STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366264	A. Building B. Wing	12/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brewster Convalescent Center	264 Mohican Street NE Brewster, OH 44613

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, staff interview, review of facility policy, and observation, the facility failed to update the physician on a change of condition for Resident #38. This affected one (Resident #38) of one resident reviewed for changes in conditions. The facility census was 55. Findings include: Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease and emphysema (a condition of the lungs that causes shortness of breath). Review of the care plan dated 04/03/23 for Resident #38 revealed she was at risk for altered respiratory status and difficulty breathing related to anxiety, chronic obstructive pulmonary disease, congestive heart failure and chronic respiratory failure. Interventions included to monitor for signs and symptoms of respiratory distress and report to the physician increased respirations, decreased pulse oximetry, restlessness, lethargy and confusion. Review of the physician's order for Resident #38 revealed an order for oxygen at two liters via nasal cannula continuously dated 07/15/24. Review of the treatment administration record for December 2024 for Resident #38 revealed nursing staff had been administering oxygen at two liters continuously and documenting her oxygen saturation at morning and bedtime. Review of the nursing progress notes for Resident #38 from 12/24/24 through 12/27/24, revealed on 12/24/24 at 4:56 A.M. Resident #38 appeared slightly lethargic when the nurse woke her for her morning medications. Resident #38 stated she was tired and oxygen saturation was checked which revealed it was 90-92 percent (%) on two liters nasal cannula. The nursing progress note dated 12/24/24 at 5:21 A.M. revealed oxygen had been increased to four liters nasal cannula. There was no indication the physician was updated related to increased need for oxygen. Observation with Registered Nurse (RN) #551 on 12/26/24 at 3:27 P.M. revealed Resident #38's oxygen concentrator was set to four liters. She verified Resident's #38's physician's orders were for two liters of oxygen continuously. RN #551 verified there was no written or verbal order for four liters of oxygen. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/26/24 at 3:53 P.M. with the Director of Nursing (DON) verified the physician was not updated on Resident #38's change of condition of lethargy, decreased oxygen saturation and need for increased oxygen. Review of the facility policy titled, Use of Oxygen, dated 05/01/16, revealed oxygen therapy must be prescribed by the resident's physician. The physician was responsible for identifying the type of therapy and the rate of oxygen based on oxygen saturation and respiratory assessment.

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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 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** 34297 Based on record review and interview, the facility failed to ensure interventions were implemented and monitored for Resident #33's trending weight loss. This finding affected one (Resident #33) of two residents reviewed for nutrition. Findings include: Review of Resident #33's medical record revealed the resident was readmitted on [DATE] with diagnoses including anxiety disorder, dementia in other diseases classified elsewhere and essential hypertension. Review of Resident #33's initial weight dated 07/29/24 revealed the resident weighed 187.2 pounds. Resident #33's weights revealed the resident weighed 196.6 pounds on 08/20/24, 183.9 pounds on 11/07/24 and 179.2 pounds on 12/04/24. Review of Resident #33's physician orders revealed an order dated 08/16/24 revealed a reduced carbohydrate diet, no added sodium with a regular texture, regular/thin consistency. There were no physician orders for nutritional supplements including the boost brought in by the resident's family members. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 exhibited severe cognitive impairment. Review of the quarterly Medical Nutrition Therapy form dated 11/05/24 revealed Resident #33 was on a reduced carbohydrate controlled diet with no added sodium, regular texture with thin liquids. The form indicated the resident received metformin as ordered and the oral intakes were greater than fifty-one percent at most per meals. The residents feeds himself after setup assistance. The weight was 183.9 pounds and has had a 3.3 pound weight loss since his initial admission weight of 187.2 pounds. No edema was noted. Review of Resident #33's nurse aide tracking from 11/28/24 to 12/26/24 revealed documentation the resident was offered the boost for weight loss on 11/29/24, 12/07/24, 12/08/24, 12/21/24, 12/22/24, and 12/25/24. The resident refused the boost supplement on 12/16/24, 12/18/24, 12/20/24 and 12/25/24. All other dates were blank or documented as not applicable. Review of Resident #33's medical record did not reveal evidence the resident's physician was notified of the resident's trending weight loss. Interview on 12/27/24 at 8:39 A.M. with Registered Dietitian (RD) #600 stated Resident #33's family brought in boost nutritional supplement from home for the resident's decreasing weight loss. RD #600 stated the resident's family supplied the boost and the facility offered and monitored the resident's boost intake. RD #600 confirmed Resident #33's medical record did not have specific orders for the implementation of the boost supplement for weight loss to determine how often or how much the resident should receive the boost supplement. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/27/24 at 9:02 A.M. with the Director of Nursing (DON) confirmed Resident #33's medical record did not have evidence the resident's boost was offered for a specific duration and stated the facility offered the boost when the resident requested the boost supplement. The DON confirmed the medical record did not have specific orders for the resident's boost as an intervention for the resident's trending weight loss. An additional interview on 12/27/24 at 2:58 P.M. with RD #600 revealed it was her understanding if Resident #33 consumed less than 50% of the meal offered, staff would grab a magic shake or boost and nurses would administer. She stated that was the facility policy and she confirmed the boost supplement was not a documented intervention for the resident's trending weight loss including physician notification and specific orders to implement the boost supplement. Review of the Significant Weight Loss policy dated 01/01/17 revealed the facility has the goal of medical nutrition therapy (MNT) to stabilize the weight, identify underlying causes or factors contributing to the significant unplanned weight loss, and intervene as appropriate to resolve the problem.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on interview, medical record review, and facility policy review, the facility failed to ensure pre-treatment and post-treatment monitoring was completed for a dialysis resident. This affected one (Resident #24) of two residents reviewed for dialysis. The facility census was 55. Findings include: Review of the medical record for Resident #24 revealed an admitted [DATE] and diagnoses including type two diabetes mellitus, diabetic chronic kidney disease, diabetic polyneuropathy, dependence on renal dialysis, acquired absence of left leg below knee, and stage four chronic kidney disease. Review of physician's order dated 09/26/24 revealed Resident #24 received dialysis treatments on Tuesdays, Thursdays, and Saturdays. Resident #24 has right sided tunneled internal jugular catheter dialysis site. The medical record revealed no evidence of monitoring of Resident #24's condition prior to or following dialysis treatments. Interview on 12/27/24 at 11:07 A.M. with Licensed Practical Nurse (LPN) #542 revealed Resident #24's blood pressure and weight were obtained at dialysis. Interview on 12/27/24 at 12:02 P.M. with Director of Nursing (DON) confirmed they do not assess Resident #24 prior to or returning from dialysis treatments. DON indicated pre and post weights were obtained as well as their blood pressure. Review of the facility policy titled Managing and Monitoring Residents Receiving Outpatient Hemodialysis dated 06/01/22 revealed residents' vitals, dialysis site, and fluid retention would be assessed prior to departing for dialysis treatment. Upon return, residents' vitals, dialysis site, and symptoms of complications would be assessed. Residents would also be weighed following dialysis treatment to compare to pre-dialysis weight.

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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** 34297 Based on observation, record review and interview, the facility failed to ensure appropriate hand washing or hand sanitization was completed prior to completing Residents #1 and #33's non-pressure wound care. This affected two (Residents #1 and #33) of two residents reviewed for general skin conditions. Findings include: 1. Review of Resident #1's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinson's disease without dyskinesia, Alzheimer's disease and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 exhibited severe cognitive impairment. Review of Resident #1's Weekly Wound Report form dated 12/17/24 revealed the resident had left buttock moisture associated skin damage (MASD)/shearing acquired 12/14/24. Review of Resident #1's physician orders revealed an order dated 12/17/24 to cleanse the open area on the left buttock with normal saline, pat dry, apply collagen moistened with normal saline to the wound bed and apply a dry dressing in the morning for wound care and as needed. Observation on 12/26/24 at 11:29 A.M. with Licensed Practical Nurse (LPN) #545 of Resident #1's left buttock wound care revealed the nurse sanitized her hands and put on gloves. Then the nurse removed the soiled dressing on the resident's left buttock, cleansed the wound with normal saline, applied the collagen and normal saline to the left buttock and placed a dry dressing on the left buttock wound. LPN #545 did not change her gloves during the treatment change. Interview on 12/26/24 at 12:47 P.M. with LPN #545 verified she did not change her gloves, wash her hands and putting on new gloves prior to completing the resident's wound care after she removed the soiled dressing. 2. Review of Resident #33's medical record revealed the resident was readmitted on [DATE] with diagnoses including anxiety disorder, dementia and essential hypertension. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 exhibited severe cognitive impairment. Review of the Weekly Wound Report dated 12/17/24 revealed Resident #33 acquired left buttock moisture associated skin damage (MASD)/shearing on the left buttock which measured 1.5 centimeters (cm) length by 1.2 cm width by 0.1 cm depth; right buttock MASD/shearing which measured 0.5 cm length by 0.5 cm width by less than 0.1 cm depth; and right buttock MASD/shearing which measured 0.5 cm length by 0.5 cm width by less than 0.1 cm depth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/26/24 at 12:40 P.M. with Licensed Practical Nurse (LPN) #545 of Resident #33's left buttock dressing revealed the resident was rolled into the common bathroom on the unit. The resident was assisted in a standing position, the nurse put on gloves and cleansed the resident's left and right buttocks with normal saline, applied the collagen and normal saline on the left and right buttocks and applied a dry dressing. LPN #545 did not wash her hands prior to putting on gloves. Interview on 12/26/24 at 12:47 P.M. with LPN #545 confirmed she did not wash or sanitize her hands prior to completing Resident #33's left buttock dressing. She stated she was nervous and that was why she forgot to disinfect her hands prior to completing the dressing. Review of the Wound Cleansing policy dated 05/01/16 indicated the procedure indicated to adhere to Standard Universal Infection Control Guidelines/Precautions, review physician orders, explain procedure to the resident, establish a clean field with all the supplies and equipment, remove tape by pushing skin from tape, remove soiled dressing, discard dressing and change gloves, decontaminate hands and don new gloves, clean a linear wound from top to bottom working outward, dress wound with appropriate dressings following the manufacturer's guidelines for use, and discard soiled supplies in the appropriate containers.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 34297 Based on record review and interview, the facility failed to ensure Residents #24 and #42's medical records have the appropriate documentation of the education provided regarding the risks and benefits of the influenza and pneumococcal vaccines. This affected two (Residents #24 and #42) of five residents reviewed for immunizations. Findings include: 1. Review of Resident #24's Consent/Declination of Pneumococcal, Influenza, and COVID-19 Vaccines form dated 11/14/23 revealed the resident did not wish to receive the pneumococcal vaccine, the influenza vaccine or the COVID-19 vaccine and/or booster. Review of Resident #24's medical record revealed the resident refused the pneumovax and the influenza immunization. The medical record did not reveal evidence the resident was educated on the risks and benefits of the pneumovax and influenza immunizations. Interview on 12/27/24 at 9:09 A.M. with Registered Nurse (RN) #538 confirmed Resident #42's medical record did not have evidence the education was provided regarding the risks and benefits of the influenza and pneumococcal vaccines. 2. Review of Resident #42's Consent/Declination of Pneumococcal, Influenza, and COVID-19 Vaccines form dated 10/05/21 revealed the resident did not wish to receive the pneumococcal vaccine the influenza vaccine or the COVID-19 vaccine and/or booster. Review of Resident #42's medical record revealed the resident refused the influenza and pneumovax vaccine. The medical record did not reveal evidence the resident was educated on the risks and benefits of the influenza and pneumovax vaccines. Interview on 12/27/24 at 9:09 A.M. with Registered Nurse (RN) #538 confirmed Resident #42's medical record did not have evidence the education was provided regarding the risks and benefits of the influenza and pneumococcal vaccines. Review of the Resident Influenza Immunization policy dated 11/05/18 revealed before offering the influenza immunization, each resident, or the resident's legal representative will receive education regarding the benefits and potential side effects of the immunization. The resident's medical record includes documentation that indicates, at a minimum, that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the influenza immunization. Review of the Pneumococcal of Residents Vaccine policy reviewed 01/01/17 revealed to provide the resident or responsible party with literature on the Pneumococcal vaccine (from the Centers for Disease Control or CDC).