STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366253	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Manor	245 South Broadway New Philadelphia, OH 44663

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, review of personal funds records and interview, the facility failed to obtain appropriate witness signatures on the authorization for handling funds. This affected one (Resident #8) of five residents whose funds were reviewed. Findings include: During an interview on 01/21/25 at 4:11 P.M., Resident #8's granddaughter stated Resident #8 was a Medicaid recipient. The family received no resources for Resident #8 and had never been asked to sign a paper authorizing the facility to handle funds. To the best of the granddaughter's knowledge, Resident #8 did not have a personal funds account with the facility. Review of a list of resident funds handled by the facility revealed Resident #8 did have a personal funds account managed by the facility. Review of the authorization and agreement to handle resident funds indicated recurring social security benefit payments were to be direct deposited into the account with automatic transfer of care cost payments to the facility with Resident #8 receiving a $50.00 monthly allowance. The area for the resident signature had an infinity sign with two witness signatures with one of the signatures having a RN (Registered Nurse) behind the name. The Administrator also signed the form as a representative payee. The form was signed 09/03/24. Review of the quarterly statements indicated the statements were sent to Resident #8 at the facility's address. Review of Resident #8's medical record revealed diagnoses including Alzheimer's disease and vascular dementia. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was rarely/never able to understand others or to make herself understood. On 01/22/25 at 10:05 A.M., the Administrator stated the two witness signatures on Resident #8's authorization to handle her personal funds were the current Director of Nursing (DON) and the interim DON. The Administrator was unable to state who authorized the facility to handle funds but she signed the form because the facility was the rep payee. (continued on next page)

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

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/22/25 at 2:34 P.M., Revenue cycle field specialist #385 stated the facility applied as Resident #8's rep payee. Stated when the application is filled out the facility listed any other interested parties who might be interested in being rep payee. It was then up to social security to notify any interested person to act as rep payee. Sometimes if there was an issue with misuse of funds the Social Security office asked the facility to apply for rep payee. Revenue cycle field specialist #385 stated she did not know that was the case for this resident. If a resident was not alert and oriented the facility applied for rep payee. It did not matter who the financial Power of Attorney (POA) was. A financial POA was not accepted by social security. Revenue cycle field specialist #385 indicated it was her understanding the facility could use anybody associated with facility to witness authorization for funds as long as they do not handle funds. On 01/22/25 at 3:15 P.M., the Administrator provided a notice dated 08/30/24 from Social Security Administration indicating the facility was chosen to be Resident #8's representative payee. The notice was addressed to Resident #8. The Administrator stated Resident #8 was admitted with a rep payee and recalled talking to that rep payee (could not recall the name) who told the facility they needed to apply for rep payee. The Administrator stated Resident #8's responsible party would have knowledge of the personal funds account through the quarterly statements sent out. Upon reviewing the quarterly statement, the Administrator verified the statements were sent to the facility's address with Resident #8's name.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, record review and interview, the facility failed to maintain air temperatures at a comfortable level and failed to ensure floors and bathtubs were cleaned on the South unit. This affected all 22 residents (#2, #3, #5, #8, #9, #10, #11, #13, #15, #16, #17, #19, #20, #22, #24, #26, #28, #29, #31, #32, #238, and #240) who resided on the South unit. Findings Included: 1. Review of an email dated 07/31/24 at 2:35 P.M. revealed the Heating and Cooling company emailed the Administrator indicating the packaged terminal air conditioner (P-TAC) units needed to be replaced in the facility due to the fact that they were [AGE] years old and could not be repaired anymore. Review of an email dated 09/11/24 at 4:18 P.M. revealed the Administrator emailed the Heating and Cooling company to ask if once the electricity was completed they would have to switch over right away with the new P-TAC units or could they do the electricity and then wait to install the P-TAC units. Review of an email dated 09/16/24 at 10:48 A.M. revealed the Heating and Cooling company emailed the Administrator indicating they would need to make the switch on all P-TAC units at once if the electricity was upgraded at once due to the existing units were not able to function with the increased voltage. Review of an email dated 09/16/24 at 12:38 P.M. revealed the Administrator emailed the Heating and Cooling company indicating it was a huge expense and one they did not believe could be done at this time and what was the ability to do them one at a time. Review of the quote dated 09/17/24 revealed the facility needed 12 new P-TAC units for $18,000.00. Review of an email dated 12/17/24 at 12:52 P.M. revealed the Administrator emailed the Heating and Cooling company indicating she was following up for their visit a few months ago regarding re-doing the electrical for the South P-TAC units. The maintenance director was out on leave so to forward any communication to the Administrator. Review of an email dated 12/26/24 at 9:27 A.M. revealed the Heating and Cooling company emailed the Administrator revealed they were having trouble getting an electrician that had the capacity to do the work and she believed he had spoken to the Maintenance Director concerning this. He was inquiring if the facility had an electrician they had worked with and to please let him know. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an email dated 01/02/25 at 6:26 P.M. revealed the Administrator emailed the Director of Environmental Services #400 indicating she believed the facility was working with him on getting all the remaining P-TAC units switched over to the new units. The facility needed an electrical update in order to run the new units and would need someone to remove the old ones and install the new ones. The heating and cooling company stated they do not have an electrician to complete the work and asked if the company had an electrician they used. Also, the local heating and cooling company they use for repairs stated they could continue to keep servicing the units and the facility needed to replace them as soon as possible as there was no way to fix them every time they break because the parts were scare to none. The facility was currently using space heaters in most of the rooms on the South Unit as the boiler pilot light keeps going out and needed a new part which they were working on getting for them and the units in the rooms were individually breaking down on and off as well. Review of an email dated 01/20/25 at 11:43 A.M. revealed the Director of Environmental Services #400 emailed the Administrator and [NAME] President of Operations #410 to send the approved quote for the electrical upgrades for the P-TAC unit replacement project. There were 22 residents, Resident #2, #3, #5, #8, #9, #10, #11, #13, #15, #16, #17, #19, #20, #22, #24, #26, #28, #29, #31, #32, #238, and #240 who resided on the South unit who had the potential to be affected by the lack of functional heating units in the rooms on this unit. Observation during the initial tour on 01/21/25 at 8:50 A.M. revealed there was a small space heater in Resident #5 and #22's room plugged in and sitting on the floor. The air temperature felt cold in the room and bathroom. The bathroom was a shared bathroom with another resident room. An interview at the time of the observation with Resident #22 revealed the bathroom was always cold. On 01/21/25 at 8:57 A.M. an interview with Registered Nurse (RN) #364 verified Resident #5 and #22 had a space heater in their room due to their room being cold. Further observation during the initial tour on 01/21/25 at 9:05 A.M. revealed there was a small space heater sitting on top of the P-TAC unit in Resident #10 and #32's room. On 01/21/25 at 9:10 A.M. an interview with Registered Nurse #364 verified Resident #10 and #32 had a space heater in their room due to their room being. On 01/21/25 at 10:04 A.M. an interview with Resident #9 revealed her room was always cold because the heater was broken. Observation of room temperatures with the Director of Clinical Services #380 and the Life Safety Code surveyor on 01/21/25 at 11:00 A.M. revealed room temperatures as follows: * room [ROOM NUMBER] was 67 degrees Fahrenheit (F) and the bathroom was 61 degrees F * room [ROOM NUMBER] was 69 degrees F * room [ROOM NUMBER] was 69 degrees F and the bathroom was 67 degrees F * room [ROOM NUMBER] was 69 degrees F and the bathroom was 60 degrees with the door open and a space heater running (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* room [ROOM NUMBER] was 75 degrees F and the bathroom was 67 degrees F * room [ROOM NUMBER] was 69 degrees F and the bathroom was 60 degrees F with the door open and a space heater running * room [ROOM NUMBER] was 69 degrees F and the bathroom was 65 degrees F with the door open and a space heater running On 01/21/25 at 11:!1 A.M. an interview with the Administrator revealed there were 10 resident rooms on the South Unit that were still on the old boiler with P-TAC units. She stated those units have not been working properly. She stated some would work and some would not and when those units go out they would use portable space heaters to heat those rooms. The Administrator revealed this had been an going issue for about an month or two due to the cold (outside) temperatures. She stated they had received the approval to have the units replaced. She stated the heating and cooling company would come out and fix them but they were not able to get parts anymore so they all needed to be replaced. Observations of air temperature with Director of Clinical Services #380 on 01/21/25 at 2:20 P.M. revealed the bathroom temperature in room [ROOM NUMBER] and 112 was 53 degrees F. On 01/21/25 at 2:59 P.M. an interview with Resident #10 revealed her room was always cold and that was why she had a space heater in her room. On 01/21/25 at 4:30 P.M. an interview with Director of Clinical Services #380 revealed they had ordered eight large industrial portable heaters for use in the hallways. On 01/21/25 at 6:00 P.M. the portable heating units that were ordered were observed to be delivered. Review of the facility temperature log dated 01/21/25 at 6:00 P.M. revealed the room temperatures were: * room [ROOM NUMBER] was 65 degrees F and the bathroom was 56 degrees F * room [ROOM NUMBER] was 71 degrees F and the bathroom was 62 degrees F * room [ROOM NUMBER] was 65 degrees F and the bathroom was 53 degrees F * room [ROOM NUMBER] was 62 degrees F and the bathroom was 54 degrees F * room [ROOM NUMBER] was 69 degrees F and the bathroom was 53 degrees F * room [ROOM NUMBER] was 76 degrees F and the bathroom was 57 degrees F * room [ROOM NUMBER] was 68 degrees F and the bathroom was 55 degrees F * room [ROOM NUMBER] was 69 degrees F and the bathroom was 57 degrees F * room [ROOM NUMBER] was 65 degrees F and the bathroom was 55 degrees F (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* room [ROOM NUMBER] was 63 degrees F and the bathroom was 59 degrees F * room [ROOM NUMBER] was 62 degrees F and the bathroom was 55 degrees F * room [ROOM NUMBER] was 72 degrees F and the bathroom was 68 degrees F * room [ROOM NUMBER] was 69 degrees F and the bathroom was 55 degrees F * room [ROOM NUMBER] was 71 degrees F and the bathroom was 68 degrees F Observation of room temperatures with Housekeeping and Laundry Supervisor #346 on 01/22/25 at 8:27 A. M. revealed the temperature in room [ROOM NUMBER] was 69 degrees F and the bathroom was 55.8 degrees F. On 01/22/25 at 1:10 P.M. an interview with Director of Clinical Services #380 revealed they were still having issues with heating the bathrooms up to a comfortable temperature. She stated they were working with the heating and cooling company to put in vents in the ceilings in the bathrooms. On 01/22/5 at 6:15 A.M. an interview with Certified Nursing Assistant (CNA) #341 revealed several of the residents on the unit had complained about their rooms being cold and that was why they had the space heaters in their rooms. Review of the facility policy titled, Provisions for Temperature and Humidity Extremes, dated 01/16 revealed a comfortable temperature would be maintained in all resident areas within the home. The temperature range would be between 71 an 81 degrees F. The policy did not address what they would do for cold temperatures just temperatures over 81 degrees F. 2. Review of the October 2024 Resident Council Minutes revealed the residents complained about housekeeping and dirty rooms and hallways. Observations on 01/21/25 at 9:00 A.M. revealed the floor were heavily dirty with dirt and ice melt salt build up in the hallways on the South Unit, the Dining room and resident rooms. Interview during the Environmental tour on 01/22/5 at 10:29 AM with the Housekeeping and Laundry Supervisor #346 revealed she had one housekeeper and one laundry girl on staff and both were full time. She stated they do have a girl that would fill in sometime in the evenings and they would sometimes have a CNA who would pick up time but it had to be approved first. She stated she had been off sick and was only working four hours a day. She stated she knows the floors in the dining and resident rooms were dirty. She stated she just does not have the staff to get it all done. She stated they have hired two new housekeepers but she does not know when they were going to start. She verified the residents' floors in room [ROOM NUMBER], 104, 105, 106, 107, 108, 109, 111, 112, 114, and 116 were dirty. 22653 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 01/21/25 at 10:04 A.M., Resident #9 reported she was allergic to dust and had asked that her fan be cleaned for three days. The fan was noted with a thick layer of dust. The heating unit was also blowing with debris noted in the heater unit. The bathtub was brown with a rusty appearance and water backed up in the drain area. On 01/22/25 at 10:18 A.M., Housekeeper #372 verified there was standing water in the bathroom with part of inner surface of the tub having a brown discoloration between rooms in which Residents #8, #9, #29 and #240 resided. Housekeeper #372 stated she had discussed this with the Administrator and she was supposed to get someone to fix it. Housekeeper #372 stated no residents use the tubs in their rooms. Observations with Licensed Practical Nurse (LPN) #302 on 01/22/25 at 4:40 P.M. revealed Resident #9's fan had been cleaned. However, the vent of the heater still had debris. LPN #302 verified the debris in the heating unit and stated she would have to reach out to maintenance to determine if the heating unit could be cleaned. 4. On 01/21/25 at 9:19 A.M., observations of the bathroom between rooms [ROOM NUMBERS] revealed the bathtub had a brown/rusty appearance. There was a bucket with water on the floor partially under the toilet tank with a urinal marked with another resident's name (not a resident who resided in room [ROOM NUMBER] or 112) and two toilet brushes. On 01/21/25 at 9:19 A.M., Registered Nurse (RN) #364 verified the tub had a brown discoloration but stated she did not know who was responsible for cleaning the tubs. Upon addressing the sanitation of the urinal and toilet brushes stored in a bucket of water and the sanitation concerns, RN #364 provided no response. On 01/22/25 at 10:18 A.M., Housekeeper #372 stated she had attempted to scrub the tub between rooms [ROOM NUMBERS] without success. The tub would not come clean. This deficiency represents non-compliance investigated under Complaint Number OH00161357.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review and interviews, the facility failed to administer medications as ordered to Resident #5 and Resident #238. This affected two (Resident #5 and #238) out of six residents reviewed for medications. Facility census was 37. Findings include: 1. Review of the medical record revealed Resident #238 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes, severe morbid obesity, history of transient ischemic attack, and major depressive disorder. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #238 was cognitively intact. Review of physician orders revealed Resident #238 was ordered Lantus (insulin) 15 units at 6:00 A.M. and Lantus 50 units at 7:00 P.M. to 11:00 P.M. Resident #238 had an order from 06/25/24 for metformin (antidiabetic agent) 750 milligrams twice a day. No special instructions or parameters were in place for metformin or Lantus to be held. Review of the medication administration record (MAR) dated 01/12/25 for the 7:00 P.M. to 11:00 P.M. medication time revealed Resident #238's blood glucose was high. Lantus 50 units was not administered due to scheduled metformin. Resident #238's blood glucose was 238 milligrams per deciliter (mg/dl) on 01/12/25 at 9:00 P.M. Review of progress note dated 01/13/25 at 5:44 A.M. revealed Resident #238's blood glucose was 164 mg/dl. The nurse held Resident #238's scheduled Lantus due to Resident #238 had scheduled metformin that morning. Resident #238 became loud and was screaming for the nurse to administer Lantus. The nurse stated she was holding Lantus until day shift arrived and gave report. Review of the MAR revealed on 01/13/25 at 6:00 A.M. revealed Lantus 15 units was not administered to Resident #238 due to Resident #238's behaviors. Resident #238's blood glucose on 01/13/25 at 11:00 A.M. was 213 mg/dl. A concern form dated 01/13/25 revealed Resident #238 reported an agency nurse did not administer scheduled insulin on 01/12/25 and 01/13/25. The MAR was reviewed and revealed insulin was not administered as ordered per nursing judgement. Interview on 01/21/25 at 10:01 A.M. Resident #238 revealed an agency nurse did not administer insulin as ordered on two separate occasions. Interview on 01/23/25 at 8:53 A.M. Social Service Designee #311 revealed a concern form was completed when Resident #238 reported an agency nurse did not administer scheduled Lantus. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 11:12 A.M. Director of Nursing (DON) verified the agency nurse held Resident #238's Lantus on 01/12/25 and 01/13/25. DON stated the nurses were able to hold medications based on nursing judgement. DON verified there was not justification for Resident #238's Lantus to be held due to Resident #238's blood glucose levels and oral metformin being administered. 35765 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses chronic kidney disease, respiratory failure, diabetes, hyperlipidemia, hypothyroidism, anemia, atrial fibrillation, mood disorder, peptic ulcer disease, obstructive sleep apnea, stage 4 pressure ulcer, hypertension, insomnia, accidental discharge of firearms, lack of expected normal physiological development in childhood, and vitamin D deficiency. Review of the physicians order dated 10/23/24 revealed Resident #5 prefer to have morning medications by 9:30 A.M. and his evening medications by 6:15 P.M. per his preference. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #5 had intact cognition. Review of the January 2025 medication administration records revealed Resident #5 was not administered his evening medication on 01/16/25 due to he was sleeping. The medications not administered were Buspar 20 milligrams (mg), Colace 100 mg , Eliquis five mg, hydroxyzine 100 mg, metoprolol succinate 12.5 mg, protonix 40 mg, simvastatin 40 mg, and tagamet 400 mg. On 01/21/25 at 9:20 A.M. an interview with Resident #5 revealed the nurses do not give him his medication as ordered. He stated on 01/16/25 the second shift nurse never gave him his medications. He stated he was told they next day he had refused them and he stated he had not refuse them because the nurse never came into his room all night. On 01/22/25 at 2:40 P.M. an interview with Director of Clinical Services #380 revealed she would expect the nurse to go back and try to administer the medications again On 01/22/5 at 5:06 P.M. an interview with Director of Clinical Services #380 revealed the Director of Nursing had called the agency nurse who had not administered the medication to Resident #5 and she stated she had not went back and offered him his medication again Review of the concern log dated 01/17/25 revealed Resident #5 complained his treatment was not completed on 01/15/25 and 01/16/25 and he was not administered his medications at 6:00 P.M. on 01/16/25. Follow up investigation revealed medication were not given by an agency nurse due to the resident was sleeping. Nurse was reeducated.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and interview the facility failed to ensure weekly wound assessments were completed for Resident #5. This affected one resident (Resident #5) of three reviewed for pressure ulcers. Findings included: Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, respiratory failure, diabetes, anemia, atrial fibrillation, obstructive sleep apnea, stage 4 pressure ulcer, hypertension and accidental discharge of firearms. Review of the plan of care dated 04/03/24 and edited 01/01/25 revealed Resident #5 had a wound to the left posterior thigh. Interventions included the in-house skin/wound team would see and treat him weekly and as needed. Review of the physician's order dated 10/23/24 revealed Resident #5 was ordered one gram of gentamicin cream 0.1 percent twice a day to the left posterior thigh, cleanse with normal saline, apply the gentamicin cream to the wound bed cover with an abdominal dressing and do not use adhesive or tape. The order was discontinued on 12/12/24. His current treatment order was for gentamicin 0.1 percent apply to the left posterior thigh, Cleanse the thigh with normal saline, apply gentamicin cream to the wound bed, cover with collagen to the wound bed, and cover with a silicone border form every shift dated 12/26/24. Review of the plan of care dated 10/29/24 and edited on 01/16/25 revealed Resident #5 was high risk for pressure injury due to chronic wound due to non-compliance with treatment plan, turning and repositioning and care plan and medications. Review of the weekly skin assessment dated [DATE] revealed Resident #5 had a stage four pressure ulcer to the left posterior thigh which measured 10.5 centimeters (cm) in length by 2.5 cm in width by 0.1 cm in depth. The wound had a moderate amount of serosanguineous (clear, blood tinged) drainage. The wound was covered in 20 percent slough (yellow or white fibrous material in the wound bed). Review of the progress note dated 12/09/24 at 5:00 A.M. revealed the physician from the hospital called and stated the blood cultures for Resident #5 were positive and she should be transported to the hospital to receive intravenous antibiotics. The resident refused. (The resident was evaluated in the emergency room and had returned to the facility) Review of the progress note dated 12/09/24 at 8:34 A.M. revealed Resident #5 agreed to go to the hospital . Review of the progress note dated 12/09/24 at 2:41 P.M. revealed Resident #5 was admitted for bacteremia. Review of the progress notes dated 12/10/24 at 5:45 P.M. revealed Resident #5 was admitted back to the facility for a wound infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weekly skin assessments revealed there were no skin measurement or wound assessment for the week of 12/10/14. Review of the weekly skin assessment dated [DATE] revealed the left posterior thigh wound for Resident #5 measured 12 cm in length by 2.5 cm in width by 0.1 cm in depth. The wound had a moderate amount of serosanguineous drainage. The wound was covered in 30 percent slough. The wound had declined. Review of the progress note dated 12/17/24 at 1:21 P.M. revealed Resident #5 was seen by the wound Nurse Practitioner, following a readmittance from the hospital. The wound was worse. It was debrided revealing 100 percent granulation. The treatment was to remain the same with lotrisone cream to the peri wound and gentamicin to wound bed, cover with abdominal dressing, and paper tape to hold dressing in place. Resident is aware that wound was worse and of treatment. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #5 had intact cognition and had one Stage Four pressure ulcer that was there upon admission. On 01/22/25 at 4:05 P.M. an interview with the Director of Clinical Services #380 revealed there was no documentation Resident #5 refused to have the wound nurse assess his wound or they attempted to ask him later. On 01/22/25 at 4:39 P.M. an interview with Licensed Practical Nurse #302 revealed Resident #5 was very regimented and liked things done a specific way. She stated he refused to see the wound nurse if she was not at the facility at the time she said she would be here. She stated she does not remember if she went back and asked him if she could measure his wound. She verified she had not documented that he had refused and there was no assessment of his wound on 12/10/24. She also verified she could have looked at the wound on 12/11/24. On 01/22/25 at 5:30 P.M. an interview with the Director of Clinical Services #380 revealed Resident #5 had gone out to the hospital on 12/07/24 then returned on 12/08/24, back out to the hospital on 12/09/24 and returned on 12/10/24. She believed that was why his weekly skin assessment was not completed on 12/10/24. Review of the facility policy titled, Skin and Wound Care Best Practice, dated 11/05/24 revealed the purpose was to provide evidence based preventative skin care and wound treatment to prevent unavoidable skin complications.

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	366253	A. Building B. Wing	01/23/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review and interview the facility failed to ensure fall interventions were in place and appropriate for Resident #14. The facility also failed to ensure Resident #26's wheelchair was not locked when Resident #26 was left unattended. This affected two (Resident #14 and #26) out of five residents reviewed for accidents. The facility census was 37. Findings include: 1. Review of the medical record revealed Resident #14 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease, major depressive disorder, anxiety, manic episode, epilepsy, acute kidney failure, fibromyalgia, and irritable bowel syndrome. A progress note dated 11/22/24 at 8:45 P.M. revealed Resident #14 was found on the bathroom floor in front of the toilet. Care plan for falls revealed an intervention dated 11/26/24 revealed a motion sensor to be placed in the bathroom. A progress note dated 11/29/24 at 12:24 P.M. revealed Resident #14 was found in the bathroom. Review of the fall documentation revealed no evidence of the motion sensor being in place or sounding. A interdisciplinary team (IDT) note dated 12/02/24 at 10:26 A.M. revealed Resident #14 had a fall in the bathroom on 11/29/24. A new intervention for restorative nursing for toileting hygiene and transfers was put in place. Review of the restorative nursing documentation revealed Resident #14 received restorative services for transfers once and there was no documentation of toileting hygiene. A progress note dated 12/02/24 at 5:05 P.M. revealed Resident #14 was lying on the floor in the bathroom. Review of the care plan for falls revealed an intervention dated 12/04/24 was put in place for Resident #14 to receive restorative therapy for transfers and hygiene care and treatment. The care plan for falls revealed an intervention dated 12/05/24 for Resident #14 to have bladder pattern monitoring. An IDT note dated 12/08/24 at 5:18 P.M. revealed Resident #14 was found on the floor in the bathroom on 12/02/24 and all interventions were in place. A new intervention for Resident #14 to be started on a bladder training and pattern tracking was put in place. Review of the bladder tracking documentation from 12/08/24 through 01/01/25 revealed Resident #14 was incontinent of urine 27 times. A progress note dated 01/02/25 at 10:00 A.M. revealed Resident #14 was on the floor beside her bed. Resident #14 stated she was attempting to go to the bathroom. Review of the bowel and bladder assessment dated [DATE] revealed Resident #14 had no incontinence and no program was required due to Resident #14 was continent. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #14 had moderate cognitive impairment. The MDS also revealed Resident #14 was frequently incontinent of urine. Interview on 01/23/25 at 8:35 A.M. with the Director of Clinical Services #380 verified there was no evidence of the motion sensor being in place or functioning when Resident #14 fell in the bathroom on 11/29/24. The Director of Clinical Services #380 also verified the bladder tracking documentation revealed Resident #14 was incontinent of urine but a toileting program was not put in place. Interview on 01/23/25 at 12:41 P.M. with the Director of Nursing verified that restorative order for transfers and toileting hygiene for Resident #14 was entered wrong and the nursing staff did not know what restorative care to provide or document on. 2. Review of the medical record revealed Resident #26 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hepatic encephalopathy, traumatic brain injury, major depressive disorder, anxiety disorder, vascular dementia, visual hallucinations, and violent behavior. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had moderately impaired cognition. A progress note dated 10/30/24 at 1:49 P.M. revealed Resident #26 an unwitnessed fall in the dining room. Resident #26 was found sitting on the floor next to his wheelchair. Resident #26 stated the wheelchair was locked and he slipped out when he tried to turn. The post fall huddle revealed Resident #26 was trying to turn his wheelchair and his wheelchair was locked and Resident #26 tipped forward. Interview on 01/23/25 at 8:25 A.M. with the Director of Clinical Services #380 verified Resident #26 could not lock his wheelchair on his own and the wheelchair should not have been locked.

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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** 30809 Based on observation, medical record review, staff interview and facility policy the facility failed to ensure Resident #137 was provided fluids to maintain hydration. This affected one resident (Resident #137) of one residents reviewed for hydration. Findings include: Review of Resident #137's medical record revealed the resident was readmitted on [DATE] with diagnoses including congestive heart failure, respiratory failure with hypoxia, type 2 diabetes mellitus, protein-calorie malnutrition, diabetic retinopathy without macular edema, chronic kidney disease stage 4 (severe), non-rheumatic mitral (valve) insufficiency, myocardial infarction, cognitive communication deficit, anxiety, and hypokalemia, Resident #137's nutritional assessment dated [DATE] indicated Resident #137's calculated fluid need was between 1900 milliliters (ml) to 2100 ml per day. Review of Resident #137's fluid intake documentation dated 01/12/25 to 01/21/25 indicated Resident #137's daily intake of fluid was between 480 ml and 960 ml a day. Resident #137's laboratory results dated [DATE] indicated the potassium level was 5.5 milliequivalents per liter (mEq/L) and the blood urea nitrogen level was 51 milligrams per diluent (mg/dL) with a creatinine level of 2.9 mg/dL The normal range levels for the potassium was 3.5 mEq/L to 5.3 mEq/L, normal BUN level was 7 mg/dL to 15 mg/dL and normal creatinine level was between 0.6 mg/dL to 1.2 mg/dL Resident #137's plan of care initiated on 04/13/24 indicated Resident #137 had dehydration or potential fluid deficit related to medication therapy secondary to heart failure, malnutrition, variable oral intakes. The goal of the plan of care was Resident #137 would not exhibit signs of side effects of complications secondary to diuretic medication use. Interventions on the plan of care included: Assess/document/report to the physician/certified nurse practitioner as needed for signs and symptoms of dehydration; Encourage the resident to drink fluids of choice according to orders.; The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor through next review; Assess/report dehydration (dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucus membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance); Report abnormal labs indicative of dehydration (e.g., elevated hemoglobin and hematocrit potassium, chloride, sodium, albumin, transferring, blood urea nitrogen [BUN], or urine specific gravity > 1. 030); Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide education on the importance of fluid intake as per routine or as needed. An observation on 01/22/25 at 10:49 A.M. revealed Resident #137 was seated in a chair beside her bed and there was not a cup of water present in her room. Resident #137 stated she had a dry cough and complained her tongue was very dry. Resident #137 opened her mouth and her tongue was swollen and very dry. (continued on next page)

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	366253	A. Building B. Wing	01/23/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/22/25 at 12:05 with Certified Nursing Assistant (CNA) #348 stated water and ice was delivered to the residents three times a day. CNA #348 stated she did not have time to deliver the water to all the residents earlier in the day because she was assisting the staff on the other nursing unit. CNA #348 verified Resident #137 did not have water at her beside. CNA #348 stated she was assigned to provide care for Resident #137 and stated none of the residents assigned to her were at risk for dehydration. An interview on 01/22/25 at 12:09 P.M. with Resident #137 stated she had requested a cup of water and the staff had delivered a box of boost supplement and a small cup of water but had not delivered additional water for the day yet. An observation of Resident #137 on 01/22/5 at 2:26 P.M. revealed there was no cup of water or water pitcher delivered to Resident #137 in her room. An interview with Registered Dietitian (RD) #363 on 01/22/25 at 2:15 P.M. revealed she assessed the residents during her visits on Thursdays in the facility. RD #363 stated she determined the fluid intake of the residents by reviewing the fluid intake documentation in the resident's chart. RD #363 verified the documentation in Resident #137s medical record indicated Resident #137 was not meeting 75 percent (1, 425 ml) of her calculated fluid requirement (1900 ml to 2100 ml) to maintain adequate hydration. RD #363 verified Resident #137's lab results had worsened when compared to the last results obtained on 01/11/25. On 01/22/25 at 2:38 P.M. an interview with RD #363 verified Resident #137 did not have a pitcher/cup of water present in her room. Resident #137's Minimum Data Set (MDS) assessment dated [DATE] indicated she had mild cognitive impairment with a Brief Interview Mental Status assessment score of 13. Review of the facility policy titled Resident Hydration Policy revised on 06/22/20 indicated residents would be offered/administered sufficient fluid intake to maintain hydration. A Variety of fluids would be offered to residents, depending on preference and nutritional/diagnosis considerations. Procedure: A dietitian will evaluate resident fluid status within 14 days of admission, quarterly and as needed. This may include laboratory testing by the provider as ordered (chemistries, Beta Naturetic Peptide (monitors for congestive heart failure etc.) Fluids include water, juices, coffee/tea, gelatin, ice cream, soups, popsicles and any other substance which is essentially liquid in nature. Nursing staff will be primarily responsible for resident fluid intake during and between meals. Fluids may be provided by others determined by resident fluid and dietary orders (such as activities, dietary, visitors). Nursing, medical providers, and dieticians will monitor for signs of dehydration and will monitor resident medications which may alter fluid balance. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluids will be provided with meals, snacks, and at the bedside, unless otherwise ordered by the provider. If resident fluid status is identified as inadequate, the interdisciplinary team will discuss with the resident and provider and determine if alternative (non-oral) methods of hydration are desired/warranted.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, interview and policy review, the facility failed to ensure monthly drug regimen reviews identified irregularities in a resident's drug regimen and failed to ensure pharmacy recommendations were responded to in a timely manner. This affected two (Residents #17 and #26) of five residents reviewed for medication use. Findings include: 1. Review of Resident #17's medical record revealed diagnoses including Alzheimer's disease, malignant neoplasm of the esophagus, and chronic pain syndrome. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #17 had short and long term memory problems and severely impaired cognitive skills for daily decison making. a. Review of a monthly pharmacy review dated 06/03/24 indicated Resident #17 had orders for both acetaminophen 650 milligrams (mg) every 12 hours as necessary and hydrocodone/acetaminophen (narcotic pain medication) 5/325 mg every six hours as needed for pain. The pharmacy requested clarification of the parameters for drug selection, reserving the hydrocodone/acetaminophen for more severe pain only. The response at the bottom of the form indicated noted. No orders were clarified and there was nothing under the area for physician response indicating whether the physician accepted or declined the recommendation. On 01/23/25 at 2:36 P.M., Regional Director of Clinical Services #380 verified she could not locate evidence of the recommendation being addressed in June 2024. Both orders were discontinued 08/14/24. b. On 08/21/24, an order was written for ativan 1 mg to be administered every six hours as necessary. There was no time limit written on the order or a time frame in which the ativan use would be re-evaluated for continued use. The order was discontinued on 01/07/25. The order for ativan on an as necessary basis without a time limitation was not addressed by the pharmacist in accordance with recommendations provided. On 01/23/25 at 2:51 P.M. Regional Director of Clinical Services #380 acknowledged pharmacy should have addressed the use of the ativan ordered on an as necessary basis without a date limit. 34298 2. Review of the medical record revealed Resident #26 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hepatic encephalopathy, traumatic brain injury, major depressive disorder, anxiety disorder, epileptic seizures, alcoholic cirrhosis, vascular dementia, visual hallucinations, and violent behavior. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of pharmacy recommendation dated 06/12/24 revealed Resident #26 was ordered Oxycodone (opioid for moderate to severe pain) five milligram (mg) every eight hours as needed for pain. Oxycodone was the only as needed pain medication ordered. A recommendation was made for acetaminophen (for mild pain) 650 mg every six hours as needed for mild to moderate pain with maximum dose for all sources in a 24-hour period and a clarification for Oxycodone to be administered for severe pain. The pharmacy recommendation was not signed or marked as accepted or declined by the physician/prescriber. Review of the medication administration record (MAR) for June and July revealed a total dosage for acetaminophen was not put in place and indication for Oxycodone listed pain and not severe pain as indicated. b. A pharmacy recommendation dated 06/12/24 revealed Resident #26 was ordered Ativan (antianxiety) one mg as needed every four hours and hydroxyzine (antianxiety) 50 mg every eight hours as needed. A recommendation was made to discontinue one order or specifying parameters for drug selection. If both medications were continued it was recommended the prescriber document an assessment of risk verses benefit, indicating it continues to be a valid therapeutic intervention for Resident #26, and the facility ensures ongoing monitoring for effectiveness and potential adverse consequences. The pharmacy recommendation was declined by the facility physician due to medications were ordered by psychiatric doctor. c. A pharmacy recommendation dated 09/12/24 revealed Resident #26's mother asked for medication review because she felt Resident #26 was over medicated. Recommendations were made to decrease mirtazapine (antidepressant) from 45 mg daily to 30 mg daily and venlafaxine 75 mg three times a day to 75 mg twice a day. If clinically appropriate, a recommendation was also made to decrease Buspar (antianxiety) from 10 mg to five mg every 12 hours and decrease hydroxyzine from 25 mg three times a day to twice a day. The recommendation was declined by the facility physician on 09/18/24 without a rationale. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had moderately impaired cognition. The MDS also revealed Resident #26 received antianxiety and antidepressant medications. Plan of care revised 11/24/24 revealed Resident #26 used psychotropic medications. Interventions included to monitor/document/report signs and symptoms of depression, arrange for psychiatric consult/follow up as indicated, assess/record occurrence of behaviors, and administer medications as ordered Interview on 01/23/25 at 10:11 A.M. the Director of Clinical Services #380 verified the one pharmacy recommendation dated 06/12/24 was not signed by the physician, the parameters for the total daily dose of acetaminophen was not added, and the parameter for Oxycodone to be administered for severe pain was not added to the order. Director of Clinical Services #380 also verified an additional pharmacy recommendation dated 06/12/24 for Ativan and hydroxyzine was not addressed by psychiatric physician. Director of Clinical Services #380 verified the pharmacy recommendation on 09/12/24 was declined but a rationale was not provided. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Regimen Review (MRR) policy and procedure revised on 06/01/24 revealed the facility should encourage physician/prescriber to act upon the recommendations contained in the MRR. For those issues that require physician/prescriber intervention, the facility should encourage physician/prescriber to either accept and act upon the recommendations or reject all or some of the recommendations and provide an explanation as to why the recommendation was rejected.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, pharmacy recommendations, and interview, the facility failed to ensure as needed psychotropic drugs were limited to 14 days without a rationale for the order to be extended. This affected one (Resident #26) out of five residents reviewed for unnecessary medications. Facility census was 37. Findings include: Review of the medical record revealed Resident #26 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hepatic encephalopathy, traumatic brain injury, major depressive disorder, anxiety disorder, vascular dementia, visual hallucinations, and violent behavior. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had moderately impaired cognition. The MDS also revealed Resident #26 received antianxiety and antidepressant medications. The pharmacy recommendation dated 09/06/24 revealed Resident #26 was ordered Ativan (psychotropic/antianxiety) one milligram twice a day as needed. The pharmacy recommendation revealed as needed psychotropic medications were to be limited to 14 days unless the prescriber documented the diagnosed specific condition being treated, the rational for the extended time period, and the duration for the as needed order. The pharmacy recommendation was not signed by the physician, the physician did not accept or decline the recommendation, and the physician did not provide a rational for the as needed Ativan to be extended past 14 days. Review of the physician orders revealed Resident #26 was ordered Ativan from 09/06/24 until 10/02/24. Interview on 01/23/25 at 8:26 A.M. Director of Clinical Services #380 verified the pharmacy recommendation was not signed and a rational was not provided why the as needed Ativan was not limited to 14 days for Resident #26. The Medication Regimen Review (MRR) policy and procedure revised on 06/01/24 revealed the facility should encourage physician/prescriber to act upon the recommendations contained in the MRR. For those issues that require physician/prescriber intervention, the facility should encourage physician/prescriber to either accept and act upon the recommendations or reject all or some of the recommendations and provide an explanation as to why the recommendation was rejected.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based of observations, review of the medical record and interview the facility failed to ensure medications were not left at bedside for Resident #15. This affected one resident (Resident #15) of five residents reviewed for accidents. Findings included: Review of the medical records revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included diabetes, hypercholesterolemia, hyperkalemia, acute respiratory failure, hypertension , glaucoma, atrial fibrillation, heart failure, kidney disease, dementia, generalized anxiety disorder, retention of urine, and abnormal weight loss. Review of the January 2025 physician's orders revealed Resident #15 had an order for fluticasone propionate nasal spray 50 micrograms one spray each nostril daily. He did not have an order to leave medications at bedside or he could administer himself. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #15 had intact cognition. Observation on 01/21/25 at 8:50 A.M. revealed Resident #15 was in bed and he had a bottle of fluticasone propionate nasal spray on his over the bed table. On 01/21/25 at 8:57 A. M. an interview with Registered Nurse # 364 verified Resident #15 should not have any medication at bedside.

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	366253	A. Building B. Wing	01/23/2025

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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** 30809 Based on record review, observation, interview and policy review the facility failed to ensure staff performed hand hygiene to prevent possible cross contamination during Resident #7's medication administration. This affected one resident (Resident #7) of five observed for medication administration. The facility census was 37. Findings include: Resident #7 was admitted to the facility on [DATE] with diagnoses including focal traumatic brain injury, contracture, hypertension (high blood pressure), mild intellectual disabilities, hearing loss, dysphagia, oral phase , pain, dysphagia, and oropharyngeal phase. An observation on 01/22/25 at 8:32 A.M. of Registered Nurse (RN) #364 administer medications to Resident #7 revealed RN #364 failed to perform hand hygiene prior to obtaining Resident #7's medications and dispensing the medications in a medication cup. RN #364 obtained a medication cup by placing her index finger inside the medication cup. RN #364 then proceeded to walk to the nursing station and opened a drawer, touching various surfaces while looking for the key to open the refrigerator door lock. RN #364 then walked to the kitchen, touching the kitchen door handle and asked kitchen staff to provide the thickened water needed to administer the medications to Resident #7. A staff member obtained a box of thickened water and RN #364 opened the box and poured the thickened water in a cup for Resident #7 to drink and swallow his medications. The following medications were administered: - Acetaminophen two 500 milligrams (mg) tablets orally - aspirin 81 mg orally - Chlorhexidine gluconate 0.12% 15 milliliters (ml) swish and spit. - Fenofibrate 145 mg orally - Lisinopril 10 mg orally - Metoprolol Succinate extended release 100 mg orally - omeprazole 20 mg orally. On 01/22/25 at 8:45 A.M. after completing the medication administration to Resident #7, RN #364 verfiied she had not performed hand hygiene prior to administering the medications to Resident #7 and verified she she should have performed hand hygiene before dispensing Resident #7's medications due to touching multiple surfaces, including the nurses' station, kitchen door handle and thickened liquid box. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366253	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Manor	245 South Broadway New Philadelphia, OH 44663

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Hand Hygiene/Handwashing Policy revised 02/21/24 indicated hand hygiene is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient. - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. - Before moving from work on a soiled body site to a clean body site on the same patient. - After touching a patient or the patient's immediate environment. - After contact with blood, body fluids, or contaminated surfaces. - Immediately after glove removal. The facility policy titled General Dose Preparation and Medication Administration revised on 11/15/24 indicated prior to preparing or administering medications, authorized and competent facility staff should follow facility's infection control policy. Appropriate hand hygiene should be performed before and after direct resident contact.