

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER Cherith Care Center at Willow Brook		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Willow Brook Way, South Delaware, OH 43015	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on record review, interview and policy review the facility failed to include all required information on the skilled nursing advanced beneficiary notice (ABN). This deficient practice affected two (Resident #14 and Resident #238) of three residents reviewed for cut letters. The facility census was 40.</p> <p>Finding include:</p> <p>1. Review of the medical record for Resident #238 revealed an admission date of 02/16/2025. Diagnoses included dementia, difficulty walking, chronic kidney disease, adult failure to thrive, dementia, pressure ulcer of the sacral region, abnormal weight loss, encephalopathy, cognitive communication deficit, and Parkinson's disease.</p> <p>Review of the Skilled Nursing Facility ABN for Resident #238 revealed Beginning on (no date written), you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.</p> <p>Interview on 05/22/2025 at 2:25 P.M. with Social Worker (SW) #360 confirmed the missing date on the ABN form for Resident #238. SW#360 confirmed that the ABN form should be filled out completely when providing them to residents or their representatives.</p> <p>2. Review of medical record for Resident #14 revealed an admission date of 03/14/25. Diagnosis included hypertension, chronic obstructive pulmonary disease, chronic pain syndrome, muscle weakness, vascular dementia, difficulty walking, cognitive communication deficit, and dysphagia.</p> <p>Review of the Skilled Nursing Facility ABN for Resident #14 revealed Beginning on (no date written), you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The cares you have been receiving during the inpatient skilled nursing facility include: physical and occupational therapy.</p> <p>Further review of Resident #14's ABN revealed We estimate that these services will cost you \$ (left blank) per day/item or service.</p> <p>Interview on 05/22/2025 at 2:26 P.M. with Social Worker (SW) #360 confirmed the beginning on date and estimated service cost were not filled out on the ABN form for Resident #14. SW#360 confirmed that the ABN form should be filled out completely when providing them to residents or their representatives.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Advance Beneficiary Notices dated 2025 revealed, The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries and For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice Form.		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on record review, interview, observation and policy review the facility failed to ensure physician ordered wound treatments were in place to promote wound healing This affected one (Resident #9) of one residents reviewed for pressure ulcers. The facility census was 40.</p> <p>Finding include:</p> <p>Review of the medical record for Resident #9 revealed an admission date of 02/10/2018. Diagnoses included dementia, chronic kidney disease stage 2, cirrhosis of the liver, malignant neoplasm of the breast, urinary incontinence, Alzheimer's disease, anorexia, pressure ulcer of the sacral region, protein calorie malnutrition, and abnormal weight loss.</p> <p>Review of wound- weekly observation tool for Resident #9 dated 04/16/2025 revealed a suspected deep tissue injury (SDTI) (a localized area of discolored, intact skin or a blood-filled blister caused by damage to the underlying soft tissue, typically from pressure or sheer) on the resident's sacrum. Review of wound- weekly observation tool for Resident #9 dated 05/19/2025 revealed the continued presence of SDTI on the resident's sacrum.</p> <p>Review of orders for Resident #9 dated 05/05/2025 revealed to cleanse the sacrum with soap and water, pat dry apply zinc barrier cream and cover with foam dressing every three days and as needed.</p> <p>Review of the care plan dated 05/13/2025 revealed Resident #9 was at risk for skin break down with interventions including to cleanse the sacrum with soap and water, pat dry, apply zinc barrier cream and cover with foam dressing every three days and as needed.</p> <p>Review of the treatment administration record (TAR) revealed the treatment was last completed to the resident's sacrum on 05/15/25. There were no as needed treatments documented on the TAR.</p> <p>Observation on 05/21/2025 at 10:44 A.M. of incontinence care revealed the resident did not have a foam dressing to the sacrum as ordered. The dressing was not observed in bed with the resident and it was not observed to be removed during incontinence care. Interview with Certified Nursing Assistant (CNA) #367 on 05/21/2025 at 10:47 A.M. verified the foam dressing was not observed to the resident's sacrum or in the resident's bed and the dressing was not removed during incontinence care.</p> <p>Interview on 05/21/2025 at 2:53 P.M. with the Director of Nursing confirmed that the expectation is for staff to follow orders as written for wound treatments.</p> <p>Review of the facility, Wound Treatment Management dated 12/2025 revealed wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** Based on record review, interview, policy and facility assessment review the facility failed to prevent Resident #88 from exiting the facility unsupervised and failed to complete a comprehensive assessment and thorough investigation following the incident. This affected one resident (Resident #88) of three residents reviewed for accidents.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #88 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease, type 2 diabetes, atherosclerotic heart disease, hyperlipidemia, mood disorder, benign prostatic hyperplasia, history of transient ischemic accident, and traumatic subdural hemorrhage.</p> <p>Review of hospital records (prior to admission) dated 04/21/25 revealed the resident had Parkinson's Disease with increased forgetfulness which was concerning with dementia. The resident had been placed on delirium precautions in the hospital.</p> <p>The wandering risk assessment dated [DATE] revealed Resident #88 was at low risk for wandering.</p> <p>The fall risk assessment dated [DATE] revealed Resident #88 was at moderate risk for falls.</p> <p>Review of the plan of care for falls dated 04/25/25 revealed Resident #88 was at risk for falls with interventions to anticipate and meet the resident's needs, ensure call light was in place, and personal alarm to bed and chair.</p> <p>The resident did not have an elopement or wandering care plan.</p> <p>A communication note dated 04/27/25 at 9:20 P.M. authored by Registered Nurse (RN) #392 revealed Resident #88's wife was informed that staff could not get Resident #88 to stay in bed or in his room (due to it being bedtime). Resident #88 was wandering in the halls and into other resident rooms. Resident #88's wife talked to Resident #88 on the phone and then stated she would come to the facility and stay with Resident #88 until he fell asleep. Record review revealed no new wandering/elopement risk assessment was completed at this time and no elopement or wandering care plan was implemented .</p> <p>Review of the facility incident log dated 04/28/25 at 1:00 A.M. revealed Resident #88 had wandered off the unit and was found sitting in a grassy area outside of the main entrance. Resident #88 had a scraped right knee and an abrasion to the left lateral knee. Resident #88 was unable to make any meaningful statements regarding the event. One-on-one (supervision) was provided due to Resident #88 having confusion with behaviors. The resident was subsequently moved to the secured unit after the incident.</p> <p>An elopement investigation dated 04/28/25 at 1:00 A.M. authored by RN #392 revealed predisposing environmental factors included a fall alarm, poor lighting, confusion, impaired memory, and recent illness. There was no additional information regarding the resident's unsupervised exit of the facility including employee statements or a root cause analysis of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A behavior note dated 04/28/25 at 1:05 A.M. authored by RN #392 revealed a Certified Nursing Assistant (CNA) notified RN #392 that Resident #88 was not in his room. Each room, bathroom, utility room, and medication room were searched. The hallways and units on the assisted living facility were also searched. A CNA went outside and circled the building and found Resident #88 sitting in the grass near the main entrance. Resident #88 was assisted back to his room and his pajama bottoms were changed. Resident #88 was put in a wheelchair at the nurse's station for one-on-one and then moved to the facility secured unit.</p> <p>An interview on 05/21/25 at 10:26 A.M. with the Licensed Nursing Home Administrator (LNHA) revealed Resident #88 did not go out main entrance but went straight down the hall and out the assisted living entrance. The LNHA stated staff had seen Resident #88 right before he left the building. When staff discovered Resident #88 was not in the building, a CNA went outside to look for Resident #88 and found him in the grass near the building. The LNHA verified there were no statements from the staff, but the nurse stated Resident #88 was only gone a few minutes. The LNHA was unsure if the resident's bed alarm was sounding at the time of the incident to alert staff that Resident #88 had gotten out of bed. The LNHA revealed the exit door did not have an alarm at that time but one had been installed since Resident #88 eloped from the building.</p> <p>An interview on 05/22/25 at 11:15 A.M. with RN #392 revealed Resident #88 had wandered from the day he was admitted , but staff kept an eye on him (the RN did not clarify what she meant by wandering). RN #392 then stated five-minute checks were done to monitor Resident #88. RN #392 stated at the time of the elopement incident, the resident's bed alarm was not sounding. RN #392 stated as a result of the incident, Resident #88 sustained a wound to one knee. RN #392 stated she cleaned the wound and applied antibiotic ointment. RN #392 stated she did not measure the wound because it was the least of her worries.</p> <p>An interview on 05/21/25 at 12:05 P.M. with the LNHA revealed any investigation pertaining to the elopement and fall were not included as part of the resident's medical record.</p> <p>An interview on 05/21/25 at 12:10 P.M. with Resident #88's wife revealed Resident #88 wandered at home and had left their home several times. Resident #88's wife believed the facility was aware Resident #88 was at risk for wandering and elopement when he was admitted . Resident #88's wife revealed at the time of the incident on 04/28/25, she was told Resident #88 was found within minutes of leaving the facility.</p> <p>An interview on 05/22/25 at 1:17 P.M. with Certified Nursing Assistant (CNA) #376 revealed Resident #88 had been walking around and staff stayed near him unless they had to provide care for other residents. On 04/28/25 the CNA indicated staff had laid the resident down in bed right before he left as they then went to provide care to other residents. CNA #376 stated at the time of the elopement, Resident #88's bed alarm was not sounding. The CNA was aware the resident sustained a little scratch on his leg after falling outside.</p> <p>The facility Elopements and Wandering Residents policy revised 2025 defined wandering as a random or repetitive locomotion that may be goal-directed or non-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The facility was equipped with door locks/alarms to help avoid elopements. Alarms were not a replacement for necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The policy included the facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation, and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.</p> <p>The facility assessment dated [DATE] revealed the facility provides care and services based on the needs of residents which included behavioral health issues, pain and pain management.</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** Based on record review, review of standing orders, and interview, the facility failed to ensure the facility bowel protocol for constipation was followed for Resident #14 and Resident #24. This affected two (Resident #14 and #24) three reviewed for bowel and bladder. Facility census was 30.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #14 was admitted on [DATE] with diagnosis that included osteoarthritis, spinal stenosis, anxiety, major depressive disorder, type 2 diabetes, and chronic pain.</p> <p>A plan of care dated 03/18/25 revealed Resident #14 was a risk for constipation due to decreased mobility and medication use. Interventions included to follow facility bowel protocol for bowel management, milk of magnesia (laxative) as needed if no bowel movement in three days, monitor bowel movements every shift, and record bowel movement pattern each day.</p> <p>A significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #14 had cognitive impairment and was frequently incontinent of bowel and bladder. Resident #14 was dependent on staff for toileting.</p> <p>Review of the treatment administration record (TAR) revealed Resident #14 did not have a bowel movement from 05/07/25 through 05/11/25. The TAR did not reveal any as needed laxative medication being administered from 05/07/25 through 05/11/25. Review of the electronic documentation by Certified Nursing Assistants (CNA) revealed no documentation of a bowel movement from 05/07/25 through 05/11/25.</p> <p>Interview on 05/22/25 at 9:26 A.M. Registered Nurse (RN) #389 verified the documentation revealed Resident #14 did not have a bowel movement for five days and there was no documentation of the facility bowel protocol being followed. RN #389 stated bowel movements were documented on paper, in point of care by CNA's, and on the TAR by nurses. RN #389 verified there was not a system in place to make sure the bowel protocol was followed.</p> <p>Review of standing order set revealed Miralax (laxative) 17 grams to be administered daily for constipation persisting three days or more and bisacodyl (laxative) suppository twice a day until the resident had a bowel movement.</p> <p>2. Review of the medical record revealed Resident #24 was admitted on [DATE] with diagnoses that included major depressive disorder, chronic kidney disease, urinary retention, and anxiety disorder.</p> <p>A plan of care dated 06/30/23 revealed Resident #24 was at risk for constipation. Interventions included fleet enema rectally as needed for constipation, follow facility bowel protocol, glycolax powder every 12 hours as needed for constipation, milk of magnesia as needed for constipation, and Psyllium Husk (fiber) every 24 hours as needed.</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>A significant change MDS dated [DATE] revealed Resident #24 was cognitively intact. The MDS also revealed Resident #24 was always incontinent of bowel and bladder and was dependent on staff for toileting.</p> <p>Review of the TAR revealed Resident #24 did not have a bowel movement from 04/30/25 through the evening of 05/04/25. The TAR did not reveal any as needed laxative medication being administered from 04/30/25 through 05/04/25. Review of the electronic documentation by the CNA's revealed no documentation of a bowel movement from 04/30/25 through the evening of 05/04/25.</p> <p>Interview on 05/22/25 at 9:26 A.M. RN #389 verified the documentation revealed Resident #24 did not have a bowel movement for four days and there was no documentation of bowel protocol being followed. RN #389 stated bowel movements were documented on paper, in point of care by CNA's, and on the TAR by nurses. RN #389 verified there was not a system in place to make sure the bowel protocol was followed.</p> <p>Review of standing order set revealed Miralax (laxative) 17 grams to be administered daily for constipation persisting three days or more and bisacodyl (laxative) suppository twice a day until the resident had a bowel movement.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on review of the payroll based journal (PBJ), staff interviews and record review, the facility failed to ensure a Registered Nurse (RN) worked at least eight consecutive hours, seven days a week. This had the potential to affect all facility residents. Facility census 30.</p> <p>Findings include</p> <p>Review of the PBJ report from the review period of 10/01/24 to 12/31/24 revealed the facility triggered for no RN for at least eight hours a day, seven days per week.</p> <p>Review of the registered nurse schedule for October 2024 revealed on 10/05/24, 10/06/24, 10/19/24, and 10/20/24 the facility had no RN working in the nursing home.</p> <p>Review of the registered nurse schedule for November 2024 revealed on 11/02/24, 11/03/24, 11/16/24, 11/17/24 and 11/30/24 had no RN working in the nursing home.</p> <p>Review of the registered nurse schedule for December 2024 revealed on 12/01/24, 12/14/24, 12/15/24, and 12/29/24 the facility had no RN working in the nursing home.</p> <p>Interviews on 05/22/25 from 1:00 P.M. to 3:30 P.M. with the Administrator and Minimum Data Set (MDS) Nurse #389 confirmed the information provided for the PBJ report identified the facility did not always have an RN scheduled to provide care in the facility. They also confirmed the schedules had several days without RN coverage including four days in October and December and five days in November. The Administrator stated the facility had been using the RN that was working in the assisted living as the RN coverage.</p>		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a rationale was provided when a gradual dose reduction for psychotropic medications was contraindicated for Resident #24. This affected one (Resident #24) of five residents reviewed for unnecessary medications. Facility census was 30.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #24 was admitted on [DATE] with diagnoses that included major depressive disorder, chronic kidney disease, urinary retention, and anxiety disorder.</p> <p>Pharmacy recommendations dated 09/23/24 revealed Resident #24 had been receiving Zoloft (antidepressant) 100 milligram (mg) daily, mirtazapine (antidepressant) 7.5 mg daily, and hydroxyzine (antihistamine also used for anxiety) 25 mg daily without a gradual dose reduction (GDR). Pharmacy asked if a GDR could be attempted in order to be sure Resident #24 was using the minimum effective dose. If a GDR was not warranted, a statement needed to be included explaining why a GDR would be detrimental.</p> <p>The physician signed the recommendations on 09/30/24 and checked the box that a GDR was contraindicated but did not provide a statement why the GDR for Zoloft, mirtazapine, and hydroxyzine would be detrimental.</p> <p>An interview on 05/22/25 at 9:06 A.M. with the Director of Nursing (DON) verified the physician did not provide a rationale why a GDR was contraindicated for Resident #24's Zoloft, mirtazapine, and hydroxyzine.</p> <p>Review of the Medication Monitoring policy dated 10/01/18 revealed if the physician declines or otherwise rejects the consultant pharmacists recommendation, an explanation as to the rationale for the rejection shall be documented in the resident's medical record. If the physician fails to address a recommendation or document a rationale for rejecting a recommendation, the director of nursing will be notified and a summary shall be provided to the quality assurance and performance improvement (QAPI) committee on a periodic basis. The incomplete recommendation should be reviewed with the physician.</p>		

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<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** Based on record review, review of the incident and accident log, interview and policy review the facility failed to maintain complete and accurate medical records related to resident incidents. This affected one resident (Resident #14) of three residents reviewed for accidents. The facility census was 30.</p> <p>Findings include:</p> <p>Review of the medical revealed Resident #14 was admitted on [DATE] with diagnosis that included osteoarthritis, spinal stenosis, anxiety, major depressive disorder, type 2 diabetes, and chronic pain.</p> <p>Review of the incident and accident log revealed on 04/02/25 at 12:00 A.M. a Certified Nursing Assistant (CNA) reported Resident #14 was on the floor. Resident #14 was found sitting on the floor in front of her recliner. The CNA stated Resident #14 was sliding out of the recliner when the CNA attempted to reposition Resident #14 but Resident #14 slid out of the chair onto the floor. A new intervention for a non-slip material was to be placed in the recliner.</p> <p>The Committee Review of Incidents dated 04/02/25 revealed Resident #14 had a fall on 04/02/25 at 12:00 A. M. A Witnessed Fall form dated 04/02/25 that was privileged and confidential and not part of the medical record-do not copy revealed Resident #14 was confused, had gait imbalance, incontinent, and weakness/fainted. The box during transfer was marked.</p> <p>A nurse's note dated 04/04/25 at 3:11 A.M. revealed Resident #14 was status post fall without injury. Resident #14 had no pain at this time.</p> <p>Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #14 had cognitive impairment.</p> <p>An interview on 05/22/25 at 12:24 P.M. with the Director of Nursing (DON) verified accidents/falls were documented in incidents which was not part of the medical record. The DON verified there was not a nurse's note, vitals, assessment, investigation, or any follow up documentation about the fall Resident #14 had on 04/02/25.</p> <p>Review of the Fall Prevention Program policy revised April 2025 revealed when a resident experienced a fall, the facility will assess the resident, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, documented all assessments and actions, and obtain witness statements if applicable.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER Cherith Care Center at Willow Brook		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Willow Brook Way, South Delaware, OH 43015	
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 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>Based on record review, interview, and policy review the facility failed to obtain resident or resident representative consent and provide education prior to administration of the influenza vaccination. This affected three resident residents (Resident #9, #10 and #20) of five residents reviewed for vaccinations.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #9 revealed an admission date of 02/10/2018. Diagnoses included dementia, atherosclerotic hear disease of native coronary artery, chronic kidney disease stage 2, cirrhosis of the liver, malignant neoplasm of the breast, Alzheimer's disease, anorexia, dysphagia, pressure ulcer of the sacral region, protein calorie malnutrition, and abnormal weight loss.</p> <p>Review of Resident #9's influenza vaccination 2024 records revealed an inoculation date of 09/17/2024. Further review of the medical record revealed no influenza consent or vaccine information/education was provided</p> <p>Interview on 05/22/2025 at 11:50 A.M. with Minimum Data Set (MDS) Coordinator #389 confirmed the facility gave Resident #9 an influenza vaccination on 09/17/2024. MDS Coordinator #389 confirmed the facility failed to obtain a 2024 consent form for influenza vaccination and failed to document that Resident #9 received education regarding the influenza vaccination.</p> <p>2. Review of the medical record for Resident #10 revealed an admission date of 11/26/2021. Diagnoses included chronic pain syndrome, orthostatic hypotension, hypothyroidism, hyperlipidemia, repeated falls, major depressive disorder, protein calorie malnutrition, pneumonia, abnormal weight loss, weakness, acute respiratory failure with hypoxia, unspecified dementia, hypotension, cognitive communication deficit, and chronic obstructive pulmonary disease.</p> <p>Review of Resident #10's influenza vaccination 2024 records revealed an inoculation date of 09/25/2024. Further review of the medical record revealed no influenza consent or vaccine information/education was provided</p> <p>Interview on 05/22/2025 at 11:50 A.M. with Minimum Data Set (MDS) Coordinator #389 confirmed the facility gave Resident #10 an influenza vaccination on 09/25/2024. MDS Coordinator #389 confirmed the facility failed to obtain a 2024 consent form for influenza vaccination and failed to document that Resident #10 received education regarding the influenza vaccination.</p> <p>3. Review of the medical record for Resident #20 revealed an admission date of 08/17/2022. Diagnosis include unspecified dementia, type 2 diabetes, atherosclerosis of aorta, thrombocytopenia, hypertension, glaucoma, hypothyroidism, chronic obstructive pulmonary disease, repeated falls, seizures, adult failure to thrive, abnormal weight loss, hemiplegia and hemiparesis following cerebral infarction, contracture of right hand, contracture of left hand, atrial fibrillation, metabolic encephalopathy, pneumonitis due to inhalation of food, chronic kidney disease, chronic obstructive pulmonary disease, muscle weakness, and nontraumatic intracerebral hemorrhage.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER Cherith Care Center at Willow Brook		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Willow Brook Way, South Delaware, OH 43015	
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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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #20 influenza vaccination 2024 records revealed an inoculation date of 09/17/2024. Further review of the medical record revealed no influenza consent or vaccine information/education was provided</p> <p>Interview on 05/22/2025 at 11:50 A.M. with Minimum Data Set (MDS) Coordinator #389 confirmed the facility gave Resident #20 an influenza vaccination on 09/17/2024. MDS Coordinator #389 confirmed the facility failed to obtain a 2024 consent form for influenza vaccination and failed to document that Resident #20 received education regarding the influenza vaccination.</p> <p>Review of facility, Influenza Vaccination policy dated 05/19/24 revealed, Prior to the administration of the influenza vaccine, the person receiving the immunization, or his/her legal representative, will be provided a copy of CDC's current vaccine information statement relative to the influenza vaccination. Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individuals medical record.</p>		