STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366269	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyandot County Skilled Nursing and Rehabilitation	7830 N St Hwy 199 Rr2 Upper Sandusky, OH 43351

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568 Based on medical record review, interviews, and policy review, the facility failed to ensure advanced directives were accurate. This affected two (Resident #18 and Resident #32) out of three residents reviewed for advanced directives. The census was 64. Findings include: 1. Review of the medical record for Resident #18 revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, type two diabetes mellitus, and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 had a Brief Interview for Mental Status (BIMS) assessment score of 13, indicating intact cognitive function. Resident #18 was dependent for toileting hygiene, lower body dressing, putting on/taking off footwear, and personal hygiene. Review of Resident #18's facesheet revealed the advance directive was listed as full code. Review of Resident #18's care plan revealed Resident #18's code status was full code. The date initiated and date created for code status was 10/17/22. Review of the multi-disciplinary care conference form dated 01/23/24 revealed Resident #18 was listed as Do No Resuscitate-Comfort Care Arrest (DNR-CCA). Review of the multi-disciplinary care conference form dated 04/15/24 revealed Resident #18 was listed as DNR-CCA. Review of the multi-disciplinary care conference form dated 07/19/24 revealed Resident #18 was listed as full code. Review of the multi-disciplinary care conference form dated 10/11/24 revealed Resident #18 was listed as full code. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's hard medical chart revealed a DNR order form for Resident #18 signed by a physician on 01/18/24. Resident #18 was listed as DNR-CCA There was also a large green page in the front of the chart that said DNR-CC Arrest. Interview on 12/04/24 at 10:43 A.M. with Licensed Practical Nurse (LPN) #132 confirmed Resident 18's advance directive was DNR-CCA. LPN #132 revealed Resident #18's advance directive was not updated in the Point Click Care (PCC) system. Interview on 12/04/24 at 11:05 A.M. with the Director of Nursing (DON) revealed a staff member would look up a resident's advance directive in the hard chart and PCC. The DON confirmed that Resident #18's advance directive was incorrect in PCC and the advance directive should match in the hard chart, PCC, and care plan. The DON revealed Resident #18's code status was DNR-CCA. Review of the, Advance Directive, policy dated 01/03/18 stated, DNR orders will be honored per established protocols and documented in the resident's care plan. 34745 2. Review of medical record for Resident #20 revealed an admitted [DATE]. The resident was admitted with diagnoses including weakness, anemia, abnormal of gait and mobility, spinal stenosis, history of venous thrombosis and embolism. Review of the DNR form dated 04/06/24 revealed the Power of Attorney (POA) signed for the resident's code status to be DNR- Comfort Care (CC). Review of the face sheet for Resident #20 revealed a code status of DNR-CCA. Review of the care conferences for 06/12/24 and 09/12/24 revealed the code status was DNR-CCA. Interview with the DON on 12/05/24 2:00 PM. verified Resident #20's DNR form which was signed by the POA indicated the resident's code status to be DNR-CC, however PCC and care conferences both had the code status as DNR-CCA. The DON verified this was inaccurate information in both areas.

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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** 34745 2. Review of medical record for Resident #20 revealed an admitted [DATE]. The resident was admitted with diagnoses including weakness, anemia, spinal stenosis, and history of venous thrombosis and embolism. The MDS assessment dated [DATE] revealed Resident #20 had intact cognition. The resident was a substantial to maximal assist for mobility. Review of the care plan revealed goals and interventions in place for anticoagulant therapy. Interventions included, observe and inform resident of signs or symptoms of bleeding tell him to inform staff of any such symptoms: black tarry stools, abnormal bleeding, administer coumadin as ordered, obtain labs and other diagnostic tests as ordered and report results, and notify physician as condition warrants. A review of the progress notes dated 12/03/24 at 6:45 A.M. revealed a CNA came and got this nurse to check on the resident related to being unconscious on the toilet after being transferred to the toilet on the sit-to-stand. The resident's vital signs were a follows: blood pressure of 84 systolic 58 diastolic and the skin noted to be pale. When asked how he felt, the resident stated, I have had two migraines. When asked how he was feeling now, the resident stated sick. After finishing on the toilet, the resident was assisted back to bed and made comfortable, call light within reach. The note was absent of notification to the physician. A progress note dated 12/03/24 at 10:46 A.M., revealed at 9:00 A.M. the resident was alert and able to eat this morning 100% and took all his fluids. The nurse had held morning blood pressure medications due to low blood pressure this morning and due to the resident passing out on toilet. The resident was in bed throughout the morning and slept after breakfast. At 10:15 A.M. the blood pressure was 81 systolic 50 diastolic, oxygen (02) saturation was 82 percent (%) on room air (RA), and the resident had a pale color. Applied O2 at two liters saturations up to 84 %. Increased to three liters saturation up to 89% and 90%. He was weak and does agree to go to hospital. Updated his daughter she also agreed to have him sent. The Certified Nurse Practitioner (CNP) aware of spell this morning and now low blood pressure and low O2 saturation. Note order to send to emergency room (ER) for evaluation. 911 called. At 10:40 A.M. squad arrived . At 10:45 A.M., the resident was transported out to ER. Report called to ER. Review of the text message sent, which was given to the surveyor by the MDS Nurse #155, revealed the CNP was sent on 12/03/24 at 10:22 A.M. which included Resident #20 had another episode of passing out on toilet. The resident had a blood pressure of 85 systolic 58 diastolic and held morning blood pressure. The resident still week and blood pressure was now 81 systolic 50 diastolic shallow respirations O2 saturation 84%. Now up to 89%. The resident was alert and talking. Resident said he will go to hospital if needed. The resident is not getting enough fluids by mouth or food. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MDS Nurse #155 on 12/05/24 at 11:20 A.M. revealed the CNP was not notified of the change in condition with low blood pressure, unconsciousness, and blood pressure medication being held for Resident #20 at 6:00 A.M. until the 10:22 A.M. which at the time the CNP stated to send out to ER. 35031 Based on medical record review, staff interview, and policy review, the facility failed to ensure the physician was notified when two residents (#07 and #20) experienced a change of condition. This affected two (#07 and #20) of 18 residents reviewed for changes in condition. The facility census was 64. Findings include: 1. Review of the medical record of Resident #7 revealed an admitted [DATE]. Diagnoses include vascular dementia, glaucoma, and repeated falls. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively impaired and required substantial/maximal assistance with transfers. The assessment further indicated one fall with minor injury. Review of the progress note dated 07/20/24 at 8:44 A.M., documented by Licensed Practical Nurse (LPN) #132, revealed Certified Nurse Assistant (CNA) reported Resident #07 was not responding as per her norm during morning care. LPN #132 documented having assessed Resident #07 and noted audible wheezing. LPN #132 called to Resident #07 and received no response. Resident #07 responded with What when a sternal rub was performed. Resident #07 did not respond to requests of hand grasp or eye opening. Resident #07's pupils were round and sluggish to light. Blood pressure, oxygen saturation temperature, and pulse (vital signs) were all within normal limits. LPN #132 documented having called the responsible party and left a message, but not the physician. Review of a second note at 12:04 P.M., documented by LPN #132, revealed Resident #07 was awake and responded Ok but could not form coherent sentences. Vital signs were within normal limits and Resident #07 refused lunch. LPN #132 documented the responsible party had not returned a phone call at that time. Still no documentation of physician notification. Review of a third note at 7:34 P.M. documented by LPN #132 revealed Resident #07 was back to baseline, alert and speaking coherently. Interview on 12/04/24 at 1:29 P.M. with LPN #132 revealed she was uncertain whether she had notified the doctor about the change of cognition for Resident #07.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34745 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure accuracy of insulin injection by priming the insulin pen prior to dialing up dose of insulin. This resulted in a significant medication error. This affected one resident (#01) of two reviewed for medications pass. The census was 64. Findings include: Review of the physician orders for Resident #01 revealed an order dated 05/16/24 for Novolog flexPen relion subcutaneous solution pen-injector 100 unit per milliter (ml) (Insulin Aspart) to inject as per sliding scale: if 0 to 150 to give 0 units; 151 to 200 to give 2 units; 201 to 250 to give 4 units; 251 to 300 to give 6 units; 301 to 350 to give 8 units; 351 to 400 to give 10 units; 401 to 500 to give 15 units, subcutaneously three times a day. An order for NovoLOG flexpen relion subcutaneous solution pen-injector 100 unit per ml (Insulin Aspart) to Inject 15 unit subcutaneously three times a day. Observation of Licensed Practical Nurse (LPN) #132 revealed LPN #132 performed glucometer test for Resident #01, which was 158. The nurse then prepared the insulin injection. LPN #132 cleaned the Novolog flexpen with alcohol pad, then opened the needle and placed on flex pen. LPN #132 drew up 17 units of insulin. There was not a prime of two units into the needle. LPN #132 gave the resident the insulin in the left abdomen and held for the appropriate amount of time. Interview with LPN #132 on 12/04/24 at 8:13 A.M. verified the flexpen was not primed prior to dialing up the 17 units. Review of the policy dated 2021, Insulin Pen Policy, revealed it is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. To prime the the insulin pen, dial up two units by turning the dose selector clockwise, with the needle pointing up, push the plunger, and watch to see at least one drop of insulin appears on the tip of the needle. Then to set the insulin dose, turn the dose selector to ordered dose.

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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. 48568 Based on observation, interview, and policy review, the facility failed to maintain the ventilation hood system in a sanitary condition. This had the potential to affect all residents in the facility. The facility census was 64. Findings include: Observation on 12/04/24 at 9:43 A.M. revealed the metal louvres in the hood system were covered in a thick coat of dust and debris. The hood system is directly above the flat top grill, burners, steamer, and convection oven. Interview on 12/04/24 at 09:43 A.M. with Dietary Manager #119 confirmed the vents need to be cleaned. Review of the undated, General Sanitation of Kitchen, policy revealed the hood system is not part of the daily cleaning schedule.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 35031 Based on record review, staff interview, and policy review, the facility failed to self-identify any areas of opportunities for improvement for the first three quarters of 2024. This had the potential to effect all 64 residents residing in the facility. Findings include: Review of the Quality Assurance Performance Improvement (QAPI) Plan revealed the meeting was held on 01/17/24. The recent survey results were reviewed and plans to monitor for missing items, audit Pre-Admission Screening and Resident Review results, review audits of baseline care plans and comprehensive care plans, review fall audits, review catheter care audits, review diet audits, review oxygen audits, review persona protection equipment audits, review pneumonia vaccine audits, and review COVID 19 testing per Center for Disease Control guidelines. A new Performance Improvement Plan was started for wound care. The audit reviews were all based on the annual survey, exited 12/28/23. The QAPI meetings held on 04/23/24 and 07/30/24 were identical with no new areas. Review of the audits listed above revealed they were completed in the first four weeks of the year. Interview on 12/05/24 at 1:40 P.M. with the Administrator revealed no notes were recorded for the meetings. The Administrator stated the facility had not attempted to self-identify any opportunities for improvement for the first three quarters of 2024. The Administrator could not identify any true course of action taken to prevent the same concerns identified. Interview on 12/05/24 at 2:00 P.M. with Director of Nursing (DON) revealed the facility had not self-identified any opportunities of improvement and had simply attempted to improve on the citation issued at the last annual survey. Review of the policy titled, Quality Assurance Performance Improvement Plan revealed the facility will establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improve quality of care and services throughout the facility. The document is to be refined and revisited.