers were timely identified, properly treated, and interventions were initiated to promote healing. Additionally, the facility failed to ensure Resident's #24, #29 and #71 had pressure ulcer risk evaluations completed quarterly, failed to ensure Resident #81 had skin checks and treatments completed as ordered, and failed to ensure Resident #81's physician orders and care planned interventions were followed for heel protectors. This affected six residents (#32, #1, #24, #29, #71, and #81) of seven residents reviewed for pressure ulcers. The facility census was 102.</p> <p>Actual Harm occurred on 08/07/24 when Resident #32, who was at risk for developing pressure ulcers, and was dependent on staff for bed mobility and incontinence care was identified to have new areas of in-house acquired skin impairment with no additional assessment or new treatment at that time. On 08/07/24 the facility assessed Resident #32 to have one new, in-house acquired Stage III pressure ulcers (full-thickness loss of skin that extended to the subcutaneous tissue, but did not cross the fascia beneath it) on his sacral area and a right below the knee amputation (BKA) eschar covered surgical wound, without proper prevention, treatment and interventions implemented. Resident #32's family voiced concerns staff did not provide timely assistance with turning and repositioning and off-loading his right BKA. Resident #32's wounds deteriorated, and he was transported to the hospital on 08/28/24 for evaluation and treatment of osteomyelitis (inflammation of the bone caused by an infection).</p> <p>Findings include:</p> <p>1. Review of Resident #32's medical record revealed an admitted [DATE] and a reentry date of 02/20/24. Diagnoses included unspecified sequelae of cerebral infarction, dementia, type two diabetes mellitus with hyperglycemia, and acquired absence of right leg below the knee (10/28/19) and left leg below the knee (08/31/21).</p> <p>Review of Resident #32's physician orders dated 04/25/24 revealed to turn and reposition frequently with rounds and as needed every shift.</p> <p>Review of Resident #32's Braden Scale for Predicting Pressure Ulcer Risk dated 05/16/24 revealed Resident #32 was at high risk for pressure ulcer development.</p> <p>Review of Resident #32's medical record, including progress notes, medication administration record (MAR), treatment administration records (TAR), physician orders from 07/01/24 through 08/14/24 did not reveal evidence Resident #32's right BKA was off loaded, or he was encouraged to off load his right BKA.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #32's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) was not completed due to the resident being rarely or never understood. Resident #32 was dependent (on staff) for toileting hygiene, personal hygiene, bathing, dressing, chair, bed-to-chair transfer and rolling left and right. Sit to lying, lying to sitting on side of bed, sit to stand, and toilet transfer were not attempted due to medical condition or safety concerns. Resident #32 was at risk of developing pressure ulcers, injuries and did not have one or more unhealed pressure ulcers, injuries. Resident #32 received 51 percent of his total calories through a tube feeding, percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>Review of Resident #32's TAR dated 07/29/24 and 07/30/24 at 6:00 P.M., 08/04/24 at 6:00 P.M., 08/10/24 and 08/11/24 at 6:00 A.M., 08/15/24 at 6:00 A.M., 08/20/24 at 6:00 P.M., and 08/21/24 at 6:00 A.M. did not reveal documented evidence Resident #32 was turned and repositioned frequently with rounds and as needed as ordered. Review of Resident #32's medical record including progress notes did not reveal documentation indicating why this was not completed.</p> <p>Review of Resident #32's shower sheet dated 08/04/24 revealed Resident #32 had an area on his buttocks (sacrum) that was not intact. There was no description of the area on the shower sheet.</p> <p>Review of Resident #32's medical record including physician orders, progress notes and evaluations from 08/04/24 through 08/07/24 did not reveal evidence Resident #32's area to his buttocks (sacrum) was evaluated, the physician was notified and a treatment ordered.</p> <p>Review of Resident #32's progress notes dated 08/07/24 at 4:07 P.M. included an unidentified State tested Nursing Assistant (STNA) notified Wound Nurse (WN) #629 that Resident #32 had a new area to the buttocks (sacrum). During the skin assessment WN #629 also noticed a new area to Resident #32's left (right) BKA surgical site. Both areas were noted to have drainage and Certified Wound Nurse Practitioner (CWNP) #700 was in the facility and evaluated the wounds. All responsible parties were notified.</p> <p>Review of Resident #32's Visit Report dated 08/07/24 and authored by CWNP #700 included this was an initial wound encounter, and Resident #32 had a sacral Stage III pressure injury, pressure ulcer. Measurements were length 2.97 centimeters (cm), width 1.89 cm and depth of 0.3 cm. Adipose (fat tissue) was exposed and there was a moderate amount of serosanguineous drainage with no odor. The wound margin was undefined, wound bed had 26 to 50 percent bright red, pink, firm, granulation, one to 25 percent slough, and one to 25 percent epithelialization. Treatment orders were to cleanse the wound with mild soap and water, apply MediHoney (antibacterial ointment that promotes a moist wound environment, reduces inflammation, reduces odor, and lifts dead tissue) to wound base, apply calcium alginate (highly absorbent wound dressing) and cover with foam dressing two times per day and as needed, and off-loading per the facility pressure injury prevention, relief protocol.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #32's Visit Report dated 08/07/24 and written by CWNP #700 included this was an initial wound encounter and Resident #32 had a right BKA eschar (dry, black, hard, dead tissue) covered surgical wound. Measurements were length 1.7 cm, width 0.93 cm and had no measurable depth. There was a moderate amount of yellow drainage noted with no odor, and the wound bed was one to 25 percent pink, firm, granulation, 76 to 100 percent slough (dead tissue, usually cream or yellow in color). Treatment orders were cleanse wound with mild soap and water, protect peri wound with no sting Skin-Prep (forms a barrier between the skin and adhesives to help preserve skin integrity), apply MediHoney to the wound base, apply calcium alginate and foam dressing daily and as needed, and off-loading per the facility pressure injury prevention, relief protocol.</p> <p>Review of Resident #32's care plan revised on 08/09/24 (with an initiation date of 02/22/24) included Resident #32 was at risk for impairment to skin integrity related to impaired mobility, incontinence, history of pressure injury to left gluteal fold, and history of pressure injury to the coccyx. Resident #32 had an actual area of skin impairment to the sacrum and right BKA. Resident #32 would maintain or develop clean and intact skin by the review date. Interventions included to administer treatments per physician order; follow facility protocols for treatment of injury; low air loss (LAL) mattress to bed at all times(AAT); monitor, document location, size and treatment of skin injury and report abnormalities, failure to heal, signs and symptoms of infection, maceration, etcetera (etc.) to the medical doctor (MD); turn and reposition frequently with rounds and as needed (PRN). Resident #32 had an amputation of bilateral lower extremities (BLE). Resident #32 would have an acceptable level of comfort and have well-controlled phantom pain (painful perception that an individual experiences relating to a limb that is not physically there) through the review date. Interventions included to change position frequently, alternate periods of rest with activity out of bed to prevent complications including skin pressure areas.</p> <p>Further review of Resident #32's care plan revised on 08/09/24 (initiated 02/22/24) did not reveal interventions to off-load right BKA or to avoid direct pressure to wound sites as ordered.</p> <p>Review of Resident #32's TAR dated 08/04/24 at 6:00 P.M., 08/10/24 at 6: A.M., 08/11/24 and 08/15/24 at 6:00 A.M., 08/20/24 at 6:00 P.M. and 08/21/24 at 6:00 A.M. did not reveal evidence Resident #32 was turned and repositioned frequently with rounds and as needed was completed. Review of Resident #32's progress notes did not reveal documentation indicating why Resident #32 was not turned and repositioned as ordered.</p> <p>Review of Resident #32's TAR dated 08/10/24, 08/20/24 and 08/21/24 did not reveal documented evidence the treatment to cleanse right BKA with normal saline, apply MediHoney then calcium alginate, overlay bordered foam dressing daily and as needed was completed as ordered. Review of Resident #32's medical record including progress notes did not reveal documentation indicating why the treatment was not completed as ordered.</p> <p>Review of Resident #32's TAR dated 08/10/24 at 6:00 A.M., 08/20/24 and 08/21/24 at 6:00 A.M., and 08/20/24 at 6:00 P.M. did not reveal documented evidence the treatment to cleanse sacrum with normal saline, apply MediHoney, calcium alginate and overlay bordered foam dressing every shift and as needed was completed as ordered. Review of Resident #32's medical record, including progress notes, did not reveal documentation indicating why Resident #32's treatment was not completed as ordered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #32's TAR dated 08/10/24 at 6:00 A.M., 08/11/24 at 6:00 A.M., 08/20/24 and 08/21/24 at 6:00 A.M., 08/25/24 at 6:00 A.M., 08/10/24 at 6:00 P.M., 08/20/24 and 08/26/24 at 6:00 P.M. did not reveal documented evidence the daily wound evaluation for sacrum document abnormalities in the progress notes, document if there was drainage, if the dressing was dry and intact, signs and symptoms of infection, necrotic tissue present, odor, surrounding skin tissue, wound pain every shift for wound assessment was completed as ordered. Review of Resident #32's medical record, including progress notes, did not reveal documentation indicating why Resident #32's assessment was not completed as ordered.</p> <p>Review of Resident #32's TAR dated 08/10/24 and 08/11/24 at 6:00 A.M., 08/20/24 and 08/21/24 at 6:00 A.M., 08/25/24 at 6:00 A.M., 08/10/24, 08/20/24 and 08/26/24 at 6:00 P.M. did not reveal documented evidence the daily wound evaluation for Resident #32's right BKA, document abnormalities in the progress notes, record drainage, if dressing dry and intact, signs and symptoms of infection, if necrotic tissue present, odor, surrounding skin appearance, wound pain every shift for wound assessment. Review of Resident #32's medical record, including progress notes, did not reveal documentation indicating why Resident #32's assessment was not completed as ordered.</p> <p>Review of Resident #32's STNA documentation in the electronic record dated 08/13/24 through 08/28/24 revealed on 08/13/24, 08/14/24, 08/17/24, 08/19/24, 08/25/24, and 08/28/24 Resident #32 was turned and repositioned two times in 24 hours. On 08/15/24, 08/20/24, and 08/24/24 Resident #32 was turned and repositioned three times in 24 hours. On 08/16/24, 08/21/24, 08/23/24, 08/26/24, and 08/27/24 documentation revealed Resident #32 was turned and repositioned one time in 24 hours. On 08/18/24 and 08/22/24 there was no documented evidence that Resident #32 was turned and repositioned.</p> <p>Review of Resident #32's Skin Only Evaluation dated 08/14/24 and completed by WN #629 included Resident #32 had a right BKA surgical wound, the length was 2.6 cm, width was 2.2 cm, and the depth was not determined. The wound exudate was serosanguineous, the dressing had moderate (26 to 75 percent) saturation, and there was no wound odor. The wound was painful to touch. Further review revealed Resident #32 had a Stage III pressure ulcer, injury to the sacrum. The length was 2.97 cm, width 1.89 cm, and the depth 0.3 cm. The wound exudate was sanguineous (bloody drainage) and dressing saturation was minimal (less than 25 percent). There was no wound odor, and the tissue was painful to the touch. The wound to Resident #32's sacrum remained stable at this time. No change to the treatment was made. The non-healing surgical wound to Resident #32's right BKA noted to be deteriorating and increased in size. The treatment remained the same.</p> <p>Review of Resident #32's physician orders dated 08/14/24 revealed an order to off-load the right BKA AAT every shift. This order was discontinued on 08/20/24.</p> <p>Review of Resident #32's TAR dated 08/15/24 at 6:00 A.M. revealed no documented evidence the right BKA was off-loaded AAT every shift as ordered. Review of Resident #32's medical record, including progress notes, did not reveal documentation why this was not done as ordered.</p> <p>Review of Resident #32's physician orders dated 08/20/24 revealed an order to encourage the resident to off-load the right BKA every shift.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512 | |
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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #32's TAR dated 08/20/24 at 6:00 P.M., and 08/21/24 at 6:00 A.M. did not reveal evidence Resident #32 was encouraged to off-load the right BKA every shift. Review of Resident #32's medical record, including progress notes, did not reveal documentation why this was not completed as ordered.</p> <p>Review of Resident #32's Visit Report dated 08/21/24 and completed by CWNP #700 included Resident #32 had an unstageable pressure injury (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed, obscured full-thickness skin and tissue loss) to the sacrum. Resident #32's pressure ulcer was acquired on 08/07/24. Measurements were length 5.06 cm, width 4.85 cm with no measurable depth. Adipose was exposed. There was a moderate amount of serosanguineous drainage with no odor. The wound bed had 51 to 75 percent bright red, pink, firm, granulation, 26 to 50 percent eschar, no slough and epithelialization present. Resident #32's wound was deteriorating. Treatment was cleanse with mild soap and water, apply MediHoney to the wound base and cover with calcium alginate, apply an abdominal (ABD) pad and secure with paper tape. Change the dressing two times a day and as needed. New orders to turn and reposition every two hours, avoid direct pressure to the wound site, and implement the facility pressure injury prevention, relief protocol.</p> <p>Review of Resident #32's Visit Report dated 08/21/24 and completed by CWNP #700 included Resident #32's right BKA was an eschar covered surgical wound acquired on 08/07/24. The wound length was 2.23 cm. width 2.17 cm with no measurable depth. There was no drainage noted. The wound bed had no granulation, 76 to 100 percent eschar, no slough and no epithelialization present. The wound was completely covered with eschar. Resident #32's wound was deteriorating. New orders included the treatment was cleanse wound with normal saline, apply MediHoney to the wound base, cover with calcium alginate apply an ABD pad, Kerlix gauze, and secure with paper tape. Use a small piece of tape to also secure the Kerlix gauze to the leg. Change the dressing daily and as needed. New orders to turn and reposition the resident every two hours, avoid direct pressure to the wound site, and implement the facility pressure injury prevention, relief protocol. An x-ray of Resident #32's right BKA was ordered to rule out osteomyelitis.</p> <p>Review of Resident #32's progress notes dated 08/21/24 at 3:35 P.M. revealed Resident #32 was seen by CWNP #700, and a new order for an x-ray of the right knee and femur was given.</p> <p>Review of Resident #32's physician orders did not reveal physician orders from 08/21/24 through 08/28/24 for turning and repositioning every two hours and avoiding direct pressure to the wound. Further review from 08/21/24 through 08/28/24 did not reveal orders for Resident #32's right BKA to cleanse wound with normal saline, apply MediHoney to the wound base, cover with calcium alginate apply an ABD pad, Kerlix gauze, and secure with paper tape. Use a small piece of tape to also secure the Kerlix gauze to the leg. Change the dressing daily and as needed.</p> <p>Review of Resident #32's medical record, including progress notes, MAR, TAR, and electronic STNA documentation from 08/21/24 through 08/28/24 revealed no documented evidence Resident #32 was turned and repositioned every two hours, or direct pressure was avoided to the wound sites.</p> <p>Review of Resident #32's TAR dated 08/25/24 revealed no documented evidence the order to cleanse the right BKA with normal saline, apply MediHoney then calcium alginate, cover with an ABD pad and paper tape every dayshift and as needed was completed as ordered. The TAR did not reflect new orders written on 08/21/24.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #32's TAR dated 08/21/24 through 08/28/24 did not reveal evidence treatments were completed for new orders written on 08/21/24 for Resident #32's right BKA which was cleanse wound with normal saline, apply MediHoney to the wound base, cover with calcium alginate apply an ABD pad, Kerlix gauze, and secure with paper tape. Use a small piece of tape to also secure the Kerlix gauze to the leg. Change the dressing daily and as needed.</p> <p>Review of Resident #32's TAR dated 08/25/24 at 6:00 A.M. revealed no documented evidence the treatment to cleanse the sacrum with normal saline, apply MediHoney, calcium alginate, and cover with an ABD pad and paper tape every shift and as needed was completed. There was no documentation in the medical record, including progress notes, indicating why the treatment was not completed.</p> <p>Review of Resident #32's Visit Report dated 08/28/24 and completed by CWNP #700 included Resident #32's sacral unstageable pressure injury acquired on 08/07/24 measured length 4.55 cm, width 4.19 cm with no measurable depth. There was no change in the wound progression. Treatment orders were unchanged from 08/21/24. Turn and reposition Resident #32 every two hours, avoid direct pressure to the wound site, implement the facility pressure injury prevention, relief protocol.</p> <p>Review of Resident #32's Visit Report dated 08/28/24 and completed by CWNP #700 included Resident #32's right BKA was an eschar covered wound acquired on 08/07/24. Wound measurements were length 2.16, width 2.54 cm and depth 1.2 cm. Bone was exposed and undermining noted at 12:00 o'clock with a maximum distance of 2.2 cm. There was a small amount of purulent drainage noted with no odor. The wound was deteriorating. Treatment orders were unchanged from 08/21/24. Turn and reposition every two hours, avoid direct pressure to the wound site, and implement the facility pressure injury prevention, relief protocol.</p> <p>Review of Resident #32's progress notes dated 08/28/24 at 12:07 P.M. included CWNP #700 evaluated Resident #32 and recommended an emergency department (ED) visit for further treatment. A new order was received to send the resident to the ED for evaluation and treatment.</p> <p>Review of Resident #32's After Visit Summary and Provider Notes for his hospital stay from 08/28/24 through 09/10/24 included Resident #32 had chronic osteomyelitis of the femur. Resident #32 had a right BKA stump complication, an open wound and was sent to the ED for an infection at the surgical site. Resident #32 had an ulceration to the surgical site of the right stump. Resident #32 had right BKA stump wound with acute right tibial osteomyelitis and was status post right BKA stump debridement on 09/03/24. Resident #32 had a full thickness wound to the right BKA stump, and the wound base was fibrotic with eschar noted. The wound was granular with edema, minor drainage and bleeding. Resident #32 had a Wound Vac placement. Resident #32 had an area of necrotic tissue on his sacrum about the size of a quarter and had a debridement of the sacral decubitus. Measurements on 08/29/24 of Resident #32's right knee were length 3.0 cm, width 3.0 cm and the depth was not determined. The wound was dry, pink, red in color and had a small amount of thick drainage. Resident #32's sacral measurements on 08/29/24 were length 8.0 cm, width 8.0 cm, depth was not determined, and there was a moderate amount of pink, red thick drainage.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/09/24 at 9:54 A.M. of Family Member (FM) #701 revealed Resident #32 was a double amputee, could not speak, was admitted to the facility and resided on the rehab nursing unit. Resident #32 developed a bed sore which cleared up, then was transferred to the long-term care nursing unit. While residing on the long-term care nursing unit, Resident #32 developed another bed sore on his bottom, a wound on his stump, and was admitted to the hospital. FM #701 stated Resident #32 had an infection that went to the bone, and he required a procedure on his stump and had a peripherally inserted central catheter (PICC) line. FM #701 stated the facility was like two separate nursing homes and one received good care, and one side (the long-term side) received poor care. FM #701 stated there was a huge difference between the nursing units. FM #701 indicated when the family visited, and Resident #32 resided on the long-term hall the call light would be activated because Resident #32 needed care, and the nurses and aides did not come. FM #701 stated Resident #32 was not turned and repositioned unless the family requested it, and his right leg was not propped up, so it wasn't resting on the mattress. FM #701 stated the right stump must have been rubbing against the sheet. FM #701 stated every time the family visited the facility, Resident #32's right stump was not propped up and they had to constantly tell the nurses and aides about it. FM #701 indicated he talked to Social Services Designee (SSD) #632 and Unit Manager (UM) #702 about Resident #32's care. FM #701 revealed on the long-term side the black props were not used and instead the staff used pillows or sheets, and often when he visited, he found Resident #32's right stump resting directly on the pillow or sheets causing pressure directly to the area where the wound developed. FM #701 stated he told SSD #632 and UM #702 the staff on the long-term side needed education on how to properly position Resident #32.</p> <p>Observation on 09/11/24 at 11:48 A.M. with CWNP #700 and WN #629 of Resident #32's dressing changes revealed his right leg amputation site dressing was intact with a moderate amount of pink and brown drainage. The wound size was approximately one inch in diameter, and the wound bed was a dark pink, red with a white center, fascia (a thin, flexible, connective tissue) per CWNP #700). CWNP #700 stated when she first saw the wound on 08/07/24 it was 100 percent covered in eschar and it progressed to have a hole in the center with purulent drainage, she ordered an x-ray to rule out osteomyelitis, but the x-ray was fine and did not show osteomyelitis. Further observation revealed Resident #32 had a bilateral sacral open area with pink, brown drainage, the wound base had a white center (fat tissue per CWNP #700) and muscle could be visualized. CWNP #700 stated an area of eschar was taken off at the hospital. The wound was cleansed with normal saline, and MediHoney, calcium alginate, and an ABD pad were applied. CWNP #700 stated it could be he was not turned and positioned, and that was how pressure ulcers work. CWNP #700 stated the black wedge positioning device should be under the sheet and under Resident #32, and it had to be positioned properly to work.</p> <p>Interview on 09/11/24 at 1:59 P.M. of FM #703 revealed Resident #32 did not have a problem with his stumps until he was moved to the long-term nursing care side of the facility. FM #703 stated when Resident #32 was moved to the long-term care unit, he was not always turned and repositioned, and his leg was not always elevated off the mattress. FM #703 stated the family often reminded staff to turn and reposition Resident #32 and to elevate his right BKA.</p> <p>Observation on 09/11/24 at 2:00 P.M. of Resident #32 revealed he was lying on his back in bed, and his right and left BKA's were lying directly on the mattress, not off-loaded.</p> <p>Interview on 09/11/24 at 2:21 P.M. of STNA #555 confirmed Resident #32's right and left BKA's were not off-loaded from the mattress.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/11/24 at 3:28 P.M. of WN #629 revealed the first time she saw Resident #32's wounds on his right stump and buttock was on 08/07/24 when the aides informed her that Resident #32 had a wound on his butt. WN #629 stated, when Resident #32 was rolled onto his side to look at his sacral area, she also saw a wound on the right BKA. WN #629 indicated Resident #32 had a sacral pressure ulcer in the past, but it was cleared up in 05/2024, and Resident #32 did not have wounds to his right BKA and sacrum before 08/07/24. WN #629 confirmed Resident #32's treatments were not documented as completed in the TAR, and it was challenging to make sure treatments and skin checks were completed as ordered. WN #629 stated, sometimes the nurses charted they did the treatments, but she would find dressings with old dates that did not correspond to the date they were signed off they were completed on the TAR.</p> <p>Interview on 09/11/24 at 3:37 P.M. of STNA #529 revealed she worked on the rehab side of the facility and took care of Resident #32. STNA #529 stated Resident #32 did not have a sore on his right BKA or a sore on his butt (sacrum) when he was transferred to the long-term care side of the facility.</p> <p>Interview on 09/12/24 at 11:16 A.M. of STNA #546 revealed Resident #32's treatments were not getting done on either his right BKA and his butt wound (sacrum). STNA #546 stated it depended on the nurse to determine if his treatments were completed.</p> <p>Interview on 09/12/24 at 11:52 A.M. of STNA #544 revealed he was aware Resident #32 had a sacral wound, but he did not know about the right BKA wound because Resident #32's right leg rested on the mattress right where the sore was.</p> <p>Interview on 09/18/24 at 1:00 P.M. of the Director of Nursing (DON) confirmed Resident #32's shower sheet dated 08/04/24 had an area to his buttocks (sacrum) identified, and the area was not documented or evaluated until 08/07/24. The DON stated the nurse did not sign the sheet and turned it in without addressing the area to Resident #32's buttocks (sacrum). The DON confirmed she was aware random treatments were not being completed for Resident #32's sacral pressure ulcer and right BKA wound.</p> <p>Interview on 09/18/24 at 2:05 P.M. of UM #702 revealed Resident #32's son talked to her about his care, and he was concerned about Resident #32 not getting turned and repositioned and was also concerned about his wound care.</p> <p>Review of the facility policy titled Prevention of Pressure Injuries, revised 04/2020, included the purpose was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Assess the resident on admission (within eight hours) for existing pressure injury risk factors and repeat the risk assessment weekly and upon any changes in condition. Inspect the skin daily when performing or assisting with personal care or activities of daily living (ADL). Identify any signs of developing pressure injuries, inspect pressure points, and reposition resident as indicated on the care plan. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. Evaluate, report and document potential changes in the skin.</p> <p>2. Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses including displaced bicondylar fracture of left tibia, Alzheimer's disease, anxiety disorder, and legal blindness.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of the Braden Scale for Predicting Pressure Ulcer Risk dated 12/03/23 revealed Resident #1 was high risk for pressure ulcer development. Further review of Resident #1's medical record did not reveal another Braden Scale for Predicting Pressure Ulcer Risk was completed until 07/18/24. On 07/18/24, Resident #1 was at high risk for developing a pressure ulcer.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #1 had moderate cognitive impairment. Resident #1 was dependent for toileting and personal hygiene, bathing, and upper and lower body dressing. Resident #1 required substantial to maximal assistance to roll left and right, and was dependent for sitting to lying, lying to sitting on side of bed, sit to stand and chair, bed-to-chair transfer. Resident #1 was always incontinent of urine and bowel. Resident #1 was at risk of developing pressure ulcers, injuries and did not have one or more unhealed pressure ulcers, injuries.</p> <p>Review of Resident #1's progress notes dated 07/18/24 at 3:56 P.M. included Registered Nurse (RN) #627 was called to Resident #1's room by an unidentified STNA who noted an area to Resident #1's sacrum. The area was assessed and cleansed with normal saline, it was not open but was dark purple in color and measured 1.0 cm by 1.0 cm and appeared to be a deep tissue injury (DTI), (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue). A new order was obtained to change to a thicker cream (Triad cream) to peri area, sacrum, and buttocks. Wound care was to refollow, and the physician, unit manager, and Resident #1's daughter were notified.</p> <p>Review of Resident #1's physician orders dated 07/18/24 revealed apply Triad cream to buttocks (purple area to sacrum), peri area, every shift for wound care.</p> <p>Review of Resident #1's medical record including progress notes, physician orders, TAR, and evaluations dated 07/18/24 through 09/12/24 did not reveal documented evidence that Resident #1's dark purple area on the sacrum was evaluated or treated.</p> <p>Review of Resident #1's care plan initiated on 10/10/23 and revised 08/26/24 included Resident #1 had actual impairment to skin integrity related to a Stage III pressure ulcer to the right buttocks present on admission to the facility and was at increased risk for further impairment to skin integrity related to incontinence, impaired mobility, and history of Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) to the left medial buttock. Resident #1 had a history of dark area to the sacrum, unopened. The goal was for Resident #1's skin injury to be healed by the review date. Interventions included to administer treatment per physician order, monitor, document location, size and treatment of skin injury. Report abnormalities, failure to heal, maceration etc.</p> <p>Review of Resident #1's shower sheet dated 08/05/24 revealed Resident #1 had a red spot on the tail bone. The shower sheet was signed by Licensed Practical Nurse (LPN) #601. There was no further evidence in Resident #1's medical record from 08/05/24 through 09/12/24 that the red spot on Resident #1's tail bone was evaluated or treated.</p> <p>Interview on 09/09/24 at 1:15 P.M. of STNA #554 revealed Resident #1 usually agreed to have all care completed and did not resist turning and repositioning.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/11/24 at 8:48 A.M. of WN #629 revealed she accompanied CWNP #700 on wound rounds every Wednesday, and if there were new wounds between wound rounds, the concerns were handled by UM's #643 and #702, and the UMs would notify her of the new wounds. WN #629 stated UM's #643 and #702 kept a wound grid and updated it every Wednesday. When there was a new pressure injury, the physician, the DON, the Administrator, and CWNP #700 were notified. WN #629 stated a picture of the wound was texted to CWNP #700 and she would order treatments until she visite [TRUNCATED]</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</p> <p>Based on observation, record review, Emergency Medical Services (EMS) documentation, hospital record review, facility policy review, and interview the facility failed to develop and implement an effective, comprehensive and individualized fall prevention program for Resident #197 to decrease the resident's risk of repeated falls. The facility failed to ensure Resident #197 was provided timely assistance with toileting and failed to ensure the resident was not left unattended in a chair in the activity room without proper footwear and clothing resulting in a fall on 08/26/24 with multiple fractures. The facility also failed to ensure accurate and complete fall risk assessments were completed for Resident #61. This affected two residents (#61 and #197) of six residents revealed for falls and/or accident hazards. The facility census was 102.</p> <p>Actual Harm occurred on 08/26/24 between approximately 1:30 A.M. to 1:40 A.M. when Resident #197, who was severely cognitively impaired, assessed to be at moderate to high risk for falls, dependent on staff for toileting and incontinent of both bowel and bladder sustained an unwitnessed fall resulting in a left femur fracture, a large left intramuscular hematoma, right tibia fracture, right fibula fracture, a non-displaced fracture of the right superior pubic ramus, an anterior acetabular column fracture, an inferior right pubic ramus fracture, and right sacrum fractures as a result of a fall. Prior to the fall, the resident had last been toileted on 08/25/24 at 9:21 P.M. (five hours earlier). The resident had been left unattended with bare feet and no pants, wearing only a brief, in a chair in the activity room at 1:00 A.M. by State tested Nurse Aide (STNA) #518. Resident #2, who was alert and oriented, was in the activity room and watched Resident #197 stand up from a regular high back chair and remove her brief, which was saturated with urine, and throw it away in the trash can. Resident #197 then walked out activity room door and walked down the hallway and entered another resident's room where she fell. The resident was hospitalized from 08/26/24 to 09/08/24 as a result of the fall with injuries.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #197 revealed an initial admitted [DATE], Resident #197 was sent to the emergency room for increase in behaviors on 05/07/24 and returned to the facility on [DATE]. Resident #197 had diagnoses included chronic atrial fibrillation, muscle weakness, type two diabetes mellitus, unsteadiness on feet, osteoarthritis, hypertension, Alzheimer's disease, cognitive communication deficit, and dysphagia.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366195 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512 | |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of the plan of care for Resident #197, initiated on 05/06/24, revealed Resident #197 was at increased risk for falls related to Alzheimer's dementia. Resident #197 had an actual fall at the facility on 05/05/24. Goals included Resident #197 would be free from injury through the review date. Interventions included to anticipate and meet the resident needs, be sure the resident's call light was within reach, and encourage the resident to use it for assistance, educate the resident/family/care givers about safety reminders and what to do if a fall occurs, encourage the resident to participate in activities that promote exercise, physical activity, for strengthening and improved mobility. Additional interventions included staff to identify cause of falls, neurological checks for unwitnessed falls, occupational therapy (OT) and physical therapy (PT), to evaluate and treat as ordered. On 05/08/24 an intervention was added for staff to encourage resident to lay down on the couch when she falls asleep in chair.</p> <p>Further review of Resident #197's care plan for falls revealed the plan of care was not updated following falls sustained by the resident on 05/20/24, 06/17/24, 06/27/24, and 08/26/24.</p> <p>Review of the plan of care for Resident #197, initiated on 05/06/24, last revised on 07/31/24 revealed Resident #197 had frequent bladder incontinence related to Alzheimer's disease. Goals and interventions included Resident #197 would remain free from skin breakdown due to incontinence and brief use. Staff were to encourage and assist with toileting frequently with rounds and as needed, staff were to ensure the resident had an unobstructed path to the bathroom, establish voiding patterns check the resident frequently with rounds and as required for incontinence. Wash, rinse, and dry perineum, change clothing as needed after incontinence episodes. (There was no documented evidence in the medical record that the facility attempted to establish voiding patterns).</p> <p>Review of Resident #197's physician orders dated July 2024, August 2024, and September 2024 revealed staff were to encourage and assist with toileting frequently with rounds and as needed.</p> <p>Review of Resident #197's medical record revealed the resident had a witnessed fall in the facility on 05/05/24 at 8:10 P.M. The fall investigation revealed an STNA notified LPN #596 they observed Resident #197 was standing up beside her wheelchair and fell. Resident #197 was attempting to fold up her blanket. LPN #596 observed the resident sitting upright on her buttocks. She denied pain and was assessed with no apparent injuries, vital signs were noted to be within normal limits (WNL), range of motion (ROM) was WNL, and the resident was noted to be alert with confusion per her usual. LPN #596 noted in the report the resident did not speak to describe what happened, she just smiled at the nurse and denied pain when asked. Immediate action taken was the resident was placed under close supervision for the remainder of LPN #596's shift. Resident #197's family was not notified until 05/06/24 at 1:45 P.M., and the physician was notified on 05/06/24 at 3:32 A.M. Additionally, under the notes section, it stated the resident stumbled and fell before the STNA could reach the resident to assist. The resident was observed between her wheelchair and a couch (it was not specific where the fall happened in the facility). The resident was assisted back to her wheelchair by two staff members. PT and OT were to evaluate and treat the resident. (PT and OT were noted to be an original order from her admission on 05/05/24).</p> <p>Review of Resident #197's Fall Risk Assessment completed on 05/06/24, revealed the resident was at a moderate risk for falls with a score of 11.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>A second witnessed fall happened on 05/20/24 at 3:30 P.M. in the lounge area. The incident description included the resident was in the lounge area sleeping in her chair, she awakened and attempted to transfer herself onto the couch, and she fell on to her buttocks. The fall was witnessed by an STNA. Resident #197 did not hit her head, ROM was WNL, and there was no discoloration noted with head-to-toe assessment. The physician and family were notified. Immediate action taken was when the staff notice that the resident is awake, they will assist in transferring the resident to the couch.</p> <p>The Fall Risk Assessment completed on 05/20/24 revealed the resident was at moderate risk for falls with a score of 14, with discrepancies in section four, staff did not mark the resident was on antihypertensives, section seven staff marked the resident was occasionally incontinent; however, all other documentation revealed the resident was totally incontinent of both bowel and bladder and dependent on staff for toileting hygiene, section eight, staff marked no behaviors noted, but nursing staff documented behaviors less than daily, and the vital signs used were from the day before on 05/19/24.</p> <p>A third unwitnessed fall occurred on 06/17/24 at 6:00 A.M. Resident #197 was found on the floor in the hallway sitting on her bottom. Resident #197 stated, going, going, fall. Nursing staff completed an assessment, vital signs were obtained, and the resident complained of pain to the right hip at a ten on a pain scale of zero to ten, ten being the worst. The physician, the on-call supervisor, and emergency medical services (EMS) were called, and the resident was taken to the hospital. Under the section titled Predisposing Environmental Factors it was marked inappropriate assistive device. The resident was admitted to the hospital from 06/17/24 to 06/20/24 for hyperkalemia (elevated potassium level). All scans and x-rays revealed no fractures. No new fall prevention interventions were implemented upon return from the hospital.</p> <p>The Fall Risk Assessment completed on 06/18/24 revealed the resident was a high risk for falls with a score of 16, with discrepancies noted in section seven, staff marked the resident was occasionally incontinent; however, all other documentation revealed the resident was totally incontinent of both bowel and bladder and dependent on staff for toileting hygiene.</p> <p>A witnessed fall occurred on 06/27/24 at 9:30 P.M. LPN #598 witnessed Resident #197 try to stand up, she asked the resident to sit back in the chair, the resident grabbed the table and was trying to sit down, there was no chair behind her, and LPN #598 guided her to the floor. LPN #598 and two STNAs assisted the resident up and back into the wheelchair, it was noted there was no intervention put in place, therapy was already working with the resident at this time.</p> <p>The Fall Risk Assessment completed on 06/27/24 was incomplete and no score was given but indicated the resident was a high risk; however, there were discrepancies noted in section four with no medications marked, the resident took antihypertensives and psychotropics, and in section seven staff marked the resident was occasionally incontinent; however, all other documentation revealed the resident was totally incontinent of both bowel and bladder and dependent on staff for toileting hygiene.</p> <p>The quarterly Fall Risk Assessment completed on 07/14/24 revealed the resident was at moderate risk for falls with a score of 13, with discrepancies noted in section four with no medications marked. The resident was on antihypertensives and psychotropics, in section eight no behaviors were marked; however, nursing documentation indicated the resident was exhibiting behaviors less than daily, and in section 11 the gait analysis was left blank.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #197's progress note dated 08/25/24 at 8:13 P.M. revealed the resident was given Benadryl 25 milligrams (mg) as needed for itching.</p> <p>Review of STNA task documentation revealed the last time Resident #197 was provided incontinence care was on 08/25/24 at 9:21 P.M.</p> <p>Review of Resident #197's progress note dated 08/26/24 at 3:02 A.M. revealed Registered Nurse (RN) #621 documented she was flagged down by Resident #74 because Resident #197 had fallen. Resident #197 was observed lying on her left side in another resident's room crying out in pain. The resident was not wearing pants or a brief, and her left leg had a visible bone protrusion mid-thigh. The resident's left thigh was observed to be swollen about two time the size of her right thigh. RN #621 documented she observed the resident approximately five minutes prior to the incident sitting in the dining room, and at that time she was wearing her pants.</p> <p>Review of Resident #197's discharge Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired. Resident #197 required set up or clean up assistance for eating, she was independent with bed mobility, she required supervision or touching assistance with walking, and was dependent on staff for oral hygiene, toileting hygiene, showering, dressing, and personal hygiene.</p> <p>Review of the ambulance run report from responding emergency medical service (EMS) revealed they received the call at 1:38 A.M., they were enroute at 1:40 A.M., on scene at 1:45 A.M., made patient contact at 1:47 A.M., and left the scene at 2:00 A.M. Review of the narrative text revealed they were dispatched for a fall. Upon arrival, they found the resident (Resident #197) lying supine on the floor. The resident was alert to self only, facility staff reported they were unsure how the resident got to the location, the resident was a fall risk, and they suspected the resident was attempting to use the restroom due to the absence of pants. At this time, the resident was noted to have remarkable deformity to the left femur. They log rolled the resident onto a sheet and lifted her onto the stretcher without incident. The resident was transported to the ambulance and secured for transport to the hospital. They applied a traction splint to the residents left leg.</p> <p>Review of Resident #197 discharge summary for hospital stay from 08/26/24 to 09/09/24 revealed the resident was treated for an acute, transverse, mildly displaced fractures of the proximal tibia and fibular shafts as seen on right knee x-rays, an acute fracture of the distal femoral diaphysis with posterior displacement and overlapping of the distal fracture fragment with anterior angulation, it also appeared laterally rotated, a large hematoma, as seen on computed tomography (CT) scan of the left femur with contrast, there were non-displaced fractures of the right superior pubic ramus and anterior acetabular column, the inferior right pubic ramus, and the right sacrum, as seen on a CT scan of the abdomen and pelvis with intravenous (IV) contrast. The resident required surgery on 08/27/24 to fix the left femur fracture and the right tibia and fibula fractures.</p> <p>Interview on 09/10/24 at 9:48 A.M. with STNA #511 (not present at the time of the fall) revealed Resident #197 walked prior to her fall on 08/26/24. She stated the resident does not know how to use her call light. Prior to her fall on 08/26/24, the resident was able to stand up on her own, she had a wheelchair to use but would often stand up from the wheelchair then walk everywhere. She stated the resident had a walker at one point, but someone took it from her. STNA #511 stated Resident #197 had been sleeping mostly since she returned from the hospital. STNA #511 stated the resident did not have any falls out of bed, all had been from her wheelchair or while she was standing.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/10/24 at 10:15 A.M. with Resident #74 revealed he came out in the hallway on the night of 08/26/24 when he heard Resident #197 screaming for help. He stated he found the resident on the floor in another resident's room. He stated there was another female resident (Resident #2) in her wheelchair outside of the room where Resident #197 was. The other female resident was trying to calm Resident #197. Resident #74 stated he then went to go and find the STNA or nurse who were assigned to the 1400 hall that night but was not able to locate anyone. He stated he went back down to where Resident #197 was on the floor and told Resident's #197 and #2 that he was going to the 1300 unit to find a nurse to help. He went to the 1300 unit and found the nurse and told her a resident needed assistance, and the 1300-unit nurse ran over. When they were returning to the 1400 unit, the nurse assigned to the 1400 unit was returning and went to where Resident #197 was at on the floor. He stated Resident #197 did not have shoes, pants, or a brief on when he saw her.</p> <p>Interview on 09/10/24 at 4:24 P.M. with Resident #2 revealed she was awake in her room on 08/26/24 and had wheeled herself in her wheelchair to the activity room and upon entering the activity room, she smelled a very strong odor of urine and watched Resident #197 stand up from a regular high back chair and remove her brief which was saturated with urine and throw it away in the trash can. Resident #197 then walked out the one door and walked down the hallway a little way and went into another resident's room. Resident #2 stated she did not follow Resident #197 down the hall but heard the resident fall then scream out in pain. At this time Resident #2 went to find Resident #197 and found her on the floor in another resident's room crying in pain. This was when Resident #74 wheeled himself to them and stated he was going to go find the STNA or nurse for the unit. Resident #2 stated Resident #74 then returned after about five minutes and stated he could not find anyone and was going to go to the 1300 unit to get the aide or nurse from that unit. When asked if the resident had on pants or shoes when she first saw her in the activity room, she stated no, she did not have on pants or shoes. She stated she was in her bare feet.</p> <p>Interview on 09/11/24 at 1:00 P.M. with STNA #518 revealed she worked the night of 08/26/24 and last saw Resident #197 at approximately 1:00 A.M. when Resident #197 was attempting to walk and could not redirect the resident to sit down in her wheelchair, so she had her sit in the activity room on the 1400 hall. She stated the resident had on a brief and a shirt but no pants or shoes, she stated she then left the unit and went to the laundry room for approximately ten minutes and when she returned the resident had fallen and was injured. (The fall occurred between 1:30 A.M. and 1:40 A.M., but she stated she was only gone for 10 minutes). She did not state why she left the resident in the common area with no pants or shoes on.</p> <p>Interview on 09/12/24 at 10:46 A.M. with RN #621 revealed she was on duty and assigned to the 1400 hall the night of 08/26/24 when Resident #197 fell . She stated she does not recall where she was or where the aide was when the resident fell . She could not recall the name of the STNA working on the unit. She could not recall if the resident was in her wheelchair or in a regular chair or if the resident took her medications that night. She could not recall the time of the fall. She stated after she called 911, she sent the Director of Nursing (DON) a text message stating that the resident was sent to the hospital. She stated she notified the family but does not know who she spoke too. RN #621 was unable to state why she documented she saw resident #197 five minutes before the fall as noted in the nursing progress note associated with the incident.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/12/24 at 10:59 A.M. with Licensed Practical Nurse (LPN) #593 revealed she was scheduled on the 1300 unit on 08/26/24 and was notified by Resident #74 there was a fall on the 1400 unit, and he could not find the nurse or aide, and Resident #197 needed assistance. She stated she was unsure of the time and printed the paperwork needed to send the resident to the hospital and showed the emergency medical technicians (EMTs) to Resident #197, and at this point, the EMTs took over care.</p> <p>Interview on 09/16/24 at 10:30 A.M. with the DON revealed she did receive a text message the night of 08/26/24 informing her Resident #197 was going to the hospital for injuries from a fall. She stated she did not know any other information until the next day. When asked what fall interventions were implemented after each of Resident #197's falls, she provided a list stating for the fall on 05/05/24 the intervention was for PT and OT to evaluate and treat as necessary; the fall on 05/20/24 staff were to encourage resident to lay down on couch or bed when falling asleep in chair; the fall on 06/17/24; the resident was sent to the hospital with no new fall prevention interventions implemented; fall on 06/27/24 referred to therapy for strengthening; and for the fall on 08/26/24 the resident was sent to the emergency room. She confirmed at this time the care plan was not updated after each fall, and proper fall prevention interventions were not in place. Investigations were completed with each fall; however, they did not conclude what the root cause of each fall, including the fall on 08/26/24.</p> <p>Interview on 09/16/24 at 1:41 P.M. with Resident #197's daughter revealed she had asked facility staff to put different fall interventions in place (specific interventions not provided); however, the daughter indicated none ever were. The resident's daughter revealed she was not notified of fall on 08/26/24 until the next morning.</p> <p>2. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included hypothyroidism, essential primary hypertension, hyperlipidemia, major depressive disorder, adjustment disorder, and dementia</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #61 was severely cognitively impaired. Resident #61 was independent with eating and personal hygiene, required supervision or touching assistance with oral hygiene, lower body dressing, and putting on and taking off footwear, required partial to moderate assistance with toileting and upper body dressing, and was dependent on for shower/bathing. Resident #61 was frequently incontinent of bowel and bladder.</p> <p>Review of the care plan dated 10/29/20 revealed Resident #61 was at increased risk for falls related to history of falling at home, decreased mobility and endurance, and Resident #61 had an actual fall at the facility.</p> <p>Review of the facility provided incident and accident log from 09/01/23 to 09/09/24 revealed Resident #61 fell on [DATE], 01/06/24, and 06/07/24 which resulted in a major injury.</p> <p>Review of assessments for Resident #61 revealed last Fall Risk Review was completed on 01/06/24 and was identified as a moderate risk for falling.</p> <p>Interview on 09/11/24 at 4:30 P.M. with the DON revealed fall assessments should be done quarterly and annually. The DON confirmed no fall risk assessments were completed since 01/06/24 for Resident #61.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of the facility policy Fall Risk Assessment, dated 03/18, revealed the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.</p> <p>Review of the facility policy titled Falls-Clinical Protocol, last revised March 2018, revealed with each fall the facility was to identify the cause of the fall, identify any injury, notify the physician, family and supervisor, implement appropriate fall interventions, monitor or continue with follow-up after each fall.</p> <p>47568</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</p> <p>Based on interview, observation, record review, and facility policy review the facility failed to ensure timely incontinence care was provided for Resident #197. This affected one resident (#197) out of four residents reviewed for timely incontinence care. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #197 revealed an initial admitted [DATE]. Resident #197 was sent to the emergency room for increase in behaviors on 05/07/24 and returned to the facility on [DATE]. Diagnoses included chronic atrial fibrillation, muscle weakness, type two diabetes mellitus, unsteadiness on feet, osteoarthritis, hypertension, Alzheimer's disease, cognitive communication deficit, history of urinary tract infections, acute cystitis, dysphagia, and neuromuscular dysfunction of the bladder.</p> <p>Review of Resident #197's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired. Resident #197 required set up or clean up assistance for eating, she was independent with bed mobility, she required supervision or touching assistance with walking, and was dependent on staff for oral hygiene, toileting hygiene, showering, dressing, and personal hygiene. Upon return to the facility after a hospital stay from 08/26/24 to 09/08/24 the resident was to have nothing by mouth (NPO), and dependent on staff for all activities of daily living (ADL) including incontinence care and bed mobility.</p> <p>Review of the plan of care for Resident #197, initiated on 05/06/24 and last revised on 07/31/24, revealed Resident #197 had frequent bladder incontinence related to Alzheimer's disease. Goals and interventions included Resident #197 would remain free from skin breakdown due to incontinence and brief use. Staff were to encourage and assist with toileting frequently with rounds and as needed, staff were to ensure the resident had an unobstructed path to the bathroom, establish voiding patterns, check the resident frequently with rounds and as required for incontinence, wash, rinse, and dry perineum, change clothing as needed after incontinence episodes, monitor and document intake and output as per facility policy, observe and document and signs or symptoms of a urinary tract infection (UTI), including pain, burning, blood tinged urine, cloudiness, no output, deepening urine color, increase pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and or a change in eating patterns. Additional review of Resident #197's care plan, initiated on 05/06/24 and last revised on 09/10/24, revealed Resident #197 had the potential for impairment to skin integrity related to incontinence and diabetes. Resident #197 had actual incisions with staples to her left upper thigh, left outer thigh, and left knee. Goals and interventions included the resident would maintain clean and intact skin by the review date, encourage and assist to turn and reposition frequently with rounds and as needed, encourage good nutrition and hydration, follow protocols for treatment of injury, keep skin clean and dry. Use lotion on dry skin, pressure redistribution mattress to bed, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate and any other notable changes or observations. There was no documented evidence in the care plan of the new area of sheering to coccyx found on 09/11/24.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512 | |
| 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) | | |
| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #197's physician's orders dated September 2024 revealed staff were to encourage and assist with toileting frequently with rounds and as needed, pressure redistribution mattress to bed, wound care to evaluate and treat as needed, weekly skin checks to be completed on Sunday nights, turn and reposition frequently with rounds and as needed, daily wound evaluations for coccyx wound, left hip incision, right anterior lower leg incision, left knee incision, right knee incision, cleanse right and left leg incisions with normal saline, and leave open to air. Cleanse the area to the coccyx with normal saline, apply Triad cream (zinc-oxide based cream) every shift and as needed.</p> <p>Observation made on 09/11/24 at 4:35 A.M. revealed Resident #197 was observed on her back and was incontinent of urine.</p> <p>Observation made on 09/11/24 at 6:15 A.M. revealed Resident #197 was observed on her back and was saturated with urine, the resident's brief, paper incontinence pad, and cloth incontinence pad were all saturated through.</p> <p>Observation made on 09/11/24 at 8:27 A.M. revealed Resident #197 was observed still on her back and was saturated with urine, her brief, paper incontinence pad, and cloth incontinence pad were saturated through. There was a brown ring present on the fitted sheet, and on the pillow elevating her legs down to the resident's mid-calf.</p> <p>Review of Resident #197's state tested nurse aide (STNA) task documentation revealed the last time there was documented evidence of turning and repositioning of the resident was on 09/11/24 at 3:46 A.M.</p> <p>Interview on 09/11/24 at 8:30 A.M. with Physical Therapy Assistant (PTA) #614 and STNA #525 revealed they confirmed the resident had been incontinent and not turned or repositioned. STNA #525 stated she had not been in the resident's room since her shift started at 6:00 A.M., she stated she was busy cleaning up from the mess the midnight aide left her. Both staff interviewed confirmed the resident was saturated with urine, her brief, paper incontinence pad, and cloth incontinence pad were saturated through. There was a brown ring present on the fitted sheet, and on the pillow elevating her legs down to the resident's mid-calf.</p> <p>Interview on 09/11/24 at 9:50 A.M. with the Director of Nursing (DON) revealed STNAs should complete rounds on incontinent residents every two hours and as needed and are to reposition the resident and turn them at this time.</p> <p>Observation made on 09/16/24 at 7:01 A.M. of Resident #197 revealed she was lying on her back, and her brief was visibly soiled with urine.</p> <p>Observation made on 09/16/24 at 9:05 A.M. of Resident #197 revealed she was lying on back, and her brief was still visibly soiled with urine.</p> <p>Interview on 09/16/24 at 9:10 A.M. with STNA #511 revealed she confirmed she had not been in Resident #197's room to perform incontinence care or turn her since her shift started at 6:00 A.M.</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation made on 09/16/24 at 9:55 A.M. of incontinence care and wound care for Resident #197 performed by STNA #511, STNA #525, and Licensed Practical Nurse (LPN) #702 revealed they washed their hands, put on appropriate personal protective equipment (PPE) as the resident was in Enhanced Barrier Precautions (EBP), placed the residents tube feed on hold lowered the residents head, raised her bed to a comfortable height, and began to perform incontinence care. They cleansed her front peri area and then rolled the resident onto her right side with assistance from STNA #511 to ensure the resident did not roll back on them, LPN #702 then removed the old dressing from the wound to Resident #197's coccyx dated 09/16/24, LPN #702 cleansed the wound with normal saline patted dry with gauze, removed old gloves, washed hands and put new gloves on then proceeded to apply Triad cream to the wound. STNA #511 and LPN #702 at this time began to close the new clean brief without performing incontinence care to the resident's backside which had visible stool present. At this time incontinence care was stopped by surveyor and asked if the staff were done performing incontinence care at this time and they all stated yes, and then proceeded to fasten the brief. This surveyor brought the visible stool to their attention and the staff then proceeded to clean the resident appropriately. LPN #702, STNA #511, and STNA #525 confirmed they did not perform appropriate incontinence care for Resident #197.</p> <p>Interview on 09/16/24 at 10:09 A.M. with LPN #702 revealed she confirmed the dressing she removed during incontinence care was not the ordered dressing the resident was to have on her coccyx. LPN #702 confirmed the resident was only to have Triad Cream applied, and the area was to be left open to air.</p> <p>Interview on 09/16/24 at 1:59 P.M. with Certified Wound Nurse Practitioner (CWNP) #700 revealed Resident #197 was seen on 09/11/24 at the request of facility staff and documented the resident had a wound located on her coccyx described as partial thickness shearing acquired on 09/11/24. Initial wound measurements were length 2.63 centimeters (cm) by 1.95 cm width. There was no depth noted. There was a scant amount of serous drainage noted with no odor, wound bed had 76-100 percent (%) epithelialization. The peri wound skin texture was normal, moist, and normal in color. There were no signs or symptoms of infection. She stated she ordered for follow up visit in one week, cleanse the wound with mild soap and water, apply Triad cream twice a day and as needed, barrier cream to surrounding area three times a day and after incontinent episodes, and to turn and reposition the resident every two hours, and to avoid direct pressure to wound site.</p> <p>Interview on 09/18/24 at 3:45 P.M. with CWNP #700 revealed Resident #197's wound was observed an assessed with measurements of length 1.44 cm by width 2.38 cm by depth (D) 0.1 cm. There continued to be scant amount of serous drainage, no odor, and no signs or symptoms of infection. There were no changes to her orders, and she will continue to follow up weekly until the wound was healed.</p> <p>Review of the facility policy titled Routine Resident Checks, last revised in July 2013, revealed staff shall make routine checks to help maintain resident safety and well-being. Under number one letter A. Residents assessed for dependence on incontinence care of bowel and/or bladder shall have a routine check as needed but should reasonably be accommodated at least every two hours.</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, record review, interview, and facility policy review the facility failed to provide adequate oversight of nutritional needs regarding weight loss, physician notification, and supplements for Residents #71, #75, #81. This affected three residents (#71, #75 and #81) of five residents reviewed for nutrition. The facility census was 102.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #71 revealed an admitted [DATE]. Diagnoses included hydrocephalus, depression, obstructive uropathy, urine retention, dementia, diabetes, and venous insufficiency.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 was severely cognitively impaired. He required set up help for eating and oral hygiene, substantial assistance for showering and was dependent for toileting. He had no pressure ulcers but was at risk, had no unknown weight loss or gain and no swallowing issues.</p> <p>Review of the physicians' orders for September 2024 revealed Resident #71 was on a mechanically altered, chopped texture diet with nectar consistency liquids which began on 08/15/24. He received Ensure Plus (supplement) eight ounces one time a day in the afternoon which began on 08/31/24. Resident #71 was ordered weekly weights for four weeks which began on 07/08/24.</p> <p>Review of Resident #71's weight revealed he weighed 200.0 pounds (lbs.) on 07/02/24 and 167.8 lbs. on 07/30/24. There was no recorded weight during the week of 07/14/24.</p> <p>Review of the medical record revealed Resident #71 was in the hospital from 07/12/24 through 07/14/24, 07/24/24 to 07/26/24, 08/06/24 to 08/15/24, 08/21/24 to 08/27/24 and 09/10/24 throughout the conclusion of the survey.</p> <p>Interview on 09/17/24 at 9:56 A.M. with Dietitian #639 revealed nursing was responsible for obtaining weekly weights and she reviewed them when she came to the facility on Fridays. She revealed the nursing department was responsible for notifying the physician if a resident had a significant weight loss. She confirmed Resident #71's weight was not obtained the week of 07/14/24 and she did not address his significant weight loss until 08/31/24.</p> <p>Interview on 09/17/24 at 10:48 AM. with the Director of Nursing (DON) revealed she was unsure who was responsible for notifying the physician of a significant weight loss or gain and identified there was an obvious breakdown in the system. She confirmed Resident #71's weight was not obtained the week of 07/14/24 as ordered and the physician was not notified of the significant weight loss.</p> <p>2. Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included uropathy, kidney failure, and diabetes.</p> <p>(continued on next page)</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #75 was moderately cognitively impaired. He required supervision for eating and oral hygiene, substantial assistance for showering and was dependent for toileting. He had no weight gain and no oral or dental issues.</p> <p>Review of the physicians' orders for September 2024 revealed an order to notify the physician of a weight gain of two pounds in a day or three to five pounds in a week which began on 06/18/24.</p> <p>Review of Resident #75's weight revealed he weighed 197.2 lbs. on 07/09/24 and 206.7 lbs. on 07/10/24.</p> <p>Review of the (Medication Administration Record) MAR for August 2024 revealed weights were not obtained on 08/02/24, 08/03/24, 08/15/24, and 08/31/24.</p> <p>Review of the medical record revealed Resident #75 was in the hospital from 07/15/24 through 07/21/24 and 08/23/24 through 08/26/24.</p> <p>Interview on 09/17/24 at 9:56 A.M. with Dietitian #639 revealed nursing was responsible for obtaining weekly weights and she reviewed them when she came to the facility on Fridays. She revealed the nursing department was responsible for notifying the physician if a resident had a significant weight loss. She revealed she was unaware of Resident #75's weight gain.</p> <p>Interview on 09/17/24 at 10:48 AM. with the DON revealed she was unsure who was responsible for notifying the physician of a significant weight loss or gain and identified there was an obvious breakdown in the system. She confirmed the physician notified of Resident #75's weight gain. She confirmed daily weights were not obtained as ordered for Resident #75.</p> <p>3. Review of the medical record for Resident #81 revealed an admitted [DATE]. Diagnoses included compression fracture of the vertebrae, asthma, depression, osteoporosis, dementia, and muscle weakness.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #81 was severely cognitively impaired. She required supervision for personal hygiene, set up help for eating and oral hygiene and substantial assistance for toileting, showering and bathing. She had no weight loss or gain.</p> <p>Review of the physicians' orders for September 2024 revealed Resident #81 was ordered a Magic cup (frozen supplement to increase calorie and protein intake) with meals which began on 09/06/24.</p> <p>Observation on 09/11/24 at 1:08 P.M. of lunch revealed Resident #81 was eating lunch in her room. The meal consisted of salmon, squash, applesauce, and a dinner roll. The resident had juice and water. No Magic cup was observed. Interview at the time of the observation with Licensed Practical Nurse (LPN) #602 revealed he was aware Resident #81 was supposed to have a Magic cup with lunch, and that she did not have one at the observed meal.</p> <p>(continued on next page)</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the facility policy titled Weight Assessment and Intervention, dated September 2008, revealed weight changes of five percent or more since the last weight assessment would be retaken the next day for confirmation. If the weight was verified, nursing would immediately notify the dietitian in writing. The dietitian would respond within 24 hours of receipt of the written notification. The dietitian would review the weight record by the 15th of the month to follow individual weight trends over time. Negative trends would be evaluated by the treatment team. Assessment information would be analyzed by the team and conclusions made regarding appropriate calorie, protein and other nutritional needs.</p> |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, record review, interview, and facility policy review the facility failed to ensure oxygen was administered and cared for appropriately for Residents #2, #35, and #252. This affected three residents (#2, #35, and #252) of four residents reviewed for respiratory care. The facility identified 21 residents (#1, #2, #5, #14, #17, #20, #24, #26, #31, #34, #35, #55, #87, #88, #91, #149, #151, #152, #247, #252 and #253) who used oxygen. The facility census was 102.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included depression, chronic respiratory failure, diabetes, anemia, heart failure, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact. He was independent in eating, required supervision for oral and personal hygiene and required partial assistance for toileting, showering, and dressing. He was on oxygen.</p> <p>Review of the physician's orders for September 2024 revealed Resident #35 was on three liters of oxygen continuously. The order began on 08/08/24.</p> <p>Review of the care plan dated 08/07/24 revealed Resident #35 had altered respiratory status and difficulty breathing. Interventions included administering medications as order, encouraging sustained deep breaths, monitoring and documenting changes in orientation, increased restlessness, anger, anxiety and air hunger, maintaining oxygen settings, and pacing and scheduling activities to provide adequate rest periods.</p> <p>Observation on 09/09/24 at 10:46 A.M. revealed Resident #35 was using a portable oxygen tank set at two liters. Interview at the time of the observation with State tested Nurse Aide (STNA) #505 confirmed the oxygen setting was two liters.</p> <p>2. Review of the medical record for Resident #252 revealed an admitted [DATE]. Diagnoses included hypertension, kidney failure, muscle weakness, and COPD.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #252 was severely cognitively impaired. She required supervision for oral and personal hygiene, set up help for eating, and substantial assistance with toileting and showering. She was on oxygen.</p> <p>Review of the physician's orders for September 2024 revealed Resident #252 was on four liters of oxygen continuously. The order began on 08/28/24.</p> <p>Observation on 09/09/24 at 9:34 A.M. revealed resident #252 was lying in bed with her oxygen in use. Her oxygen was set at 3.5 liters. Interview at the time of the observation with STNA #548 confirmed her oxygen was set at 3.5 liters.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the facility policy titled Oxygen Administration, dated October 2010, revealed the facility would review the physician's orders prior to administering oxygen to ensure accurate guidelines were followed.</p> <p>44461</p> <p>3. Review of Resident #2's medical record revealed an admitted [DATE]. Diagnoses included anxiety, cerebral infarction, Sjogren syndrome with lung Involvement, chronic respiratory failure with hypoxia, congestive heart failure, multiple sclerosis, and atrial fibrillation.</p> <p>Review of Resident #2's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact. She was independent with eating, oral hygiene, toileting hygiene, dressing, personal hygiene, and bed mobility. She required set up help or clean up assistance with showers.</p> <p>Review of Resident #2's care plan dated 08/16/24 revealed the resident had congestive heart failure and was at risk for complications, goals and interventions included the resident will have clean lung sounds, heart rate and rhythm within normal limits through the review date. Staff to check breath sounds as needed and observe/document for labored breathing. Observe/document for the use of accessory muscles while breathing, encourage adequate nutrition, give cardiac medications as ordered, oxygen therapy per order, and vital signs per order and as needed. The resident had coronary artery disease related to atrial fibrillation, hypertension, and was at risk for complications. Interventions and goals included the resident will be free from signs and symptoms of complications of cardiac problems through the review date, staff to give all cardiac medications as ordered by the physician, observe and document side effects, and report adverse reactions to physician as needed. Resident #2 required oxygen therapy related to chronic heart disease and history of tobacco use. Interventions and goals included the resident would have no signs or symptoms of poor oxygen absorption through the review date, staff to encourage the resident to change positions with rounds and as needed to facilitate lung secretion movement and drainage, staff to encourage or assist with ambulation, staff to give medications as ordered by the physician. Observe and document side effects and effectiveness. Staff to observe for signs and symptoms of respiratory distress and report to the physician as needed including respirations, pulse oximetry, increased heart rate, restlessness, sweating, headaches, lethargy, confusion, atelectasis, cough, pleuritic pain, usage of accessory muscles, and skin color. Oxygen (O2) settings include O2 via nasal prongs at two liters (L) continuously. O2 tubing to be changed weekly on Sundays and as needed. Staff must date and tubing kept in a bag at all times when not in use.</p> <p>Review of Resident #2's physician orders dated September 2024 revealed orders for O2 at 2L via nasal cannula continuously, O2 tubing to be changed weekly on Sunday and as needed, tubing must be dated. O2 tubing to be kept in bag at all times if not in use.</p> <p>Observation on 09/10/24 at 10:54 A.M. of Resident #2's oxygen tubing revealed there were multiple dates on the tubing related to when the tubing was said to be changed. The first date observed on the tubing closest to the resident just under her chin was 09/07/24, further down the oxygen tubing closest to the oxygen concentrator, which was located between the wall and behind the resident's nightstand, the date was 07/22/24 with initials from the nurse who changed it. Additionally, located on the floor next to the oxygen concentrator was another nasal cannula not in a bag dated for 07/29/24.</p> <p>(continued on next page)</p> |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 09/10/24 at 10:59 A.M. with STNA #511 revealed she verified all the dates on the oxygen tubing Resident #2 was using and the date on the oxygen tubing located on the floor.</p> <p>Interview on 09/10/24 to 11:05 A.M. with Resident #2 revealed when asked when the last time someone change her oxygen tubing, she stated the midnight nurse had come in the other day and just put a piece of tape on the tubing with a date on it. She stated she did not change the tubing at all.</p> <p>Review of the facility policy titled Departmental (Respiratory Therapy)-Prevention of Infection, last revised November 2011, revealed under the Steps in the Procedure Infection Control Considerations Related to Oxygen Administration, number seven Change the oxygen cannula and tubing every seven days, or as needed.</p> |

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| <p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</p> <p>Based on observation, interview, record review, local police department call detail report, self-reported incident (SRI) review, review of prehospital care report summary, emergency department (ED) provider note, and facility policy review the facility failed to develop and implement an effective and individualized pain management program for Resident #147 following a significant change in condition resulting in severe pain that was not treated timely. This affected one resident (#147) of three residents reviewed for pain. The facility census was 102.</p> <p>Actual Harm occurred on 09/04/24 at 3:42 P.M. when Resident #147 notified staff repeatedly that she was having severe pain in her right knee and staff failed to thoroughly assess the resident, failed to notify the physician, and failed to administer pain medication resulting in the resident calling the local police for help three times (at 5:50 P.M., 5:56 P.M., and 6:59 P.M.). Local police subsequently sent an ambulance to the facility. Resident #147 was transferred to the local hospital where x-ray results revealed she had an acute fracture of the distal right femur, the fracture was slightly angulated and comminuted (broken into many pieces), and she had right knee soft tissue swelling and joint effusion.</p> <p>Findings include:</p> <p>Review of Resident #147's medical record revealed an admitted [DATE] and a reentry date of 07/09/24. Diagnoses included unspecified fracture of the right ilium, sequela, fracture of sacrum, osteonecrosis of the right femur (death of bone tissue due to lack of blood supply), dependence on renal dialysis, and type two diabetes mellitus.</p> <p>Review of Resident #147's care plan dated 07/10/24 and revised on 08/27/24 included Resident #147 had pain related to a sacral fracture and right femur osteonecrosis. Resident #147 would verbalize adequate relief of pain or the ability to cope with incompletely relieved pain though the review date. Interventions included to administer analgesics per orders and give a half hour before treatments or care; anticipate Resident #147's need for pain relief and respond immediately to any complaint of pain; monitor and document for probable cause of each pain episode; monitor, record pain characteristics for example sharp, burning, and the pain severity on a scale of zero to ten, anatomical location, duration, aggravating factors and relieving factors; monitor, record and report to nurse any signs and symptoms of non-verbal pain; monitor, record, report to the nurse resident complaints of pain or requests for pain treatment; notify the physician if interventions were unsuccessful or if current complaint is a significant change from residents past experience of pain.</p> <p>Review of an (admission) Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #147 was cognitively intact. The assessment revealed Resident #147 was dependent (on staff) for toileting hygiene, bathing and lower body dressing, and required partial to moderate assistance for chair, bed-to-chair transfer. Resident #147 was occasionally incontinent of urine and always continent of bowel. Resident #147 experienced pain frequently in the last five days, pain made it hard for her to sleep at night, and she frequently limited her participation in rehabilitation therapy sessions due to pain. Resident #147 described her worst pain over the last five days as moderate.</p> <p>(continued on next page)</p> | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #147's physician orders dated 09/03/24 revealed hemodialysis Monday through Friday, with Dialyze Direct (in-facility hemodialysis treatment center) via right chest tesio (a twin catheter system that can be inserted into the chest through the internal jugular vein).</p> <p>Review of Resident #147's hemodialysis treatment information dated 09/04/24 included at 3:42 P.M. Resident #147 complained of a pain level of seven out of ten, ten being the worst pain, in her right knee. Further review revealed on 09/04/24 at 5:10 P.M. Resident #147 complained of pain rated a ten out of ten, ten being the worst pain, in her right knee. There was no documented evidence that Resident #147 was assessed, the physician was notified and/or pain medication was administered.</p> <p>Review of Resident #147's progress notes, physician orders and Medication Administration Record (MAR) from 09/04/24 at 3:42 P.M. through 09/04/24 at 5:10 P.M. revealed no documented evidence Resident #147 was assessed for pain by the facility nurses while she was in the on-site facility hemodialysis. There was no evidence Resident #147's physician was notified she was having pain, no documented evidence her pain level was rated on a scale of zero to ten, ten being the worst pain, and no evidence she had pain medication ordered and administered.</p> <p>Review of Resident #147's progress note dated 09/04/24 at 5:12 P.M. written by Licensed Practical Nurse (LPN) #589 included Resident #147 was having increased behaviors towards the staff and called a State tested Nursing Assistant (STNA) an inappropriate name. Resident #147 activated her call light multiple times and stated she transferred herself on and off the toilet by herself. Resident #147 sat in the common area, then was assisted back to her room and into her bed by the STNAs using a mechanical lift. Resident #147 had no concerns or complaints. The local police department called and told LPN #589 that Resident #147 called them and stated she fell and needed an ambulance because her knee hurt. LPN #589 explained to the police Resident #147 recently returned to the facility after a hospital stay for a toe amputation. The local police decided not to dispatch police to the facility. A registered nurse (RN) was notified and went with LPN #589 to assess Resident #147 and look at her knee. No areas of redness swelling were noted, and Resident #147 was resting in bed and her dinner tray was in the room. There was no documented evidence that Resident #147 was assessed for pain or was asked to rate her pain using a pain scale of zero to ten, ten being the worst pain.</p> <p>Review of Resident #147's progress note dated 09/04/24 at 5:26 P.M. written by RN #629 revealed Resident #147 stated we broke her and my knee is killing me. Resident #147's skin was intact and no noticeable bruising was noted during the assessment. There was no documented evidence Resident #147 was assessed for pain or asked what her pain level was using a scale of zero to ten, ten being the worst pain.</p> <p>Review of Resident #147's local police department call detail report dated 09/04/24 between 5:50 P.M. and 5:56 P.M. included Resident #147 stated two aides hurt her, and she needed help. At 5:56 P.M. the report stated this was the second call from Resident #147, the facility was contacted, the police were told an order for an x-ray was obtained (ordered on 09/04/24 at 7:24 P.M.), and Resident #147 did not have visible injuries. The facility stated they did not want anyone sent right now, and the police department representative told them they would call back if Resident #147 continued to call.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #147's local police department call detail report dated 09/04/24 at 6:59 P.M. included Resident #147 was calling again and saying she needed help. The dispatcher called the facility again and spoke to LPN #596 and advised her she was sending a squad. The ambulance company was notified and was enroute.</p> <p>Review of Resident #147's physician orders dated 09/04/24 at 7:15 P.M. revealed a new order for Xanax (anti-anxiety) oral tablet 0.5 milligrams (mg), one tablet by mouth every eight hours as needed for anxiety and record unsuccessful medication in the progress notes.</p> <p>Review of Resident #147's progress note dated 09/04/24 at 7:20 P.M. revealed the police contacted the facility and stated Resident #147 called again and an ambulance would be sent due to multiple calls being made (from the resident). Resident #147 was alert and oriented, vital signs were within normal limits, range of motion was within normal limits. Emergency medical technicians (EMTs) arrived at this time.</p> <p>Review of Resident #147's physician orders dated 09/04/24 at 7:24 P.M. revealed an order for an x-ray to the right knee due to pain.</p> <p>Review of Resident #147's progress note and MAR dated 09/04/24 from 5:10 P.M. through 7:32 P.M. when she was transported via ambulance to the local ED revealed no documented evidence Resident #147 was administered pain medication, or her pain was comprehensively assessed.</p> <p>Review of Resident #147's pre-hospital care report summary dated 09/04/24 included a call was received at 7:02 P.M. and they were on scene at 7:19 P.M. Resident #147's nurse stated she did not know anything about what happened with Resident #147 because it happened on day shift, and when she arrived for work, she was told Resident #147 called the police three times because she said the staff at the facility bumped her right knee and bent it the wrong way, on the mechanical lift during a transfer, causing severe pain. Resident #147 also reported she fell out of bed onto the floor, when she was trying to walk to the bathroom. The staff reported Resident #147 was unable to walk and if she had fallen, she would not be able to get herself off the floor. The facility staff stated none of this happened, and the physician was contacted for a portable x-ray and to restart Resident #147's Xanax (anti-anxiety) medication. The nurse thought all this was related to behavior problems Resident #147 had in the past. Resident #147 refused the portable x-ray because the images would be crappy and not show anything and insisted on being transported to the hospital for x-rays and treatment. Resident #147's right knee, where she reported having most of her pain was examined and found to be very swollen and painful. Resident #147 also complained of pain in her foot and ankle. EMS administered Fentanyl (narcotic pain reliever) to Resident #147 with no improvement in her pain and she was crying and sobbing, and she was transported to the local hospital and her care was transferred to the charge nurse at the hospital.</p> <p>Review of Resident #147's Emergency Department (ED) provider notes dated 09/04/24 through 09/05/24 included on 09/04/24 at 9:25 P.M. Resident #147's x-ray results revealed she had an acute fracture of the distal right femur, fracture was slightly angulated and comminuted, and she had right knee soft tissue swelling and joint effusion. Resident #147 presented to the ED for knee pain. Upon arrival to the ED, Resident #147 was hypertensive with otherwise stable vital signs. On exam Resident #147 had obvious swelling noted to the right knee with severe pain to palpation. Due to Resident #147's severe pain she was administered intravenous Morphine (narcotic pain reliever) and Zofran (antiemetic) for nausea.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #147's after visit summary for the hospital stay, 09/05/24 through 09/06/24, included Resident #147 had a closed fracture of the right femur, unspecified fracture morphology (number of fragments and fracture lines), unspecified portion of the femur.</p> <p>Review of facility self-reported incident (SRI) tracking number 251548 dated 09/05/24 at 11:48 A.M. revealed the facility reported an allegation of staff-to-resident physical abuse involving Resident #147. The staff, including the Administrator and Director of Nursing (DON), became aware of the incident on 09/05/24 at approximately 9:00 A.M. (the nurses were aware on 09/04/24). The SRI included Resident #147 did not provide meaningful information when she was interviewed, and was care planned for making false allegations (not included in the care plan until 09/04/24), behaviors, refusing care, and dialysis. Resident #147 was cognitively intact with confusion. Resident #147 frequently yelled out, moaned, and was verbally aggressive with staff. On the evening of 09/03/24 Resident #147 returned from the hospital at approximately 6:00 P.M. Upon entering the room to answer her call light, an unidentified STNA found Resident #147 had transferred herself into her wheelchair and then onto the toilet by herself. The STNAs assisted Resident #147 to her wheelchair and then she was transferred to her bed. On 09/04/24, Resident #147 had onsite dialysis at the facility and had no issues in dialysis (Resident #147 complained of pain at a seven out of ten pain while in dialysis). After dialysis, Resident #147 was in the common area and at 5:00 P.M. per her request she was transferred into her bed and voiced no concerns (she told staff she had pain). Later that evening the facility received a call from the police stating Resident #147 called and stated she was in pain. An unidentified nurse went into Resident #147's room, and Resident #147 complained of right leg pain. The nurse noted no swelling or discoloration (the ambulance personnel found her right knee swollen and painful). Resident #147 did not have orders for pain medication, the on-call nurse, and physician were notified, and new orders for pain medication (no pain medication was ordered; Xanax was ordered on 09/04/24 after the resident was transferred to the ED), and an x-ray was to be completed. An unidentified aide entered Resident #147's room to collect her tray and check on Resident #147, found her crying, she stated she was in pain and called 911. The police contacted the facility stating Resident #147 called them three times, and they were sending an ambulance to the facility. Resident #147 was yelling and told the nurse she needed to go to the hospital because her leg was broken. Resident #147 was told the facility had an order for an x-ray, and Resident #147 was insistent and screamed she wanted to go to the hospital. On 09/05/24, the facility was made aware via the hospital that Resident #147 had a fractured femur and reported she was dropped or fell from the mechanical lift. An SRI was initiated, and an investigation began. Resident #147 was not witnessed to have a fall, and not witnessed to have a fall from the mechanical lift. Resident #147 told the social worker she fell while transferring herself in the bathroom. Resident #147 had a complex medical history, idiopathic aseptic necrosis, an unhealing fractured pelvis, Resident #147's bones were fragile, and the bones could fracture with the slightest movement. The fracture could have happened anytime Resident #147 moved her leg, Resident #147 transferred herself, or possibly from the movement that occurred naturally during mechanical lifts. Resident #147 called 911 herself to be sent out to the hospital, and an investigation was immediately started (the investigation was not initiated until 09/05/24 at 11:48 A.M). The allegation was unsubstantiated.</p> <p>Review of a witness statement dated 09/04/24 and written by STNA #524 stated, on 09/04/24 she entered Resident #147's room to collect her dinner tray, and Resident #147 was crying. Resident #147 stated she was crying and saying she could not eat because she was in pain, someone pushed her too hard, and she called 911.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of a witness statement dated 09/05/24 and written by LPN #596 stated, on 09/04/24 the police called and told her Resident #147 called 911, this was the third call today, and the police were sending an ambulance. LPN #596 found Resident #147 crying when she entered her room, and said she wanted to leave and go to the hospital. LPN #596 asked Resident #147 why, and she said, my leg is broke, they were rough with me, I want to go, I want to go. The ambulance arrived shortly after and the DON and LPN #596's supervisor were notified. LPN #596 stated, Resident #147 did not have a prescription for pain medication because her pain medication was discontinued at the hospital prior to her discharge. LPN #596's unidentified supervisor told her Resident #147 had an order for Xanax and an order for an x-ray. Resident #147 refused the x-ray ordered to be done at the facility and left the facility via the ambulance on 09/04/24 at approximately 7:32 P.M.</p> <p>Review of Resident #147's progress note dated 09/07/24 at 2:11 P.M. and written by Medical Director #640 included Resident #147 had concerns including leg pain (was transferred from the local ED for a femur fracture) and had a knee immobilizer to her right leg. Resident #147 was at the acute care facility and had excruciating pain in the right leg and was recognized to have a right distal femur fracture. Resident #147 was offered pain control, nonoperative management, and a brace. Resident #147 had been in and out of acute care facilities multiple times.</p> <p>Interview on 09/16/24 at 4:48 P.M. of LPN #589 revealed on 09/04/24 she spoke to the police one time about Resident #147, and Resident #147 told the police she was hurt by the Hoyer (mechanical lift) when they got her up in the morning. LPN #589 stated the police told her Resident #147 needed to go to the hospital and called two more times on the next shift regarding Resident #147. LPN #589 stated she went with RN #629 to evaluate Resident #147 for cuts, bumps, bruises, swelling, redness because she was complaining of knee pain. LPN #589 stated she did not remember if Resident #147 was asked how bad her pain was, it was towards the end of the shift, and the physician was not notified Resident #147 was having right knee pain. Resident #147 was lying in bed, they moved her arms and legs and checked for redness inside her legs. LPN #589 stated Resident #147 stated she needed to go to the hospital because her knee hurt and said it was bumped when they were getting her up in the morning, but she did not identify any staff. LPN #589 indicated Resident #147 told them that was why she called the police. LPN #589 stated STNA #555 took care of Resident #147 on 09/04/24 and said Resident #147 did not get hurt while they were using the mechanical lift to transfer her. Resident #147's narcotic was discontinued at the hospital, and she did not have anything ordered for pain when she said her knee hurt. LPN #589 stated she did not call the physician, and she was not sure if anyone else did. LPN #589 stated her shift was over, and she left the facility shortly after Resident #147 was evaluated.</p> <p>Interview on 09/17/24 at 9:33 A.M. of STNA #529 revealed on 09/04/24 she helped STNA #555 transfer Resident #147 from the wheelchair to her bed, using the mechanical lift, and Resident #147 did not fall or slip and hit her knee, nor did her knee get caught on the bar.</p> <p>Interview on 09/17/24 at 10:42 A.M. of Resident #147 revealed I broke my femur at the facility when two aides were transferring her. Resident #147 stated the mechanical lift kind of collapsed and I slipped down and hit my femur but she could not remember which aides were transferring her. Resident #147 stated she told a nurse it happened but could not remember which nurse because she stated she was in so much pain.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/17/24 at 10:57 A.M. of STNA #540 revealed Resident #147 had already hit her knee and stated her knee hurt when she assisted STNA #555 with Resident #147's transfer on 09/04/24. STNA #540 stated she told a nurse Resident #147 was complaining her knee hurt, but the nurses already knew because Resident #147 was complaining loudly about it in the common areas when she was being transported, and everyone could hear her say it.</p> <p>Interview on 09/17/24 at 12:02 P.M. of RN #629 revealed (on 09/04/24) she answered Resident #147's call light and Resident #147 stated she was in pain. RN #629 stated LPN #589 was Resident #147's nurse and the two of them checked Resident #147 for bruising, redness, cuts, but nothing was identified. RN #629 stated Resident #147 could not give them a straight answer about what happened and said she was dropped from the mechanical lift, and she also stated she fell in the bathroom. RN #629 stated Resident #147 called the police. RN #629 stated Resident #147 was in a lot of pain, was crying, and she did not remember if Resident #147 was asked to rate her pain on a scale of zero to ten. RN #629 stated she did not give Resident #147 pain medication or call the physician for an order for pain medication because she was not the resident's assigned nurse. RN #629 stated the physician was notified, an x-ray was ordered, and her shift was over, the resident left the facility and she did not know what happened after that.</p> <p>Interview on 09/17/24 at 3:30 P.M. of STNA #555 revealed she provided care for Resident #147 on 09/04/24 and Resident #147 did not tell her she had pain in her right knee, and there was no fall from the mechanical lift. Resident #147's leg never hit the mechanical lift (unable to give times). STNA #555 stated later in the day, Resident #147 put her call light on and said her knee hurt, and she called the police a few times and was transported to the hospital. STNA #555 stated Resident #147 did not tell her how bad the pain was, and she had behaviors. STNA #555 stated Resident #147 was not bumped or dropped during her transfers using the mechanical lift.</p> <p>Interview on 09/18/24 at 7:56 A.M. of Dialysis Nurse #644 revealed on 09/04/24 Resident #147 was upset and said her right leg was bumped when the girls were moving her. Dialysis Nurse #644 confirmed Resident #147 had pain rated a seven out of ten on a pain scale of zero to ten, ten being the worst pain, during dialysis and had complaints of pain at a ten out of ten when dialysis was finished on 09/04/24. Dialysis Nurse #644 stated the dialysis nurses did not give pain medication, but stated she told the facility nurses about Resident #147's complaints of severe pain. Dialysis Nurse #644 stated she did not document that she told the nurses about the pain, and stated she could not remember who she told.</p> <p>Review of the facility policy titled Administering Pain Medications, revised 03/2020, included the purpose of the procedure was to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. Pain management was a multidisciplinary care process that included the following: assessing the potential for pain, recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the pain, developing and implementing approaches to pain management, monitoring the effectiveness of interventions and modifying approaches as necessary. Comprehensive pain assessments were conducted upon admission to the facility, at the quarterly review, whenever there was a significant change in condition, and when there was onset of new pain or worsening of existing pain. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief was obtained. Document the following in the resident's medical record: results of the pain assessment, medication, dose, route of administration, results of the medication.</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568</p> <p>Based on record review, observation, and interview the facility failed to ensure competent nursing staff as evidenced by a nurse leaving Resident #62, who was cognitively impaired with diagnoses of Alzheimer's disease, dysphagia (difficulty swallowing), flaccid hemiplegia, and a history of medication refusals, with a cup of pills to take to take independently. This affected one resident (#62) of 47 sampled residents. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included urinary tract infection (UTI), chronic pain syndrome, cerebral infarction, essential primary hypertension, mixed hyperlipidemia, dysphagia, anxiety disorder, major depressive disorder, obsessive compulsive disorder, unspecified sequelae of cerebral infarction, flaccid hemiplegia affecting the left non-dominant size, and Alzheimer's disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively impaired. Resident #62 required setup or clean up assistance with eating, partial to moderate assistance with oral hygiene, and was dependent on staff for toileting hygiene, shower/bathing, upper and lower body dressing, putting on and taking off footwear and personal hygiene. Resident #62 was always incontinent of bowel and bladder.</p> <p>Review of the care plan dated 03/11/22 revealed Resident #62 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease, dementia, and Resident #62 was resistive to care related to medication refusals.</p> <p>Review of the physician orders for September 2024 revealed Resident #62 was ordered Vitamin D tablet 50 micrograms (mcg) daily for supplementation, Crestor 10 milligrams (mg) daily for high cholesterol, Namenda 10 mg daily for cognition, omeprazole 40 mg daily for acid reflux, rivastigmine 6 mg twice daily for Alzheimer's disease, levetiracetam 500 mg twice daily for seizure prevention, Tylenol 650 mg every eight hours as needed for pain, Ibuprofen 200 mg every eight hours as needed for pain, baclofen 10 mg three times a day for muscle relaxation, Cymbalta delayed release 60 mg twice a day for depression, potassium chloride extended release 20 milliequivalents (mEq) daily for supplementation, Omega three fatty acid 1000 mg daily for supplementation, gabapentin 300 mg three times a day for nerve pain, aspirin 81mg daily for blood thinning, and Vistaril 25 mg every six hours as needed for anxiety.</p> <p>Observation on 09/10/24 at 9:45 A.M. revealed Resident #62 was observed lying in bed slumped leaning towards the right holding a medicine cup filled with approximately five unknown pills. Resident #62 appeared to be struggling to put pills from the medicine cup into her mouth. No staff member was observed in the room at that time.</p> <p>Interview and observation on 09/10/24 at 9:48 A.M. with Licensed Practical Nurse (LPN) #601 verified she left a cup full of medicine at Resident #62's bedside which she normally does and would go back and check to make sure Resident #62 took all her medication.</p> | | |

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| <p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review, interview, and facility policy review the facility failed to ensure parameters were in place for the administration of pain medications for Resident #22. This affected one resident (Resident #22) of five reviewed for unnecessary medications. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included panic disorder, depression, alcohol dependence, respiratory failure, and osteoarthritis.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact. She was independent in eating, dressing, toileting and personal hygiene, and required supervision for showering.</p> <p>Review of the physician's orders for September 2024 revealed an order for Tramadol 50 milligrams (mg) every 12 hours as needed for pain and an order for Acetaminophen 650 mg every six hours as needed for pain.</p> <p>Review of the care plan dated 08/16/24 revealed Resident #22 had pain interventions included anticipating the residents need for pain relief and responding immediately to any complaint of pain, evaluating the effectiveness of pain interventions, and monitoring and documenting the probable cause for any pain.</p> <p>Review of the Medication Administration Record (MAR) for August 2024 revealed Resident #22 received one dose of Acetaminophen (analgesic) for a pain level of zero on 08/19/24, two doses for a pain level of five on 08/20/24, one dose for pain level of four on 08/21/24, one dose for pain level of six on 08/22/24, one dose for a pain level of six on 08/24/24, one dose for pain level of six on 08/28/24, one dose for pain level of seven on 08/29/24, one dose for pain level of eight on 08/29/24, one dose for a pain level of zero on 08/31/24 and one dose for pain level five on 08/31/24. Resident #22 received one dose of Tramadol (narcotic pain medication) for a pain level of six on 08/17/24, one dose for a pain level of eight on 08/17/24, one dose for a pain level of eight on 08/18/24, one dose for a pain level of zero on 08/19/24, one dose for a pain level of zero on 08/20/24, one dose for pain level of seven on 08/21/24, one dose for a pain level of a nine on 08/21/24, one dose for pain level of seven on 08/22/24, one dose for a pain level of two on 08/23/24, one dose for pain level of eight on 08/23/24, one dose for pain level of nine on 08/24/24, one dose for pain level of six on 08/24/24, one dose for pain level of nine on 08/25/24, one dose for a pain level of seven on 08/25/24, one dose for a pain level of seven on 08/28/24, one dose for a pain level of seven on 08/29/24, one dose for pain level of five on 08/30/24, and one dose for pain level of zero on 08/31/24.</p> <p>Interview on 09/12/24 at 11:50 A.M. with the Director of Nursing (DON) confirmed the facility did not offer a lower-level pain medication prior to administering a stronger one. There were no parameters directing nursing which pain medication to administer.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366195 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512 | |

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| <p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of the facility policy titled Administering Pain Medications, dated March 2020, revealed the facility would conduct a pain assessment including whether the pain has improved or worsened since the last assessment, the general condition of the resident, verbal and nonverbal signs of pain, level of consciousness and evidence or reports of adverse consequences related to medications. Pain medication would be administered as ordered.</p> |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461</p> <p>47568</p> <p>Based on observation, interview, record review, review of manufacturer instructions, and facility policy review the facility failed to prevent a significant medication error for Resident #60 and Resident #149. This affected one resident (#60) of five residents reviewed for unnecessary medications and one resident (#149) of four residents reviewed for medication administration. The facility census was 102.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #60 revealed an admitted [DATE]. Medical diagnoses included cerebral infarction due to thrombosis of right posterior cerebral artery, flaccid hemiplegia affecting right dominant side, type two diabetes mellitus, hyperlipidemia, Bell's palsy, essential primary hypertension, transient ischemic attack, dysphagia, acute respiratory failure with hypoxia, chronic kidney disease, and epilepsy.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was moderately cognitively impaired. Resident #60 required setup or clean-up assistance with eating, partial to moderate assistance for oral hygiene and upper body dressing, and was dependent on staff for toileting, shower/bathing, lower body dressing, putting on and taking off footwear, and personal hygiene. Resident #60 was always incontinent of bowel and bladder.</p> <p>Review of the care plan dated 11/08/24 revealed Resident #60 had a seizure disorder related to stroke with intervention to give seizure medication as ordered by doctor, monitor labs and report any sub therapeutic or toxic results to physician, and obtain and monitor lab and diagnostic work as ordered.</p> <p>Review of the physician's orders for September 2024 revealed Resident #60 was ordered Keppra 100 milligrams (mg)/milliliters (ml) give five ml (medication to treat seizures) daily and give an additional two and a half ml on Monday through Friday. Further review of physician orders revealed no orders for a Keppra level check. Resident #60 was also ordered metoprolol 25 mg (medication to treat high blood pressure, chest pain, and heart failure) daily for hypertension with no blood pressure parameters.</p> <p>Review of the medication administration records (MAR) for July 2024, August 2024, and September 2024 revealed metoprolol was held on 07/01/24, 07/02/24, 07/07/24,07/09/24, 07/18/24, 07/29/24, 07/30/24, 08/08/24, 08/09/24, 08/12/24, 08/22/24, 08/23/24, 08/26/24, 08/27/24, 09/03/24, 09/06/24, 09/09/24 and 09/12/24.</p> <p>Review of Resident #60 progress notes revealed metoprolol was held due to blood pressure readings prior to dialysis. Further review of progress notes revealed no documented communication with physician regarding when metoprolol should be held depending on blood pressure readings.</p> <p>(continued on next page)</p> |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 09/17/24 at 3:45 P.M. with the Director of Nursing (DON) confirmed metoprolol was held due to nursing judgement; however, there was no documented communication that the physician was notified the medication was held due to blood pressure results.</p> <p>Review of the lab results revealed Resident #60's last Keppra level check was completed in the facility was on 11/07/23.</p> <p>Review of the progress notes revealed on 08/26/24 Resident #60 was sent to the emergency department for seizure like activity.</p> <p>Review of the hospital documentation for hospitalization on [DATE] revealed Resident #60 was treated for breakthrough seizures with a loading dose of 1,000 mg intravenous (IV) Keppra and sent back to the facility.</p> <p>Interview on 09/16/24 at 3:42 P.M. with Unit Manager (UM) #702 confirmed last documented Keppra level was drawn on 11/07/23, and there were no standing orders to recheck.</p> <p>Interview on 09/16/24 at 4:20 P.M. with Nurse Practitioner (NP) #642 stated that they have not ordered a Keppra level on Resident #60 since November 2023, and they would be getting a level drawn on 09/17/24. NP #642 further stated that they usually would order a Keppra level to be drawn every four to six months.</p> <p>2. Review of Resident #149's medical record revealed an admitted [DATE]. Diagnoses included displaced comminuted fracture of left tibial shaft, chronic kidney disease stage III B, type two diabetes mellitus, atrial fibrillation, and hypertension.</p> <p>Review of the Medicare five-day MDS assessment dated [DATE] revealed Resident #149 had intact cognition, required setup or cleanup assistance for eating, oral hygiene, and dressing. She required supervision or touching assistance for personal hygiene, she required partial to moderate assistance with bed mobility, substantial to maximal assistance for toileting hygiene, and showers and finally she was dependent for lower body dressing.</p> <p>Review of Resident #149's physician's orders dated for September 2024 revealed the resident was to have her blood sugar checked before meals and at bedtime with a Lispro insulin sliding scale of if blood sugar (BS) was 150-200 give 2 units (u), 201-250 give 4 u, 251-300 give 6 u, 301-350 8 u, 351-400 give 10u, 401-450 give 12u, and if over 450 notify the physician. Additionally Resident #149 was to receive Lantus 100 unit/milliliter (u/mL) inject 18 units subcutaneously (SQ) every night, and inject 3 u SQ one time a day in the A.M.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observations made on 09/11/24 from 8:30 A.M. to 8:51 A.M., 09/12/24 from 6:52 A.M. to 7:10 A.M. and on 09/18/24 at 8:51 A.M. to 9:00 A.M. of medication administration for Residents #7, #18, #32, and #149 by Licensed Practical Nurse (LPN) #600, LPN #602, LPN #603, and Registered Nurse (RN) #622 revealed there were 34 opportunities observed with all medications given per physician's orders. There were no medications omitted or given in error. There was one observation made on 09/18/24 from 8:51 A.M. to 9:00 A.M. of LPN #600 administering Lantus insulin to Resident #149 without performing hand hygiene before or after administering the medication, LPN #600 did not cleanse the top of the insulin pen with alcohol prior to putting on a new needle, LPN #600 did not waste two units of insulin to clear the air out of the needle per manufacturer's instructions, and she did not perform hand hygiene once she returned to the medication cart.</p> <p>Interview on 09/18/24 at 9:05 A.M. with LPN #600 revealed she confirmed she did not cleanse the insulin pen prior to putting on a new needle, she confirmed she did not waste two units prior to dialing to pen to the resident prescribed dose of three units, additionally she confirmed she did not perform hand hygiene before or after administering insulin Resident #149, nor did she preform hand hygiene once at the medication cart. LPN #600 questioned if they had to waste the two units each time they used the insulin pen.</p> <p>Review of the facility policy titled Adverse Consequences and Medication Errors, last revised April 2014, revealed under section titled Policy Interpretation and Implementation, number five: A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.</p> <p>Review of the manufacturer's instructions for the insulin pen revealed step one: remove the pen cover and clean the top with an alcohol swab, step three: [NAME] the pen needle A. turn the dial up to two units, B. press down on the dose knob until the dial is back to zero, C. repeat until insulin drops or stream appears. Step four: Select the dose, A. turn the dial to the dose given to you by your provider, B. double check the dose window to assure you have selected the proper dose.</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44461</p> <p>Based on observation, interview, and facility policy review the facility failed to ensure medications were not kept past the recommended storage dates, failed to ensure medications were not loose in the medication cart, failed to ensure medications were dated when opened, and failed to ensure medications were not expired. This was observed on the three carts (1200, 1300, and 1400) of four medication carts in the facility. This affected one resident (#82) and had the potential to affect all 80 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #11, #12, #13, #14, #15, #17, #18, #19, #20, #21, #23, #24, #25, #26, #27, #28, #29, #32, #33, #34, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #49, #50, #52, #53, #54, #56, #57, #58, #60, #61, #62, #64, #65, #66, #67, #68, #69, #70, #73, #74, #76, #79, #80, #82, #83, #84, #85, #86, #87, #88, #89, #93, #147, #148, #149, #150, #151, #152, #197) residing on the 1200, 1300, and 1400 units. The facility census was 102.</p> <p>Findings include:</p> <p>Observation on 09/12/24 at 2:15 P.M. of the 1200-unit medication cart revealed a vial of Novolog insulin for Resident #82 opened on 07/27/24 with a sticker stating do not use after date of 08/31/24. Additionally, there was a vial of Lantus insulin for Resident #82 that was not dated by staff when opened but had a sticker on it stating to not use after 08/31/24. There was no other insulin observed in the cart for Resident #82 for staff to use. There were two small white round medications, and one pale yellow medication found loose in the medication cart as well.</p> <p>Interview on 09/12/24 at 2:30 P.M. with Licensed Practical Nurse (LPN) #638 revealed she verified the dates on the insulin vials, the loose medications, and that there was no other insulin for Resident #82 for staff to use.</p> <p>Observation on 09/12/24 at 2:51 P.M. of the 1300-unit medication cart revealed an over the counter (OTC) bottle of aspirin 325 milligrams (mg) tablets was marked open on 03/21/24 with an expiration date of 08/2024, OTC bottle of Iron 325 mg tablets was marked open on 09/01/24; however, there was no expiration dated printed on the bottle from the manufacturer, an OTC bottle of Flaxseed 1000 mg capsules was marked opened on 09/01/24; however, the expiration date was 07/2024. There was liquid protein observed spilled in top drawer of the cart, and there was a total of 29 loose medications found throughout the cart.</p> <p>Interview on 09/12/24 at 3:25 P.M. with Registered Nurse (RN) #627 revealed she confirmed all expired medications, spilled liquid protein, and the 29 loose medications found throughout the 1300-unit medication cart.</p> <p>Observation on 09/12/24 at 3:30 P.M. of the 1400-unit medication cart revealed there were OTC medications Citrucel plus D, and Famotidine 20 mg tablets that were open but not dated.</p> <p>Interview on 09/12/24 at 3:35 P.M. with LPN #603 revealed she verified the two medications on the 1400-unit medication cart were opened but not dated.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the facility policy titled Storage of Medications, last revised November 2020, revealed the facility stores all drugs and biologicals in a safe, secure, and orderly manner</p> | | |

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| <p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review, interview, and facility policy review the facility failed timely notify the physician of lab results for Resident #81. This affected one resident (#81) of one resident reviewed for laboratory and diagnostic services. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #81 revealed an admitted [DATE]. Diagnoses included compression fracture of the vertebrae, asthma, depression, osteoporosis, dementia, and muscle weakness.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 was severely cognitively impaired. She required supervision for personal hygiene, set up help for eating and oral hygiene, and substantial assistance for toileting, showering, and bathing. She had no pressure ulcers but was at risk, no oral issues, and no weight loss or gain.</p> <p>Review of the nursing progress note dated 09/04/24 at 5:01 P.M. revealed a pustule like rash was noted to Resident #81's bilateral gluteal folds. An order was obtained for a culture with sensitivity.</p> <p>Review of the lab results dated 09/05/24 revealed the culture was obtained from the lab at 8:48 A.M. and reported to the facility on [DATE] at 12:31 P.M. There was no documented evidence the physician was notified of the lab results.</p> <p>Review of the lab results reported to the facility on [DATE] at 12:31 P.M. revealed heavy growth of lactose fermenter, heavy growth probable non-hem strep, and heavy growth diphtheroid bacillus.</p> <p>Interview on 09/12/24 at 10:53 A.M. with Licensed Practical Nurse (LPN) #643 confirmed the physician never reviewed the culture for Resident #81. She confirmed the facility should notify the physician of any lab results within 24 hours.</p> <p>Review of the nursing progress dated 09/12/24 at 11:30 A.M. revealed the culture results were reported to the physician and no new orders were given.</p> <p>Review of the facility policy titled Lab and Diagnostic Test Results, Clinical Protocol, dated November 2018, revealed when test results were reported to facility the nurse would review the results and notify the physician via phone, fax, voicemail, e-mail, pager, or telephone message. The facility would document when, how, and whom the information was provided to and the response.</p> | | |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47568</p> <p>Based on record review, observation and interview, the facility failed to ensure appealing and palatable food was served to Resident #45 and #152. This affected two residents (#45 and #152) out of nine residents reviewed for food and nutrition, and had the potential to affect 100 residents who received meals in the facility. The facility identified Resident #25 and #197 did not receive meals from the kitchen. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the facility menu for 09/09/24 revealed residents were to have ham and hash brown skillet with a blueberry muffin for breakfast.</p> <p>Review of the recipe Homemade Blueberry Muffin dated 09/09/24 revealed once ingredients were mixed to then portion batter with a number 20 dipper into greased muffin pans about two thirds full. The recipe further stated that a regular portion was one whole muffin.</p> <p>Observation on 09/09/24 at 7:48 A.M. of breakfast meal service revealed Dietary Manager (DM) #576 was placing a scooper full of a grayish-blue food item on plates for resident breakfast tray line.</p> <p>Interview on 09/09/24 at 8:18 A.M. with Resident #45 revealed Resident #45 was unable to identify what a lump of dark brown crusty food on his breakfast tray was supposed to be. State tested Nurse Aide (STNA) #554 at the time of the interview with Resident #45 stated the lump appeared to be a muffin and verified it was not in the shape of a muffin and looked over cooked.</p> <p>Interview on 09/09/24 at 8:33 A.M. with Resident #152 revealed Resident #152 pointed to a clump of food on the plate, which was dark brown, crusty with some dark spots throughout and asked what that was. STNA #554 at the time of the interview with Resident #152 stated it was a blueberry muffin.</p> <p>Interview on 09/09/24 at 9:34 A.M. with Resident #44 revealed he stated the facility food is not good, it does not taste good or look appealing. He stated he ordered food out a lot due to how horrible the facility food is. He stated he often received burnt food that was extremely hard and inedible.</p> <p>Interview on 09/09/24 at 11:44 A.M. with DM #576 stated she could not find muffin tins so she prepared the muffins on an edged cookie sheet for breakfast and scooped out what she believed would be equivalent to one muffin. DM #576 verified the residents were to receive one whole muffin and not a scoop of muffin.</p> <p>Interview and observation on 09/10/24 at 9:23 A.M. with Resident #44 revealed a burnt food item in the shaped of a slice of bread was on his plate. Resident #44 stated he thought it was supposed to be French toast but did not appear to be.</p> <p>Interview on 09/11/24 at 4:20 P.M. with DM #576 revealed since the blueberry muffins were made on an edged cookie sheet she had cut them into two by two square but could not definitively say she gave the proper serving of one muffin.</p> | | |

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| <p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>47568</p> <p>Based on observation, interview, and record review the facility failed to ensure meals were served timely. This had the potential to affect 100 residents who received meals from the kitchen. The facility identified Resident #25 and #197 as not receiving meals from the kitchen. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the untitled and undated facility-provided document revealed the following meal delivery schedule for the facility: breakfast was scheduled to be delivered on the 1300 hallway at 8:00 A.M., 1400 hallway at 8:15 A.M., 1100 hallway at 8:35 A.M., and 1200 hallway at 8:50 A.M., lunch was scheduled to be delivered on the 1300 hallway at 11:45 A.M., 1400 hallway at 12:00 P.M., 1100 hallway at 12:20 P.M. and 1200 hallway at 12:45 P.M., and dinner was scheduled to be delivered to 1300 hallway at 4:35 P.M., 1400 hallway at 4:50 P.M., 1100 hallway at 5:05 P.M., and 1200 hallway at 5:20 P.M.</p> <p>Review of Resident Council meeting minutes dated 05/24/24, 06/02/24, 07/15/24 and 08/19/24 revealed residents voiced complaints regarding the timeliness of meals being delivered to the units.</p> <p>Observation on 09/16/24 at 1:45 P.M. revealed 1100 hallway's lunch trays were just being delivered.</p> <p>Interview and observation on 09/17/24 at 9:25 A.M. with State tested Nurse Aide (STNA) #529 revealed breakfast was delivered at 9:15 A.M. and was supposed to be on the floor at 8:30 A.M. STNA #529 further stated she usually worked six days a week and most of those days she worked breakfast was not delivered until about 10:30 A.M and would be late to all units. STNA #529 verified late meal service was an ongoing problem in the facility.</p> <p>Interview on 09/18/24 at 9:00 A.M. with Dialysis Nurse (DN) #644 revealed the facility was often late with delivering meal trays which caused residents who received services for the in-house dialysis program to be late to dialysis because they were either waiting for their meal trays or were eating which caused dialysis to be late. DN #644 further stated that if a resident ate a full meal just before receiving dialysis, they could become hypotensive if fluid needed to be drawn off or they could get nauseated and throw up. DN #644 stated residents often refuse their meal trays because the meals are delivered so late and they do not want to be late to dialysis.</p> | | |

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| <p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, record review and interview, the facility failed to ensure residents had the required assistive devices to aid in maintaining independence while eating. This affected one resident (Resident #81) of nine residents reviewed for food/nutrition. The facility identified two residents (#46 and #81) who required assistive devices while eating. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #81 revealed an admitted [DATE]. Diagnoses included compression fracture of the vertebrae, asthma, depression, osteoporosis, dementia and muscle weakness.</p> <p>Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #81 was severely cognitively impaired. She required supervision for personal hygiene, set up help for eating and oral hygiene and substantial assistance for toileting, showering and bathing. She had no weight loss or gain.</p> <p>Review of the care plan dated 07/01/24 revealed Resident #81 had a nutritional problem due to dementia, hypertension, depression and schizophrenia. Interventions included monitoring and documenting signs and symptoms of pocketing, choking, coughing, drooling or holding food in mouth, obtaining and monitoring labs as ordered, occupational therapy screening and providing adaptive equipment as needed and providing and serving the residents' meal as ordered.</p> <p>Review of the meal ticket for Resident #81 for lunch 09/12/24 revealed she was to receive a sectional plate.</p> <p>Observation on 09/11/24 at 1:08 P.M. of lunch revealed Resident #81 was eating lunch in her room. The meal consisted of salmon, squash, applesauce and a dinner roll. No divided dish/sectional plate was observed. Interview at the time of the observation with Licensed Practical Nurse (LPN) #602 verified Resident #81 did not have a sectional plate.</p> <p>Review of the facility policy titled Assisting the Impaired Resident with In-Room Meals dated September 2013 revealed the facility would provide appropriate support to residents who needed assistance during meals including ensuring residents had the necessary items needed such as silverware, napkins and special devices.</p> |

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| NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512 | |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47568</p> <p>Based on observation, interview, record review, and policy review the facility failed to ensure food was stored, prepared and served under safe and sanitary conditions. This had the potential to affect all 100 residents who received meals from the kitchen. The facility identified Resident #25 and #197 did not receive meals from the kitchen. The facility census was 102.</p> <p>Findings include:</p> <p>1. Observation of the kitchen area on 09/09/24 from 9:00 A.M. to 9:50 A.M. revealed the following findings which were verified by Dietary Manager (DM) #567:</p> <p>Inside the reach in cooler was a container of four hard boiled eggs, a container of cut cucumbers, a container of cut watermelon, an open jug of of garlic parmesan sauce and approximately 24 covered prepared cups of fruit with no date. There was also a container labeled pizza sauce with a date of 08/18 and an open can of cheese sauce loosely covered with plastic wrap that was dated 05/27.</p> <p>Inside the walk-in cooler was a container of hot dogs with no date, a container of leftover sausage and peppers dated 08/26 and seven containers of moldy strawberries dated delivered on 08/26/24.</p> <p>Subsequent observations of the general kitchen environment during this observation period revealed the wall behind the shelves to the right of the entrance to the walk-in freezer had red and black drippings dried on the wall. The side of the convection oven next to the stove was covered with dried food splatters. The top of the convection oven was covered with visible dust. The front right of the convection oven where the controls were was a build up dust and dried food. The front of the steam table where the controls were to control the heat had dried food drippings.</p> <p>2. Observation of tray line on 09/09/24 from 11:54 A.M. to 1:00 P.M. revealed Dietary Aide (DA) #645 returned to the kitchen without washing hands and immediately started to assist with plating lunch. DA #645 was observed to not have a hair net on, rubbed eyes, face hair and nose multiple times while plating lunch. DA #645 was told to put a hair net on 20 minutes into tray line. DA #645 dropped a hot plate and the bottom of the plastic dome. DA #645 proceeded to pick the plastic bottom off the floor and placed it on the plate dispensary next to clean plates and continued to use oven mitts to pick up the hot plate on the floor. DA #645 walked the hot plate and plastic bottom over to the dishwashing area and returned. DA #645, without performing hand hygiene, continued to use the dirty oven mitts that had touched the floor to put clean hot plate and plates together for use for resident meals during the remaining of tray line.</p> <p>Interview on 09/09/24 at 12:50 P.M. with DA #645 confirmed they had not put a hair net on when they returned and immediately started to assist with tray line. DA #645 confirmed they had continuously touched their hair, nose, eyes and face multiple times without performing hand hygiene during tray line. DA #645 also confirmed that they did not perform hand hygiene or get new clean oven mitts after they picked the dropped hot plate and plastic bottom off the floor.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Observation on 09/09/24 at 12:55 P.M. confirmed by DA #562 revealed four racks of bread and buns were sitting on the floor on top of a puddle of water next to a mop bucket filled with brown water.</p> <p>Observation on 09/09/24 at 12:55 P.M., confirmed by DA #562 revealed he had not had a hair net on since the morning due to forgetting to put one on. DA #562 stated he had prepared pudding for lunch without wearing a hair net.</p> <p>3. Observation and Interview on 09/11/24 at 10:55 A.M. of preparation of pureed diets with [NAME] #572 revealed [NAME] #572 prepared pureed salmon in a blender then went over to the three-compartment sink and rinsed the blender and spatula, without washing or sanitizing proceeded to begin pureeing sweet potatoes in the same blender. [NAME] #572 confirmed they had only rinsed the blender and spatula between pureeing the salmon and the sweet potatoes and had not washed or sanitized the blender.</p> <p>4. Review of the reach in cooler, walk-in cooler and walk-in freezer September 2024 temperature logs revealed temperatures were checked for 09/02/24, 09/03/24, 09/04/24 as well as 09/09/24, no other dates were completed. The facility was unable to provide temperature logs from June 2024 or July 2024.</p> <p>Interview on 09/09/24 at 3:29 P.M. with DM #576 confirmed they were not able to find temperature logs for June 2024 or July 2024 and confirmed the only days temperature checks were completed were for 09/02/24, 09/03/24, 09/04/24 as well as 09/09/24.</p> <p>Review of facility meal temperature logs revealed no documentation completion of meal temperatures were found for breakfast or lunch on 09/01/24, lunch on 09/02/24, breakfast and lunch on 09/03/24 and 09/04/24, breakfast lunch or dinner on 09/05/24, 09/06/24, 09/07/24, and 09/08/24, and dinner temperatures on 09/09/24. The facility was unable to provide meal temperature logs prior to 09/01/24.</p> <p>Interview on 09/11/24 at 1:10 P.M. with DM #576 confirmed documented completion of meal temperatures were missing for breakfast or lunch on 09/01/24, lunch on 09/02/24, breakfast and lunch on 09/03/24 and 09/04/24, breakfast lunch or dinner on 09/05/24, 09/06/24, 09/07/24, and 09/08/24, and dinner temperatures on 09/09/24. DM #576 also confirmed there were no meal temperature logs prior to 09/01/24.</p> <p>Review of facility policy Food Storage (2023) revealed food will be stored in an area that is clean, dry and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Food items will be stored on shelves, with heavier and bulkier items stored on lower shelves. Food should be dated as its placed on the shelves. Date making should be visible on all high-risk food to indicate the date by which a ready to eat food should be consumed or discarded. Food should be stored a minimum of six inches above the floor. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within seven days or discarded. All refrigerator units should be kept clean and in good working condition at all times. Thermometers should be checked at least two times each day. All foods should be covered, labeled and dated and routinely monitored to ensure foods will be consumed by their use by dates, or frozen or discarded.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of facility policy Food Safety and Sanitation (2023) revealed all staff in good health, will practice good hygiene and will use safe food handling practice. Hair restraints are required and should cover all hair on the head. Employees will wash their hands just before they start to work in the kitchen and after smoking, sneezing, using the restroom, handling poisonous compounds or dirty dishes, and touching face, hair, other people or surfaces or items with potential contamination. When a food package is opened, the food item should be marked to indicate the open date.</p> <p>Review of facility undated policy Resource: Sanitation of Dishes/Manual Washing revealed for sanitizing using immersion in hot water, water must be maintained at 171 degrees Fahrenheit for 30 seconds. For manual washing using chemicals to sanitize an exposure time of at least ten seconds for a chlorine solution of 50 milligrams (mg) per liter (L) that has a potential of hydrogen (pH) of ten or less and a temperature of at least 100 degrees Fahrenheit.</p> <p>5. Observation on 09/09/24 at 7:48 A.M. revealed three large round trash cans on wheels throughout the kitchen without lids and contained trash. One of the large trash cans was observed uncovered and sitting right next to the stove where DM #576 was actively cooking lunch.</p> <p>Interview on 09/09/24 at 9:50 A.M. with DM #576 confirmed all three large trash cans on wheels did not have any lids on. DM #576 further stated she only had one lid for the large trash cans and did not have lids for the other two.</p> <p>Review of facility policy titled Waste Disposal (2023) revealed prior to disposal, all waste shall be kept in leak-proof, non-absorbent, fireproof containers that are kept covered when not in use.</p> |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review, review of administrative job descriptions and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident which included failure to appropriately manage pressure ulcer prevention, accident prevention and pain management programs, and related quality of care indicators. This had the potential to affect all 102 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the facility job description labeled Administrator revealed the Administrator signed the job description on 06/28/21. The description revealed the Administrator would establish and maintain systems that were effective and efficient to operate the facility and safely meet the needs of residents. Responsibilities included but were not limited to operating the facility in accordance with established policies and procedures, establishing policies regarding responsibilities and activities on the individuals employed, establishing systems to enforce facility policies, establishing personnel policies and job descriptions, supervising all departments and administrative staff, ensuring all necessary supplies were purchased and available, determining the personnel requirements of the facility and hiring or arranging for sufficient staff to implement the facilities policies and procedures, assuming responsibility for reviewing and evaluating all recommendations of the facilities' committees and consultants and establishing systems to ensure compliance with federal and state regulations.</p> <p>During the onsite investigation, the following concerns were identified related to a lack of comprehensive and effective administrative oversight:</p> <p>Interview was conducted on 09/18/28 at 1:08 P.M. with the Administrator and Director of Nursing (DON) regarding the identified survey findings. The Administrator and DON were asked if they were currently working on any Quality Assurance Performance Improvement (QAPI) projects in the areas identified. Both revealed they had not developed any type of quality improvement plans for the following identified non-compliance:</p> <p>1. Actual Harm occurred on 08/07/24 when Resident #32, who was at risk for developing pressure ulcers, and was dependent on staff for bed mobility and incontinence care was identified to have new areas of in-house acquired skin impairment with no additional assessment or new treatment at that time. On 08/07/24 the facility assessed Resident #32 to have one new, in-house acquired Stage III pressure ulcers (full-thickness loss of skin that extended to the subcutaneous tissue, but did not cross the fascia beneath it) on his sacral area and a right below the knee amputation (BKA) eschar covered surgical wound, without proper prevention, treatment and interventions implemented. Resident #32's family voiced concerns staff did not provide timely assistance with turning and repositioning and off-loading his right BKA. Resident #32's wounds deteriorated, and he was transported to the hospital on 08/28/24 for evaluation and treatment of osteomyelitis (inflammation of the bone caused by an infection).</p> <p>(continued on next page)</p> | | |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #32's After Visit Summary and Provider Notes for his hospital stay from 08/28/24 through 09/10/24 included Resident #32 had chronic osteomyelitis of the femur. Resident #32 had a right BKA stump complication, an open wound and was sent to the ED for an infection at the surgical site. Resident #32 had an ulceration to the surgical site of the right stump. Resident #32 had right BKA stump wound with acute right tibial osteomyelitis and was status post right BKA stump debridement on 09/03/24. Resident #32 had a full thickness wound to the right BKA stump, and the wound base was fibrotic with eschar noted. The wound was granular with edema, minor drainage and bleeding. Resident #32 had a Wound Vac placement. Resident #32 had an area of necrotic tissue on his sacrum about the size of a quarter and had a debridement of the sacral decubitus. Measurements on 08/29/24 of Resident #32's right knee were length 3.0 cm, width 3.0 cm and the depth was not determined. The wound was dry, pink, red in color and had a small amount of thick drainage. Resident #32's sacral measurements on 08/29/24 were length 8.0 cm, width 8.0 cm, depth was not determined, and there was a moderate amount of pink, red thick drainage.</p> <p>Interview on 09/09/24 at 9:54 A.M. of Family Member (FM) #701 revealed Resident #32 was a double amputee, could not speak, was admitted to the facility and resided on the rehab nursing unit. Resident #32 developed a bed sore which cleared up, then was transferred to the long-term care nursing unit. While residing on the long-term care nursing unit, Resident #32 developed another bed sore on his bottom, a wound on his stump, and was admitted to the hospital. FM #701 stated Resident #32 had an infection that went to the bone, and he required a procedure on his stump and had a peripherally inserted central catheter (PICC) line. FM #701 stated the facility was like two separate nursing homes and one received good care, and one side (the long-term side) received poor care. FM #701 stated there was a huge difference between the nursing units. FM #701 indicated when the family visited, and Resident #32 resided on the long-term hall the call light would be activated because Resident #32 needed care, and the nurses and aides did not come. FM #701 stated Resident #32 was not turned and repositioned unless the family requested it, and his right leg was not propped up, so it wasn't resting on the mattress. FM #701 stated the right stump must have been rubbing against the sheet. FM #701 stated every time the family visited the facility, Resident #32's right stump was not propped up and they had to constantly tell the nurses and aides about it. FM #701 indicated he talked to Social Services Designee (SSD) #632 and Unit Manager (UM) #702 about Resident #32's care. FM #701 revealed on the long-term side the black props were not used and instead the staff used pillows or sheets, and often when he visited, he found Resident #32's right stump resting directly on the pillow or sheets causing pressure directly to the area where the wound developed. FM #701 stated he told SSD #632 and UM #702 the staff on the long-term side needed education on how to properly position Resident #32.</p> <p>Interview on 09/18/24 at 1:00 P.M. of the Director of Nursing (DON) confirmed Resident #32's shower sheet dated 08/04/24 had an area to his buttocks (sacrum) identified, and the area was not documented or evaluated until 08/07/24. The DON stated the nurse did not sign the sheet and turned it in without addressing the area to Resident #32's buttocks (sacrum). The DON confirmed she was aware random treatments were not being completed for Resident #32's sacral pressure ulcer and right BKA wound.</p> <p>(continued on next page)</p> | | |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>2. Actual Harm occurred on 08/26/24 between approximately 1:30 A.M. to 1:40 A.M. when Resident #197, who was severely cognitively impaired, assessed to be at moderate to high risk for falls, dependent on staff for toileting and incontinent of both bowel and bladder sustained an unwitnessed fall resulting in a left femur fracture, a large left intramuscular hematoma, right tibia fracture, right fibula fracture, a non-displaced fracture of the right superior pubic ramus, an anterior acetabular column fracture, an inferior right pubic ramus fracture, and right sacrum fractures as a result of a fall. Prior to the fall, the resident had last been toileted on 08/25/24 at 9:21 P.M. (five hours earlier). The resident had been left unattended with bare feet and no pants, wearing only a brief, in a chair in the activity room at 1:00 A.M. by State tested Nurse Aide (STNA) #518. Resident #2, who was alert and oriented, was in the activity room and watched Resident #197 stand up from a regular high back chair and remove her brief, which was saturated with urine, and throw it away in the trash can. Resident #197 then walked out activity room door and walked down the hallway and entered another resident's room where she fell . The resident was hospitalized from 08/26/24 to 09/08/24 as a result of the fall with injuries.</p> <p>Interview on 09/16/24 at 10:30 A.M. with the DON revealed she did receive a text message the night of 08/26/24 informing her Resident #197 was going to the hospital for injuries from a fall. She stated she did not know any other information until the next day. When asked what fall interventions were implemented after each of Resident #197's falls, she provided a list stating for the fall on 05/05/24 the intervention was for PT and OT to evaluate and treat as necessary; the fall on 05/20/24 staff were to encourage resident to lay down on couch or bed when falling asleep in chair; the fall on 06/17/24; the resident was sent to the hospital with no new fall prevention interventions implemented; fall on 06/27/24 referred to therapy for strengthening; and for the fall on 08/26/24 the resident was sent to the emergency room . She confirmed at this time the care plan was not updated after each fall, and proper fall prevention interventions were not in place. Investigations were completed with each fall; however, they did not conclude what the root cause of each fall, including the fall on 08/26/24.</p> <p>Interview on 09/16/24 at 1:41 P.M. with Resident #197's daughter revealed she had asked facility staff to put different fall interventions in place (specific interventions not provided); however, the daughter indicated none ever were. The resident's daughter revealed she was not notified of fall on 08/26/24 until the next morning.</p> <p>3. Actual Harm occurred on 08/26/24 between approximately 1:30 A.M. to 1:40 A.M. when Resident #197, who was severely cognitively impaired, assessed to be at moderate to high risk for falls, dependent on staff for toileting and incontinent of both bowel and bladder sustained an unwitnessed fall resulting in a left femur fracture, a large left intramuscular hematoma, right tibia fracture, right fibula fracture, a non-displaced fracture of the right superior pubic ramus, an anterior acetabular column fracture, an inferior right pubic ramus fracture, and right sacrum fractures as a result of a fall. Prior to the fall, the resident had last been toileted on 08/25/24 at 9:21 P.M. (five hours earlier). The resident had been left unattended with bare feet and no pants, wearing only a brief, in a chair in the activity room at 1:00 A.M. by State tested Nurse Aide (STNA) #518. Resident #2, who was alert and oriented, was in the activity room and watched Resident #197 stand up from a regular high back chair and remove her brief, which was saturated with urine, and throw it away in the trash can. Resident #197 then walked out activity room door and walked down the hallway and entered another resident's room where she fell . The resident was hospitalized from 08/26/24 to 09/08/24 as a result of the fall with injuries.</p> <p>(continued on next page)</p> | | |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Resident #197 discharge summary for hospital stay from 08/26/24 to 09/09/24 revealed the resident was treated for an acute, transverse, mildly displaced fractures of the proximal tibia and fibular shafts as seen on right knee x-rays, an acute fracture of the distal femoral diaphysis with posterior displacement and overlapping of the distal fracture fragment with anterior angulation, it also appeared laterally rotated, a large hematoma, as seen on computed tomography (CT) scan of the left femur with contrast, there were non-displaced fractures of the right superior pubic ramus and anterior acetabular column, the inferior right pubic ramus, and the right sacrum, as seen on a CT scan of the abdomen and pelvis with intravenous (IV) contrast. The resident required surgery on 08/27/24 to fix the left femur fracture and the right tibia and fibula fractures.</p> <p>Interview on 09/16/24 at 10:30 A.M. with the DON revealed she did receive a text message the night of 08/26/24 informing her Resident #197 was going to the hospital for injuries from a fall. She stated she did not know any other information until the next day. When asked what fall interventions were implemented after each of Resident #197's falls, she provided a list stating for the fall on 05/05/24 the intervention was for PT and OT to evaluate and treat as necessary; the fall on 05/20/24 staff were to encourage resident to lay down on couch or bed when falling asleep in chair; the fall on 06/17/24; the resident was sent to the hospital with no new fall prevention interventions implemented; fall on 06/27/24 referred to therapy for strengthening; and for the fall on 08/26/24 the resident was sent to the emergency room . She confirmed at this time the care plan was not updated after each fall, and proper fall prevention interventions were not in place. Investigations were completed with each fall; however, they did not conclude what the root cause of each fall, including the fall on 08/26/24.</p> <p>4. Actual Harm occurred on 06/17/24 at 7:55 P.M. when Resident #7 experienced a fall, voiced severe pain after the fall, did not have pain medication ordered, and the physician was not contacted and notified Resident #7 had a fall and was experiencing severe pain until 06/18/24 at 6:36 A.M., ten hours after the fall. The physician issued an order to send Resident #7 to the hospital for right hip and leg pain post fall. Evaluation at the hospital revealed Resident #7 was non-ambulatory, reported significant tenderness with right leg weight bearing, and significant tenderness to palpation of the right femur and right hip, and was diagnosed with a closed displaced fracture of the right acetabulum the socket of the hip joint, where the head of the femur sits).</p> <p>Review of Resident #7's Emergency Department (ED) Provider Notes dated 06/18/24 at 2:55 P.M. included Resident #7 had a fall at the facility last night when he was transitioning from his bed to the wheelchair, and he fell on his right hip. Resident #7 has been experiencing pain since his fall. Resident #7 was non-ambulatory and reported significant tenderness with weight bearing on the right leg, and significant tenderness to palpation on right femur and right hip. Resident #7 had a closed nondisplaced fracture of the right acetabulum.</p> <p>(continued on next page)</p> | | |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Interview on 09/10/24 at 4:15 P.M. of the DON revealed when a resident had a fall a nurse assessed the resident, and the resident was not to be moved or touched until the nurse arrived. Vital signs including neuro checks should be documented in the nurse's notes, but neuro checks were documented on paper and were not uploaded into the electronic record. The nurse should check for range of motion, internal or external rotation, length of leg, skin redness, discoloration, pain and this should also be documented in the nurse's notes or on the incident report. The DON stated if the resident had pain, it should be documented where the pain was and how bad it was. If a resident was having pain such as in the hip, neck, back staff should not move the resident and call 911. The DON confirmed 911 was not called when Resident #7 fell on [DATE] at 7:55 P.M. and Resident #7 reported pain at a ten out of a ten.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366195 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Beeghly Oaks Center for Rehabilitation & Healing | | STREET ADDRESS, CITY, STATE, ZIP CODE 6505 Market Street Youngstown, OH 44512 | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568</p> <p>Based on interview, record review and review of facility policy the facility failed to ensure resident records reflected Resident #61 leaving and returning from the hospital. This affected one resident (#61) of 36 residents reviewed for accurate documentation. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #61 was most recently admitted to the facility on [DATE]. Medical diagnoses included hypothyroidism, essential primary hypertension, hyperlipidemia, vitamin D deficiency, major depressive disorder, adjustment disorder, anxiety disorder, dementia, fracture of unspecified part of left shoulder scapula, multiple fractures of ribs, stress fractures of ulna and radius, and laceration without foreign body of scalp.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 was severely cognitively impaired. Resident #61 was independent with eating and personal hygiene, required supervision or touching assistance with oral hygiene, lower body dressing, and putting on and taking off footwear, required partial to moderate assistance with upper body dressing and was dependent on staff for shower and bathing. Resident #61 was frequently incontinent of bowel and bladder.</p> <p>Review of the progress note dated 06/07/24 at 6:36 P.M. Resident #61 was heard in the hallway yelling for help. Resident #61 was seen sitting on the floor with blood coming from her nose. The Nurse Practitioner was in the building and assessed Resident #61 with a new order to send to the emergency room for evaluation and possible treatment. Resident #61 was cleaned up, and an ambulance was called. Further review of progress notes revealed no further progress notes were entered until 06/08/24 at 5:26 P.M. which revealed Resident #61 did not complain of any pain post fall. Steri-strips (secures, closes, and supports small cuts) to the laceration to the nose were intact. No other injuries were noted.</p> <p>Review of document Prehospital Care Report Summary from Ambulance Service dated 06/07/24 revealed Resident #61 was transferred to hospital from the facility on 06/07/24 at 8:58 P.M.</p> <p>Review of Resident #61's progress notes from 06/07/24 to 06/08/24 revealed no progress note was entered regarding Resident #61 leaving the facility or returning from the hospital.</p> <p>Interview on 09/11/24 at 4:30 P.M. with the Director of Nursing (DON) confirmed there was no documentation of when Resident #61 was picked up by the ambulance or when Resident #61 returned from the hospital between 06/07/24 and 06/08/24.</p> <p>Review of the facility policy Charting and Documentation, last reviewed on 07/17, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the medical physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Events, incidents, or accidents involving the resident must be documented in the resident's medical record.</p> | | |

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| <p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>45441</p> <p>Based on observation, interview, review of survey history from 12/16/22 through 06/05/24, review of approved plans of correction, and review of the State Operations Manual the facility failed to ensure concerns were addressed in a timely manner and failed to ensure their Quality Assurance and Performance Improvement (QAPI) program committee thoroughly evaluated, identified areas in need of improvement, and prior deficient practices were being monitored to determine if the plan of correction was being implemented as written and corrections were being sustained. This has the potential to affect all 102 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the facility's survey tracking history revealed the facility had an annual survey completed on 12/16/22 and complaint surveys on 05/02/23, 06/14/23, 04/24/24 and 06/05/24 which all resulted in citations related to the kitchen and dining services.</p> <p>Review of the facility's written plan of corrections (POCs) for the repeated dietary concerns for the annual survey completed on 12/16/22, the complaint survey completed 05/02/23, the complaint survey completed 06/14/23, the complaint survey completed on 04/24/24, and the complaint survey completed on 06/05/24 revealed the facility had approved corrective action plans in place, including ensuring staff were educated regarding appropriate kitchen and dining services, policies and procedures, and audits of resident meals.</p> <p>Review of Resident Council minutes from September 2023 through August 2024 revealed multiple food complaints related to temperatures, condiments, portions, and variety of foods.</p> <p>Interview on 09/18/24 at 9:19 A.M. with the Administrator and Director of Nursing (DON) revealed the facility did not routinely monitor for quality assurance (QA) issues related to the kitchen and dining services, except for dietary preferences, and did not address the repeated concerns in Resident Council multiple food complaints related to temperatures, condiments, portions, and variety of foods.</p> <p>Interview on 09/23/24 at 9:39 A.M. with the Administrator revealed since the previous annual survey, the facility had a complete change in staffing in the kitchen to include the director, supervisor, and several cooks and aides. He could provide no evidence the facility had educated all newly hired staff on previously cited deficient practices.</p> <p>Observations and interviews throughout the annual survey revealed the facility failed to ensure recipes were followed, food was palatable, food was stored appropriately, and the kitchen was clean and sanitary.</p> <p>Review of the State Operations Manual (SOM), chapter seven, section S7317 titled Acceptable Plan of Correction effective 11-16-18 revealed the facility must develop a plan to monitor their ongoing performance toward compliance and ensure solutions put into place are sustained. Section S7317 also revealed when a plan of correction is approved, it is the facility who is ultimately accountable for managing their own compliance.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, record review and interview, the facility failed to ensure transmission-based precautions (TBP) were implemented appropriately, oxygen and urostomy was cared for appropriately, hand hygiene was performed and enhanced barrier precautions (EHB) were followed. This affected five residents (Residents #24, #62, #71, #252 and #254) of eight reviewed for infection control and had the potential to affect all residents in the facility. The facility census was 102.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #71 revealed an admitted [DATE]. Diagnoses included hydrocephalus, depression, obstructive uropathy, urine retention, dementia, diabetes and venous insufficiency.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 was severely cognitively impaired. He required set up help for eating and oral hygiene, substantial assistance for showering and was dependent for toileting.</p> <p>Review of the physicians' orders for September 2024 revealed Resident #71 was on contact isolation for Vancomycin Resistant Enterococci (VRE) (a type of bacteria that is resistant to many antibiotics, including vancomycin) and klebsiella (an infection commonly found in wounds, catheters, and intravenous (IV) line sites). The order began 08/28/24.</p> <p>Observation on 09/09/24 at 9:34 AM. revealed the door to resident #71's room revealed he was on EHB. Interview at the time of the observation with Licensed Practical Nurse (LPN) #599 confirmed the resident was on contact precautions. He located a sign in the resident's closet that identified him as being on contact precautions and confirmed the sign should be on the exterior door of the resident's room.</p> <p>2. Review of the medical record for Resident #252 revealed an admitted [DATE]. Diagnoses included hypertension, kidney failure, muscle weakness and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #252 was severely cognitively impaired. She required supervision for oral and personal hygiene, set up help for eating and substantial assistance with toileting and showering. She was on oxygen.</p> <p>Review of the physician's orders for September 2024 revealed resident #252 was on four liters of oxygen continuously. The order began on 08/28/24.</p> <p>Observation on 09/09/24 at 9:29 A.M. revealed resident #252's oxygen tubing was lying on the floor. Interview at the time of the observation with State tested Nursing Assistant (STNA) #548 confirmed her oxygen tubing should be off the floor when not in use.</p> <p>3. Review of the medical record for Resident #254 revealed an admitted [DATE]. Diagnoses included anxiety, kidney disease, intestinal obstruction, stomach inflammation, constipation and neuromuscular dysfunction of bladder.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #254 was cognitively intact. She required supervision for oral and personal hygiene, set up help for eating and substantial assistance with toileting, showering and dressing. She had an ostomy.</p> <p>Review of the care plan dated 09/03/24 revealed Resident #254 had an ostomy. Interventions included keeping the ostomy site clean, free from infection, emptying the device as needed. and providing ostomy care every shift.</p> <p>Review of the physician's orders for September 2024 revealed an order to keep the ostomy tubing straight to drain, keep below the level of the bladder, check placement and function and keep the urinary drain bag covered which began on 09/06/24.</p> <p>Observation on 09/09/24 at 9:49 A.M. revealed Resident #254 was lying in her bed. Her ostomy bag was laying on the floor, uncovered. Resident #254 revealed there was a black bag attached to her bed where the ostomy bag should have been. Interview at the time of the observation with LPN #599 confirmed the ostomy bag should be hanging in the black bag and should not be on the floor.</p> <p>4. Review of medical record for Resident #24 revealed an admitted [DATE]. Medical diagnoses included pneumonia, acute on chronic combined systolic congestive and diastolic heart failure, unspecified atrial fibrillation, dysphaia oropharyngeal phase, hyperkalemia, essential primary hypertension, elevated white blood cell count, peripheral vascular disease, type two diabetes mellitus, acute respiratory failure, and disorder of the skin and subcutaneous tissue.</p> <p>Review of Medicare five-day MDS assessment dated [DATE] revealed Resident #24 had moderate cognitive impairment, required setup or cleanup assistance with eating and was dependent on staff for oral hygiene, toileting hygiene, shower and bathing, upper body dressing, lower body dressing, and putting on and taking off footwear. Resident #24 was always incontinent of bowel and bladder. Resident #24 had one stage three unhealed pressure ulcer.</p> <p>Review of care plan dated 10/08/15 revealed Resident #24 had an actual impairment to skin integrity. Further review of care plan revealed Resident #24 was in enhanced barrier precautions to prevent the spread of multidrug-resistant organisms (MDROs) related to wound care.</p> <p>Review of physician orders for Resident #24 revealed an order dated 07/24/24 for enhanced barrier precautions.</p> <p>Observation on 09/10/24 at 11:43 A.M. of incontinence care by STNA #543 and #646 revealed Resident #24 had an enhanced barrier precautions sign hanging under name on wall outside room stating gowns and gloves need to be worn during hands on care. STNA #543 and #646 washed hands, applied gloves and performed incontinence care for Resident #24. Once completed STNAs #646 and #543 removed gloves and washed hands. STNAs #543 and #646 were not observed wearing gowns during incontinence care.</p> <p>Interview on 09/10/24 at 12:00 P.M. with STNA #543 and #646 confirmed Resident #24 was in enhanced barrier precautions and did not wear a gown when they performed hands on care for Resident #24.</p> <p>Interview on 09/11/24 at 3:00 P.M. with the Director of Nursing (DON) confirmed Resident #24 was in enhanced barrier precautions due to an open wound on her coccyx and staff should wear gown and gloves when they provided hands on care.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Observation on 09/12/24 at 3:30 P.M. with Unit Manager #702 revealed she had washed hands, applied gloves and then started providing hands on care by turning resident to expose coccyx wound to evaluate area. Once done evaluating the wound Unit Manager #702 rolled Resident #24 back and assisted her into a comfortable position. During this observation Unit Manager #702 stated she had forgotten to put on a gown prior to hands on care.</p> <p>Review of facility policy Enhanced Barrier Precautions dated 04/01/24 revealed enhanced barrier precautions apply to all residents with any skin openings that required a dressing and/or other medical device regardless of MDRO colonization. Personal Protective Equipment (PPE) was to be used in situations during high-contact resident care activities such as providing hygiene, changing linen and changing briefs or assisting with toileting. PPE required included gloves and gown prior to high contact care activity.</p> <p>5. Review of medical record for Resident #62 revealed an admitted [DATE]. Medical diagnoses included urinary tract infection, chronic pain syndrome, cerebral infarction, essential primary hypertension, mixed hyperlipidemia, dysphagia, anxiety disorder, major depressive disorder, obsessive compulsive disorder, unspecified sequelae of cerebral infarction, flaccid hemiplegia affecting left non-dominant size, and Alzheimer's disease.</p> <p>Review of Resident #62's Quarterly MDS assessment revealed Resident #62 was cognitively impaired. Resident #62 required setup or clean up assistance with eating, partial to moderate assistance with oral hygiene, and was dependent on staff for toileting hygiene, shower/bathing, upper and lower body dressing, putting on and taking off footwear and personal hygiene. Resident #62 was always incontinent of bowel and bladder.</p> <p>Review of care plan dated 03/11/22 revealed Resident #62 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease, dementia and Resident #62 was resistive to care related to medication refusals.</p> <p>Observation on 09/10/24 at 9:45 A.M. revealed Resident #62 was observed laying in bed slumped and leaning towards the right holding a medicine cup filled with approximately five unknown pills. Resident #62 appeared to be struggling to put pills from the medicine cup into her mouth. No staff member observed in the room at that time.</p> <p>Interview and observation on 09/10/24 at 9:48 A.M. with LPN #601 confirmed she had left a cup full of medicine at Resident #62's bedside. During the interview Resident #62 spilled remaining pills in the bed. LPN #601 assisted Resident #62 at first by scooping the spilled pills with the empty medicine cup but then started to pick up spilled pills with bare hands and placed them in the medicine cup and proceeded to give the pills to Resident #62. Hand hygiene was not observed during this interaction.</p> <p>Interview with LPN #601 on 09/10/24 at 9:58 A.M. confirmed she had not performed hand hygiene before or put on gloves before picking up residents spilled pills and giving them back to Resident #62 to take</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the facilities' Infection Prevention and Control Plan revealed the facility would proactively prevent, identify report and investigate infections, initiate proper measures to limit the unprotected exposure to pathogens and implement infection prevention and control policies and protocols. The facility would also monitor for infection control practices pertaining to the residents, employees, visitors and the environment.</p> <p>Review of facility policy Handwashing/Hand Hygiene dated 08/19 revealed all personnel shall follow the handwashing and hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Alcohol-based hand rubs or alternatively soap and water is to be used before and after direct contact with residents, and before and after entering isolation precaution setting.</p> |

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| <p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review and interview the facility failed to ensure all residents were offered and received the influenza vaccine. This affected two residents (Residents #7 and #255) of five reviewed for vaccinations. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included heart disease, head injury, diabetes, hypertension, anxiety, kidney disease and overactive bladder. There was no documentation Resident #7 had been offered or refused the influenza vaccine.</p> <p>Review of Resident #7's immunization history revealed he last received an influenza vaccine on 10/28/22.</p> <p>Review of the influenza vaccine log for 2023 revealed Resident #7 consented to the influenza vaccine on 10/23/23 but never received it.</p> <p>Review of the medical record for Resident #255 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included heart disease, hypertension, depression, diabetes, hyperlipidemia, vitamin D deficiency and muscle weakness. There was no evidence Resident #255 had been offered or refused the influenza vaccine.</p> <p>Review of resident #255's immunization history revealed no evidence she had been offered an influenza vaccine.</p> <p>Review of the influenza vaccine log for 2023 revealed Resident #255 consented to the influenza vaccine on 10/23/23 but never received it.</p> <p>Interview on 09/12/24 at 1:23 P.M. with the Director of Nursing (DON) revealed Residents #7 and #255 both consented to the influenza vaccine but subsequently refused when the nurse went to administer it. She confirmed she had no evidence the resident's were offered and refused.</p> <p>Review of the facility policy titled Vaccination of Residents dated October 2019 revealed all residents would be offered vaccines that aided in the prevention of infectious disease unless the vaccine was medically contraindicated, and any refusals would be documented in the medical record.</p> |

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| <p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review and interview the facility failed to ensure all residents were offered the COVID-19 vaccine. This affected two residents (Residents #7 and #255) of five residents reviewed for vaccinations. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included heart disease, head injury, diabetes, hypertension, anxiety, kidney disease and overactive bladder.</p> <p>Review of Resident #7's immunization history revealed no evidence she had been offered a COVID-19 vaccine.</p> <p>Review of the medical record for Resident #255 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included heart disease, hypertension, depression, diabetes, hyperlipidemia, vitamin D deficiency and muscle weakness.</p> <p>Review of resident #255's immunization history revealed no evidence she had been offered a COVID-19 vaccine.</p> <p>Interview on 09/12/24 at 12:56 P.M. with the Director of Nursing (DON) revealed the facility had been asking residents if they wanted the COVID-19 vaccination but most residents declined and they did not document any declinations. She could provide no evidence Resident #7 and #255 had been offered the COVID-19 vaccination.</p> <p>Review of the facility policy titled Vaccination of Residents dated October 2019 revealed all residents would be offered vaccines that aided in the prevention of infectious disease unless the vaccine was medically contraindicated, and any refusals would be documented in the medical record.</p> | | |

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| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Keep all essential equipment working safely.</p> <p>47568</p> <p>Based on observation, interview and review of facility work orders the facility failed to ensure the facility kitchen had a working garbage disposal. This had the potential to affect 100 residents who received meals from the kitchen. The facility identified Residents #25 and #197 as not receiving meals from the kitchen. The facility census was 102.</p> <p>Findings include:</p> <p>Observation on 09/09/24 at 7:48 A.M. of the facility kitchen dish room revealed the table sink that led into the dishwasher did not have a garbage disposal or pipes connected at the bottom to catch food and water. Instead, there was a hole that opened under the table sink and there was a basin on the floor that was filled with brown water, food scraps and a mug. Kitchen staff were rinsing off the dirty dishes in the sink and water and food scraps fell from the sink into the basin on the floor.</p> <p>Follow up tour of the kitchen on 09/09/24 at 9:00 A.M. with Dietary Manager (DM) #576 revealed staff continued to use the table sink next to the dishwasher that did not have a garbage disposal.</p> <p>Review of facility work orders from 06/01/24 to 09/09/24 revealed there was no work order in the system regarding the kitchen garbage disposal.</p> <p>Interview on 09/09/24 at 3:06 P.M. with Maintenance Director (MD) #606 revealed the garbage disposal had not been functioning for about a month. MD #606 stated the garbage disposal had not been connected to the table sink for approximately a week and instead a basin that was placed under the sink for the time being that was catching water and food falling from the hole where the garbage disposal should be . MD #606 revealed they were unable to order a new garbage disposal due to the replacement parts would not fit on the current sink, so they were going to get quotes for a new table sink. MD #606 further stated that they were waiting on quotes.</p> <p>Interview on 09/11/24 at 4:35 P.M. with DM #576 confirmed they had been waiting for quotes to get a new table sink due to the garbage disposal not working and that it could not be replaced since the parts did not fit the sink they had.</p> | | |