STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apostolic Christian Home Inc	10680 Steiner Road Rittman, OH 44270

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, interview, and facility policy review, the facility failed to timely address a significant weight loss for one resident (#43) out of three residents reviewed for weight loss. The facility census was 70. Findings include: Record review for Resident #43 revealed an admitted [DATE]. Diagnosis included stiff man syndrome, abnormalities of gait and mobility, and lack of coordination. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #43 was moderately cognitively impaired. Resident #43 had no impairment to the upper or lower extremities, used a walker or wheelchair for mobility, and required set up or clean up assistance for meals. Resident #43 had no or unknown weight loss or gain. Review of the care plan dated 12/05/24 revealed Resident #43 had potential for altered nutrition. Interventions included to provide alternatives of similar nutritive value for oral intake <50% at meals and provide and serve nutritional supplements as ordered. Review of the physician orders for Resident #43 revealed orders included a regular diet, regular texture, and regular/thin consistency. An additional order included sherbet with lunch and supper dated 11/22/23. Review of Resident #43's Nutrition Quarterly assessment dated [DATE] at 11:53 A.M. completed by Dietitian #635 revealed Resident #43's weight was stable overall for the last six months. The goal would be weight maintenance between 160 and 170 pound range. Review of the facility weight record for Resident #43 revealed on 11/13/24 Resident #43's recorded weight was 166 pounds. On 02/12/25 Resident #43's recorded weight was 149 pounds (reflecting a 10.24 % weight loss). On 02/19/24, Resident #43 weighed 147 pounds, a loss of an additional two pounds. Review of Resident #43's record revealed Resident #43 had weekly weights recorded. Weekly weights obtained and recorded between 11/27/24 and 02/19/25 revealed a steady and consistent loss of body weight. Resident #43's record reflected no evidence the continued weight decline was monitored or addressed by the Dietitian or physician after 11/22/24 for further interventions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366248	A. Building B. Wing	02/20/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 11:54 A.M. with Licensed Practical Nurse (LPN) #509 confirmed Resident #43 had been eating less. Interview on 02/20/25 at 12:21 P.M. with Dietitian #635 confirmed she did not address Resident #43's weight loss after 11/22/24. Review of the policy Weight Committee revised 11/13/23 revealed the purpose of the weight committee is to identify and monitor current weight issues in the facility and recommend solutions using an interdisciplinary approach. Resident's recording unplanned weight loss or gain will be followed by the weight committee until weight is determined to be stable. Significant weight change would be defined as a loss or gain of 5% within a 30-day time frame, a loss or gain of 7.5% within a 90-day time frame, and/or a loss or gain of 10% within a 180-day time frame.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45442 Based on observation, interview, and review of facility policy, the facility failed to ensure the resident refrigerator was consistently monitored, failed to ensure food items were appropriately labeled, and failed to ensure food was discarded by the expiration date. This had the potential to affect 68 residents. The facility identified two residents (#29 and #30) who received nothing by mouth. The facility census was 70. Findings include: Observation on 02/19/25 at 1:50 P.M. of the resident refrigerator in the activity room (which was used to store residents' personal food items and containers) with Executive Chef #635 revealed the following: 1. An unlabeled and undated styrofoam container of soup with Resident #5's name on it. 2. An unlabeled and undated styrofoam container of soup with Resident #42's name on it. 3. A fast-food hamburger dated 01/23/25 with Resident #5's name on it. 4. An unlabeled and undated black container of leftover food for Resident #11. 5. An unlabeled and undated clear plastic container of what appeared to be soup for Resident #26. 6. A one-pound, clear plastic container of unlabeled liquid dated 10/26/24. 7. An unlabeled clear plastic container with an unidentified dessert dated 01/02/25. 8. A 36-ounce glass container of red-beet eggs with a use-by date of 11/24/24 for Resident #64. 9. A clear plastic container labeled beef broth with a date of 08/08/23 on the side of the container. At the time of observation Executive Chef #635 confirmed he was unaware there was a refrigerator for resident food in the facility and was unsure who was monitoring it. Executive Chef #635 confirmed the refrigerator should be monitored daily and the items should have been dated and labeled with the residents' name, open date, and use-by date. Review of the policy Food from Outside Sources revised 11/13/23 revealed the facility will provide safe and sanitary storage, handling and consumption of all food, including taking reasonable measures to ensure the same for food and beverages brought to residents by family and other visitors. The outside foods will include the resident name, resident room, common name of food, date of storage, the use by date and initials of the staff completing the storage label.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure coordination of care between Resident #59's hospice provider and the facility. This affected one resident (#59) of two residents reviewed for hospice care. The facility census was 70. Findings include: Review of the medical record for Resident #59 revealed an admitted [DATE]. Diagnosis included but not limited to degenerative disease of the nervous system, multiple fractures, and history of falling. Review of the physician orders revealed an order dated 01/01/25 for Resident #59 to be admitted to hospice care effective 01/01/25. Resident #59's diagnosis for hospice care was recorded as of cerebral atrophy. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #59 had intact cognition. Resident #59 required set up assistance for eating and oral hygiene tasks. Resident #59 was dependent on staff for all other activities of daily living (ADL). Review of the care plan dated 12/31/24 revealed Resident #59 had a terminal prognosis and received hospice services. Interventions included comfort will be maintained, administer medications as ordered, and work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. The care plan listed a company name and phone number to call with any changes or concerns. Interview on 02/19/25 at 11:56 A.M. with ADON #623 revealed she is the point person for the different hospice providers who provide care to facility residents. ADON #623 reported hospice binders are kept at the nurse's station and the hospice nurses and aides record visits in the hospice binder. ADON #623 reported all the hospice notes are kept in the binder. Observation on 02/19/25 at 11:56 A.M. with ADON #623 of the facility hospice binder for Resident #59 revealed there were no hospice notes in the binder for Resident #59. ADON #623 confirmed there were no documentation of hospice notes in the Hospice binder and there should be notes from every hospice visit to facility. ADON #623 was not sure how hospice left or provided their notes to facility staff. Interview on 02/19/25 at 12:11 P.M. ADON #623 revealed she contacted the Hospice RN #637 regarding the hospice notes and she reported Hospice RN #637 had never left notes from her visits with Resident #59 at the facility. ADON #623 reported ensuring hospice collaboration with facility staff is a task she will have to add to her list of things to complete or monitor moving forward. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/25 at 11:33 A.M. with Hospice RN #637 revealed she did not recall seeing any binder at the facility for the hospice notes. Hospice RN #637 reported Hospice LPN #634 was supposed to put electronic hospice notes in the binder during her visit to the facility. Hospice RN #637 reported she was not aware hospice notes were not being provided and she would be checking every time she is at the facility to make sure it is being done. Interview on 02/20/25 at 12:33 P.M. with DON revealed he wasn't sure how hospice worked and knows the facility has a binder, but ADON #637 takes care of it. Interview on 02/20/25 at 12:38 P.M. with Hospice LPN #638 revealed she brings the hospice electronic notes to the facility when she is scheduled. Hospice LPN #638 reported the last time she brought notes to the facility was around December 2024. Hospice LPN #638 estimated she only brought hospice electronic notes to the facility on ce every couple of months. Review of the facility policy, Hospice Services, revised 12/25/24 revealed the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure infection control practices were maintained during incontinence care for two residents (#16 and #20) of three residents reviewed for incontinence care. The facility identified 25 residents who were noted to be incontinent of bowel and/or bladder. The facility census was 70. Findings include: 1. Record review for Resident #20 revealed an admitted [DATE]. Diagnosis included obstructive and reflux uropathy and age-related physical debility. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 had an indwelling catheter, was dependent for personal hygiene, and was always incontinent of bowel. Review of the care plan dated 01/06/25 revealed Resident #20 had an alteration in bowel and bladder status related to bowel incontinence. Interventions included for staff to perform post-bowel incontinence care every two hours and as needed. Observation on 02/19/25 at 9:20 A.M. with Certified Nursing Assistant (CNA) #578 revealed she provided incontinence care after a bowel movement for Resident #20. After cleaning Resident #20, CNA #578 assisted in dressing Resident #20. CNA #578 did not remove her gloves or wash her hands after providing the incontinence care and before dressing Resident #20. CNA #578 then removed her gloves, did not wash her hands, and exited the room to obtain a sit-to-stand lift. CNA #578 returned with the lift, did not wash her hands, and transferred Resident #20 to the chair using the sit-to-stand lift. CNA #578 then put gloves on (still never washed her hands) left the room again, (continued observation) went to the linen closet, obtained a pillow case and returned to Resident #20's room. CNA #578 placed the soiled linen, towels, washcloths, and the soiled brief in the pillow case. CNA #578 removed the gloves, (still never washed her hands or used hand sanitizer) put Resident #20's shoes on, and assisted Resident #20 to the bathroom sink. Resident #20 began combing his own hair. Observation revealed CNA #578 then removed the sit to stand lift and placed it in room [ROOM NUMBER]. CNA #578 revealed she was going to get the resident in room [ROOM NUMBER] up next using the lift. CNA #578 then returned to Resident #20's room, (still never washed her hands or used hand sanitizer) took the pillowcase with the soiled linen and brief to the soiled linen room, put gloves on, removed the soiled brief from the pillow case, placed it in a bin, then placed the pillow case with the soiled linen in a separate bin. CNA #578 confirmed she never washed her hands from the time she initiated incontinence care with Resident #20 until after separating the soiled brief and linen in the soiled linen room. CNA #578 confirmed during that time she left Resident #20's room several times to obtain or return items without washing her hands. Continuous observation during the care confirmed CNA #578 also never used hand sanitizer. Interview on 02/19/25 at 1:41 P.M. with the Director of Nursing (DON) revealed hand washing should be completed before and after care. 43061 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnosis included but not limited to hemiplegia and hemiparesis following cerebral vascular disease affecting left dominant side, dementia, anxiety disorder, history of falling, and Alzheimer's disease, Review of the MDS quarterly assessment dated [DATE] revealed Resident #16 had severely impaired cognition. Review of the bladder and bowel revealed Resident #16 was always incontinent of bladder and bowel. Review of the Care Plan dated 12/10/24 revealed Resident #16 had alteration in bowel and actual alteration in bladder related to urinary incontinence, impaired cognition and impaired mobility. Interventions included clean peri-area with each incontinence episode per facility policy, medications as ordered, and post bowel incontinence care every two hours and as needed (PRN). Observation on 02/19/25 at 12:35 P.M. of incontinence care for Resident #16 revealed CNA # 507 and CNA #582 gathered supplies, provided privacy, washed hands in the bathroom, and applied gloves. CNA #582 removed Resident #16's brief soiled with medium amount of urine and small amount of stool. CNA #582 began to clean his buttocks area first with wipes. CNA #582 completed cleaning the bowel movement and the proceeded to provide peri care to the resident's front area, wearing the same gloves. CNA #582 was then observed to touch a moisturizer container with same gloves and handed container to CNA #507 who placed the container in Resident #16's drawer. CNA #582 then applied a new brief. Before exiting the room CNA #507 and #582 removed their soiled gloves and washed their hands. Interview on 02/19/25 at 12:44 P.M. with CNA #582 verified she provided incontinence care incorrectly and she did not change gloves and perform hand hygiene during the procedure. Interview on 02/19/25 at 12:48 P.M. with CNA #507 verified incontinence care was performed incorrectly by CNA #582, and she did not change her gloves, did not perform hand hygiene, and touched the moisturizer container with same gloves she had worn while cleansing Resident #16's buttocks and peri area. Interview on 02/19/25 at 1:33 P.M. with the DON revealed CNA #582 performed incontinence care incorrectly and did not maintain infection control. DON reported incontinence care should consist of cleansing the perineal area first, then the buttocks, and gloves should be changed and hand hygiene performed. Review of facility policy, Incontinence Care - Bladder and Bowel, revised 10/02/2002, revealed a resident who is incontinent of bladder and/or bowel will receive the appropriate treatment and services to restore as much normal bladder and bowel function as possible. Review of the facility policy titled, Infection Prevention and Control Program revised 02/06/24 revealed the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures. (continued on next page)

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Hand Hygiene for Healthcare Personnel, revised 01/23/24, revealed the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand hygiene is indicated and will be performed under the conditions listed in but not limited to the attached hand hygiene table to include after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when during resident care, moving from a contaminated body site to a clean body site, after assistance with personal body functions eg. Elimination, and after handling contaminated objects.