STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366297	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lima Convalescent Home	1650 Allentown Road Lima, OH 45805

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, and facility policy, the facility failed to ensure a resident's dignity was maintained. This affected one resident (#47) of one resident reviewed for dignity. The facility census was 66. Findings include: Review of the medical record for Resident #47 revealed she was admitted on [DATE] with diagnoses of hypertension and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #47 revealed she was cognitively intact and required supervision assistance for showering and personal hygiene. Review of the care plan revised 04/25 for Resident #47 revealed she was care planned for self-care deficit related to decreased activities of daily living (ADL), activity intolerance, and arthritis with interventions of one to two assist for care, ADLs, and monitor the five P's (pain, potty, position, proximity of items, and personal needs) during rounding Observation on 04/21/25 at 11:48 A.M. of Resident #47 revealed chin hair at least one quarter of an inch long, and along her chin (greater than 10 hairs.) Concurrent interview with Resident #47 stated the staff assist with removing her chin hair and Resident #47 then stated I don't want to look masculine, I want to look feminine. Observation on 04/22/25 08:47 A.M. of Resident #47 revealed she was sitting at the dining room table eating breakfast and the hair on her chin remained. Interview on 04/22/25 08:49 A.M. with Licensed Practical Nurse (LPN) #124 verified the presence of chin hairs on Resident #47. Review of the facility policy titled, Promoting/Maintaining Resident Dignity, dated 12/24 revealed it is the practice of the facility to protect and promote residents' rights and treat each resident with respect and dignity. Residents should be assisted to be groomed and dressed according to their preference.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, staff interviews, and facility policy, the facility failed to ensure care plans were accurate. This affected four (#8, #9, #26, #54) of 23 residents reviewed for care planning. The facility census was 66. Findings include: 1. Review of medical record for Resident #8 revealed admitted [DATE] with diagnoses including diabetes mellitus, dehydration, depression, non-pressure chronic ulcer of lower leg, and chronic osteomyelitis of her right ankle and foot. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she had intact cognition and required extensive one person assistance for bed mobility, transfers, limited assistance with toileting and supervision for eating. Record review revealed there was no plan of care for a pressure ulcer. Review of the 04/01/25 wound center documentation revealed a stage three pressure injury to her right heel. Interview on 04/24/25 at 9:43 A.M. with MDS Nurse #200 verified there was no pressure wound care plan. 2. Review of medical record for Resident #9 revealed admitted [DATE] with diagnoses including diabetes mellitus, stroke, depression and Parkinson's disease. The MDS dated [DATE] revealed she had impaired cognition and required extensive two-person assistance for bed mobility, transfers, toileting and supervision for eating. Record review revealed there was no plan of care for a pressure ulcer. A record review of the 02/24/25 wound note revealed a stage three pressure wound to the left gluteal fold. Interview on 04/24/25 at 9:43 A.M. with MDS Nurse #200 verified there was no pressure wound care plan. 3. Review of medical record for Resident #26 revealed admitted [DATE] with diagnoses including pulmonary hypertension, unspecified dementia without behaviors, peripheral vascular disease and chronic respiratory failure. The MDS dated [DATE] revealed she was cognitively intact and she required set up assistance for eating, dependent for toileting hygiene, substantial assistance for and maximum assistance for transfers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed there was no plan of care for a pressure ulcer. Review of the 03/12/25 podiatry notes revealed an unstageable wound to right second toe. Interview on 04/24/25 at 9:43 A.M. with MDS Nurse #200 verified there was no pressure wound care plan until 04/23/25 when the wound was discussed during survey. 4. Review of medical record for Resident #54 revealed admitted [DATE]. The resident was admitted with diagnoses including dementia. The MDS dated [DATE] revealed the resident had severe cognitive impairment. The resident was on hospice. Review of the physician's orders revealed the resident was admitted to hospice with diagnosis of senile degeneration of the brain. Review of the care plan revealed no goals or interventions in place for hospice. Interview with MDS #200 on 04/24/25 at 10:22 P.M. verified Resident #54 did not have a care plan for hospice. Review of the facility policy, Comprehensive Care Plans, dated 02/10/25 documented it is the policy of the facility to develop and implement a comprehensive person centered care plan for each resident to meet that includes measurable objectives and time frames to meet the residents medical needs.

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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 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** 44076 Based on observations, record review, staff and resident interview, and facility policy the facility failed to follow physician orders for wound care. This affected one resident (#8) of three reviewed for wounds. The facility census was 66. Findings include: Review of medical record for Resident #8 revealed admitted [DATE] with diagnoses including diabetes mellitus, dehydration, depression, non-pressure chronic ulcer of lower leg, and chronic osteomyelitis of her right ankle and foot. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she had intact cognition and required extensive one person assistance for bed mobility, transfers, limited assistance with toileting and supervision for eating. Review of the physician orders revealed an order for left forearm to keep steri-strips (skin closure) in place until healed. Cover the wound with dressing (Island) once daily and discontinue when healed with a start date of 04/13/25. Observation on 04/22/25 at 12:54 P.M. with Licensed Practical Nurse (LPN) #124 of dressing change revealed the dressing on Resident #8's left forearm was dated 04/15/25. Interview on 04/22/25 with LPN #124 directly following wound care verified the left forearm dressing was dated 04/15/24 and was ordered to be changed daily. Further review of the physician orders revealed an order for bilateral compression pumps twice daily and every evening shift for circulation with a start date of 03/17/25. Observation and interview on 04/22/25 at 1:00 P.M. with both LPN #124 and Resident #124 revealed no bilateral compression pumps were present in the room, and each denied placement of the compression pumps. Review of the facility policy, Wound Treatment Management dated 02/03/25 documented wound treatments to be completed in accordance with physician orders, including the cleansing method, type of dressing and frequency if dressing change.

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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 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** 44076 Based on observations, staff interviews, record reviews, and facility policy, the facility failed to accurately assess wounds and failed to complete treatments as ordered. This affected one (Resident #8) of three residents reviewed for pressure ulcers. The facility census was 66. Findings include: Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including diabetes mellitus, dehydration, depression, non-pressure chronic ulcer of lower leg, and chronic osteomyelitis of her right ankle and foot. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had intact cognition and required extensive one person assistance for bed mobility, transfers, limited assistance with toileting, and supervision for eating. Review of the care plan revealed no current plan of care for a pressure wound. Review of the 03/01/25 skin and wound assessment revealed documentation of type of wound as other and measuring three centimeters (cm) in diameter, scab to the back of the right heel. Scab was intact with scant serous drainage. Review of the 03/04/25 After Visit Summary of the wound care center documented debridement of the right heel. There was no description of the wound, dressing orders were given with a follow up in four weeks. Review of the 03/29/25 skin and wound assessment revealed documentation of type of wound as other and measuring one cm by (x) one cm to right heel. Additional information described a small area from previous surgical procedure, with no drainage or pain. Review of the 04/06/25 skin and wound assessment revealed documentation of type of wound as other and measuring one centimeter (cm) by (x) one cm to right heel. Additional information described a small area from previous surgical procedure, with no drainage or pain. Review of the 04/12/25 skin and wound assessment revealed documentation of type of wound as other and measuring one centimeter (cm) by (x) one cm to right heel. Additional information described a small area from previous surgical procedure, with no drainage or pain. Interview on 04/23/25 at 2:37 P.M. with Wound Registered Nurse #201 revealed Resident #8 had chosen to go to an outside wound clinic for her wounds. She acknowledged the facility wound assessments did not accurately describe the type of heal wound. She acknowledged the current documentation from the wound clinic did not specify the description of the heel wound. WRN #201 acknowledged the facility should obtain information on the type of wound. (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 wound care center progress note which was obtained by the facility on 04/24/25, revealed Resident #8 was seen on 04/01/25 for a previous ulceration to the posterior aspect of the calcaneus previous wound which had healed. Physical exam revealed a stage three pressure ulcer measuring 0.4 cm x 0.7 cm x 1 cm on the posterior aspect of the calcareous with some slough (yellow/white accumulation of dead cells) and some debris around the margin which was removed and derided. Observation on 04/22/25 at 12:54 P.M. with Licensed Practical Nurse (LPN) #124 of dressing change revealed the dressing removed from Resident #8's right heel was dated 04/17/25. Observation of the dressing revealed an approximately two cm in diameter yellow/green drainage. Interview on 04/22/25 with LPN #124 directly following wound care verified the right heel dressing was dated 04/17/24 and was ordered to be changed three times weekly. Review of the progress note dated 04/22/25 revealed observation of yellowish green drainage on the old dressing to the right heel during the dressing change. Review of the physician orders revealed an order to apply collagen to right heel wound, moisten with normal saline and cover with silicone foam border dressing at bedtime every Tuesday, Thursday and Saturday for wound healing. Review of the facility policy, Wound Treatment Management, dated 02/03/25 documented wound treatments to be completed in accordance with physician orders, including the cleansing method, type of dressing and frequency if dressing change. Treatment changes will be based on the etiology of the wound. Pressure ulcers will be differentiated from non-pressure ulcers.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on resident interview, staff interview, review of the nursing schedule, and facility policy, the facility failed to ensure sufficient staffing to complete resident's activities of daily living. This affected one resident (#34) of 24 reviewed for sufficient staffing. The facility census was 66. Findings include: Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses of congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease (COPD), and cerebral vascular accident (CVA) (stroke). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #34 revealed she was cognitively intact and was dependent for showering. Review of the current physician orders for 04/25 for Resident #34 revealed she had ordered showers on Tuesday and Friday on night shift. Review of the care plan revised 02/25 for Resident #34 revealed she was care planned for self-care deficit related to decreased activities of daily living (ADL) function and activity intolerance with intervention for one to two assist with ADL care. Interview on 04/21/25 at 10:01 A.M. with Resident #34 stated she does not get her showers when the staffing is short. Resident #34 stated when there is only one Certified Nursing Assistant (CNA) to both houses (house pods each house had the capacity to hold 12 residents) the aides do not have time to give her a shower. Resident #34 stated her preference for showers was early in the morning to be done for the day. Review of the physician orders and shower schedule for Resident #34 revealed she should have had a shower on 04/11/25 and 04/18/25 on third shift. Review of the CNA documentation for showers for Resident #34 for the past 30 days revealed on 04/11/25 there was no documentation for Resident #34 getting her shower and on 04/18/25 the documentation indicated not applicable. Interview on 04/24/25 at 12:33 P.M. with the Director of Nursing (DON) verified no documentation to account for a shower for Resident #34 for 04/11/25. The DON further stated if no documentation, then the shower was not completed. Further interview with the DON stated the documentation by the CNA on 04/19/25 at 1:19 A.M. verified the documentation showed the shower as not applicable and she would assume the CNA documented that to reflect the shower was not given. The DON further stated if the shower was refused by Resident #34 the CNA would have documented the refusal. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing schedule provided by the DON for 04/18/25 revealed one CNA called for third shift on 04/18/25 leaving one CNA to cover both of the houses that shift. Concurrent interview with the DON verified the nursing schedule for 04/18/25 that reflected one CNA assigned to both of the houses for that shift. Review of the facility assessment dated ,d+[DATE] revealed the facilities average daily census was 68 residents. The facility assessment also revealed bathing preferences: a shower schedule for routine showers is maintained at the facility and resident preferences are considered into the schedule. Further review of the facility assessment revealed staffing requirements for third shift are the facility needs five CNAs. Further review of the nursing schedule for 04/18/25 revealed for third shift there were four CNAs that worked and three nurses scheduled. Review of the facility policy titled, Resident Showers, dated 09/24 revealed is it the practice of the facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, and facility policy review, the facility failed to ensure food preparation and storage was maintained. This had the potential to affect all residents. The facility census was 66. Findings include: Observation during initial kitchen tour on 04/21/25 between 8:20 A.M. to 8:40 A.M. revealed the stand-up freezer had one bag of French fries and one bag of chicken that were opened, unsealed, unlabeled, and undated, the walk-in freezer had two stacks of boxes sitting on the floor of the freezer. The two stacks contained the following food: four boxes were [NAME] frozen cakes and one box of wild caught cod. Concurrent observation revealed [NAME] #201 who prepared and served breakfast was not wearing a hat or hairnet, or hairnet covering his full beard. Interview during initial tour with Assistant Dietary Manager (ADM) #197 verified the boxes on the floor in the walk-in freezer, [NAME] #197 not wearing hairnet, and the opened, unsealed, undated, and unlabeled food in the stand-up freezer. Observations on 04/22/25 between 11:55 A.M. to 12:20 P.M. during tray line revealed [NAME] #200 was serving tacos for lunch and while making the tacos the [NAME] #200 did not use any tongs to add the cheese, lettuce, tomato, or onion to the tacos, she used her gloved hand. Concurrent observations of [NAME] #200 revealed the cook prepared alternate menu options for resident's to include chicken tenders, hamburger, hotdog, and fish filet and during the serving did not use tongs to retrieve any of the items and used her gloved hand and did not change gloves or perform hand hygiene. Additional observations during tray line revealed Maintenance Worker (MW) #196 and Food Service Director (FSD) #224 of which both are males with full beards, entered the kitchen and walked all around the kitchen, including the tray line, during tray line without wearing hairnet covers on their full beards and MW #196 did not wear a hairnet or hat on his head. Interview on 04/22/25 at 12:20 P.M. following tray line with [NAME] #200 verified she did not use tongs for the toppings for the tacos, and verified she did not use tongs to grab a hamburger on three occasions, a hotdog, three chicken strips, and one filet of fish. [NAME] #200 verified she used her gloved hand that she had touched other surfaces with to include the fryer handle, spoon handle for the taco meats, the suction cup handle to retrieve the hot plates and the dishes. Review of the facility policy titled, Maintaining a Sanitary Tray Line, dated 07/24 revealed the facility prioritizes tray assembly to ensure foods are handled safely to prevent the spread of bacteria. During tray line assembly staff shall use utensils such as tongs, serving spoons to handle food as much as possible. Review of the facility policy titled, Date Marking for Food Safety, dated 04/25 revealed food shall be clearly marked to indicate date or day by which the food shall be consumed or discarded. Review of the facility policy titled, Food Safety Requirements, dated 01/25 revealed food will be stored, prepared, distributed, and served in accordance with professional standards for food service safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, review of facility Legionella control measures, and policy review, the facility failed to follow facility control measures for Legionella. This had to potential to affect all resident residing in the facility. Additionally, the facility failed to follow infection prevention procedures during wound care observation. This affected one resident (#8) of two residents observed for wound care dressing change. The facility census was 66. Findings include: 1. Review of the facility's Legionella control measures revealed the facility would obtain resident room water temperatures. Further review of the facility's control measures revealed no empty resident rooms or shower room water flushes if a room is unoccupied. Review of the facility's Legionella log revealed no water temperatures for the resident's rooms and no unoccupied rooms water flushing. Interview on 04/24/25 at 11:05 A.M. with Maintenance Director (MD) #185 stated he does not keep a log of empty resident rooms and does not flush empty resident rooms no matter how long the rooms are empty and verified he does not test residents water temperatures any longer. Concurrent interview with MD #185 revealed the facility does not have a Legionella policy other than the facility control measures. Review of the facility policy titled Infection Prevention and Control Program, revised 02/25 revealed a water management program has been established as part of the overall infection prevention and control program. Control measure and testing protocols are in place to address potential hazards associated with the facility's water systems. 44076 2. Review of medical record for Resident #8 revealed admitted [DATE] with diagnoses including diabetes mellitus, dehydration, depression, non-pressure chronic ulcer of lower leg, and chronic osteomyelitis of her right ankle and foot. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she had intact cognition and required extensive one person assistance for bed mobility, transfers, limited assistance with toileting and supervision for eating. Observation on 04/22/25 at 12:54 P.M. of Licensed Practical Nurse (LPN) #124 completing the dressing change to right heel revealed LPN #124 removed the stocking of right leg of Resident #8. LPN #124 proceeded to remove the dressing from her right heel. She then disposed of the dressing into the trash can. Without removing her gloves, LPN #124 retrieved a bottle of saline with her right hand and a four by four with her left. She placed she held the four by four in her left hand under the heel and used her right hand to pour the saline over the wound to wash it. She then put the saline bottle back onto the table and removed her gloves, without performing hand hygiene she put on a second set of gloves and proceeded to dress the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 04/22/25 at 1:07 P.M. directly following the dressing change, LPN #125 acknowledged she did not remove her gloves after removing the soiled dressing, and when she did remove her gloves after cleansing the wound she did not wash her hands prior to putting on another pair of gloves. Review of the facility policy, Clean Dressing Change, date 02/17/25 documented after removing the dressing to remove gloves, pulling inside out over the dressing, discard, wash hands and put on clean gloves.