

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Ohio Living Sarah Moore		STREET ADDRESS, CITY, STATE, ZIP CODE 26 North Union Street Delaware, OH 43015	

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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064</p> <p>Based on staff interview and record review, the facility failed to provide a resident her physician-ordered nutritional supplements routinely. This affected one resident (#30) of four residents reviewed for nutrition. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included dysphagia, chronic obstructive pulmonary disease, Alzheimer's disease, and protein-calorie malnutrition.</p> <p>Review of Resident #30's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood. The resident was not on any therapeutic diets.</p> <p>Review of Resident #30's physician order dated 02/15/24 revealed fortified ice cream nutritional supplement was to be given with lunch and dinner twice a day.</p> <p>Review of Resident #30's plan of care revised 03/26/24 revealed she was at nutrition and dehydration risk due to diagnoses, need of nutritional supplement, and mechanically altered diet. Interventions included offering the supplement the doctor ordered.</p> <p>Review of Resident #30's Medication Administration Record (MAR) for March 2024 revealed the fortified ice cream nutritional supplement was not administered 13 times due to the item being unavailable on the following days: once on 03/02/24, 03/03/24, 03/08/24, 03/13/24, 03/21/24, 03/22/24, 03/25/24, 03/30/24, and 03/31/24 and twice on 03/16/24 and 03/27/24. The MAR from 04/01/24 to 04/15/24 revealed the fortified ice cream was not administered five times due to the item being unavailable on the following days: once on 04/09/24, 04/13/24, and 04/14/24, and twice on 04/05/24.</p> <p>Review of Resident #30's progress note dated 03/01/24 to 04/15/24 revealed no notes related to the missing nutritional supplements.</p> <p>Interview on 04/16/24 at 3:32 P.M. with Diet Technician #301 verified Resident #30 had not been given her supplement as ordered. She reported the kitchen had run out of fortified ice cream nutritional supplement at times, but she was unsure how often. She reported when they ran out, the kitchen was substituting it with ice cream, yogurt, or pudding depending on diet texture. She reported the kitchen should have been notifying the nurse when doing this.</p> <p>(continued on next page)</p>

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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/17/24 at 10:22 A.M. with Director of Nutrition Services #207 revealed the fortified ice cream nutritional supplement was missing from one to two deliveries a month because of availability. Director of Nutrition Services #207 verified they substituted with ice cream, pudding, or yogurt depending on the diet texture and notified the nurses.</p> <p>Interview on 04/17/24 at 2:37 P.M. with the Director of Nursing (DON) verified that in Resident #30's medical record, there was no way to identify if Resident #30 got a nutritional supplement substitute or did not get anything from the kitchen. She reported the nursing staff was documenting it as unavailable because the supplement was not there and they were not aware of the item being substituted. The DON reported the kitchen had not communicated they were doing substitutions.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>41266</p> <p>Based on observations, review of menu, review of resident diets, review of recipes, staff interviews, and facility policy review, the facility failed to ensure pureed foods and mechanical soft foods were prepared in an appropriate consistency. This affect three residents (#14, 15, and 22) on a pureed diet and two residents (Residents #30 and #32) on a mechanical soft diet. The facility census was 45.</p> <p>Findings include:</p> <p>1. Review of the menu for the lunch meal on 04/17/24 revealed the planned meal was zucchini casserole or barbecue ribs with baked sweet potatoes, peas, and assorted cookies or sugar-free cookies.</p> <p>Review of the list of residents with current diet orders revealed Residents #14, #15, and #22 had an ordered pureed diet.</p> <p>Review of the pureed casserole recipe, undated, revealed the directions stated to measure freshly cooked/baked casserole portions drained of liquid. Puree well. Add liquid gradually to achieve appropriate consistency. Be sure it is pureed until completely smooth.</p> <p>Observations completed on 04/17/24 from 10:51 A.M. to 11:22 A.M. of pureed zucchini casserole preparation with Cook #273 revealed the regular food processor used for pureed foods was broken and Cook #273 would use a small blender to complete the task. Cook #273 added four scoops of zucchini casserole to a plastic container. There was a pitcher of chicken broth next to the blender. Cook #273 added two scoops of the casserole to the blender with four tablespoons of chicken broth to the blender and began blending. When Cook #273 felt the mixture was properly blended, she removed it from the blender with a clean spatula and placed into another container. At 11:05 A.M., an additional scoop of casserole with two tablespoons of broth were added to the blender. Once, blended, it was placed into the container. At 11:07 A. M., an additional scoop of casserole with two tablespoons of broth were added to the blender. Once blended, it was removed from the blender and placed into the container. The container was placed into the microwave to bring the pureed casserole up to an appropriate temperature. Once the casserole reached the needed temperature, Cook #273 used a clean spatula to pour the pureed casserole into a metal serving container to place into the steamer to keep warm until it was time to be plated.</p> <p>Interview on 04/17/24 at 11:22 A.M. with Cook #273, prior to placing the metal container of pureed casserole into the steamer, confirmed she felt the pureed casserole was an appropriate texture and was prepared to serve it to the residents for lunch meal. This surveyor requested to taste the pureed casserole. Upon observing the mixture in the metal container, there were visible chunks of zucchini and chicken seen. This surveyor tasted a spoonful of the mixture and a small chunk of zucchini was felt in the bite and visible on tongue. Cook #273 confirmed there was a chunk of zucchini. Cook #273 began using a clean spoon to mix up the pureed casserole and stated, I can see it, it is still chunky. I don't need to taste it. At that time, Cook #273 removed the metal container and confirmed the pureed casserole was not an appropriate texture to serve to residents and would need to be pureed again.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of the menu for the lunch meal on 04/17/24 revealed the planned meal was zucchini casserole or barbecue ribs with baked sweet potatoes, peas, and assorted cookies or sugar-free cookies.</p> <p>Review of the list of residents with current diet orders revealed Residents #30 and #32 had mechanically soft diets ordered.</p> <p>Review of the dietary spreadsheet revealed for a mechanically soft diet, residents should receive six ounces of zucchini casserole.</p> <p>Review of the chicken zucchini casserole recipe revealed ingredients included one six ounce package chicken stuffing mix, a half cup of melted butter, four medium diced zucchinis, three cooked and shredded boneless skinless chicken breasts, one can of cream of chicken soup, one half of a diced onion, and one half cup of sour cream.</p> <p>Observation on 04/17/24 at 12:55 P.M. of Resident #30 in the second floor dining room. Stated tested Nurse Aide (STNA) #214 was present sitting next to the resident. Observed the resident to have plate in front of her with zucchini casserole on it. Resident #30 took a bite of the casserole. The resident began coughing after swallowing the bite of the casserole. STNA #214 asked the resident if she wanted something easier to eat.</p> <p>Interview on 04/17/24 at 1:00 P.M. with STNA #214 confirmed there were visible chunks of zucchini in the casserole dish.</p> <p>Interview via telephone on 04/17/24 at 2:57 P.M. with Speech Language Pathologist (SLP) #400 revealed she was not familiar with the recipe for zucchini casserole. SLP #400 stated any meats or other items in the casserole should be chopped finely in order to be considered mechanical soft.</p> <p>Interview on 04/17/24 at 4:27 P.M. with Director of Dietary Services (DDS) #207 and Dietary Supervisor (DS) #249 confirmed a mechanical soft zucchini casserole had not been prepared for the lunch meal. DDS #207 and DS #249 confirmed the zucchini casserole served to Residents #30 and #32 had chunks of chicken and zucchini in it and was not at an appropriate texture for residents who had a mechanical soft diet order.</p> <p>Review of the facility's undated policy titled Mechanically Altered Diets, revealed mechanically altered diets shall be prepared and served as prescribed by the physician. Pureed: all residents with a physician's order for a pureed diet shall receive pureed, homogenous, and cohesive foods. Food shall be pudding-like. No coarse textures, raw fruits or vegetables, nuts, etc. are allowed. Any foods that require bolus formation, controlled manipulation, or mastication (chewing) are excluded.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41266</p> <p>Based on observations, staff interview, and facility policy review, the facility failed to follow proper handwashing and glove use during lunch meal service. This had the potential to affect all 45 residents in the facility who receive food from the kitchen. The facility did not have any residents with a physician ordered nothing by mouth (NPO) diet.</p> <p>Findings include:</p> <p>Observation of lunch meal service on 04/17/24 from 11:34 A.M. to 11:55 A.M. revealed Cook #273 completed food temperatures. After obtaining food temperatures, with bare hands, Cook #273 lifted the metal lid that was covering the zucchini casserole dish on the steam table. Cook #273 donned clean gloves. The cook did not wash her hands with soap and water before donning the clean gloves. At 11:43 A.M., Cook #273 unwrapped the tin foil from a baked sweet potato with gloved hands, then used her fingers to open up the sweet potato. Next, Cook #273 was observed touching the peas while plating them to keep them on the plate with the same gloves on. At 11:47 A.M., Cook #273 was observed completing the same tasks, unwrapping the tin foil, using same gloved fingers to open up the sweet potato, and then touching the peas to keep them on the plate while wearing the same gloves. At 11:48 A.M., Cook #273 was observed handling paper meal tickets with the same gloves on and then touched peas while plating them again with the same gloves on. At 11:52 A.M., Cook #273 removed her gloves, threw them in the trash can, and donned a new clean pair of gloves. The cook did not wash her hands with soap and water after removing the gloves and before donning the new clean gloves. At 11:54 A.M., Cook #273 was observed touching a towel that was hanging over the handle of the steamer with gloves on, then, handled a resident's cheeseburger to place on plate with the same gloves on.</p> <p>Interview on 04/17/24 at 4:27 P.M. with Director of Dietary Services (DDS) #207 and Dietary Supervisor (DS) #249 confirmed Cook #273 did not follow appropriate hand hygiene while completing lunch meal service. DDS #207 stated, I saw that too and I tried to intervene when I saw it. DDS #207 stated Cook #273 should have washed her hands before donning clean gloves and after she removed gloves. Also, DDS #207 stated Cook #273 should not have touched any food items directly, even with gloves on.</p> <p>Review of the facility's undated policy titled Disposable Gloves revealed disposable gloves shall be used for only one task and shall be discarded when damaged or soiled or when interruptions occur in operation. Hand washing must occur prior to putting on gloves and whenever gloves are changed or removed. Gloved hands are considered a food contact surface that can become contaminated or soiled. Disposable gloves need to be changed between tasks and as often as hands need to be washed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794</p> <p>Based on observations, record review, staff interview, review of the facility policy, and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to wear appropriate personal protective equipment and perform proper hand hygiene during care of a resident under transmission-based precautions. This had the potential to affect 27 residents (#1, #6, #8, #9, #16, #17, #18, #19, #20, #23, #25, #28, #30, #31, #33, #34, #90, #92, #93, #94, #95, #96, #240, #241, #242, #243, and #244) receiving care on the second-floor rehab unit and healthcare two. The facility census was 45.</p> <p>Findings include:</p> <p>Review of medical chart for Resident #91 revealed an admitted [DATE]. Diagnoses included enterocolitis due to Clostridioides difficile (C. diff). Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #91 had intact cognition. Resident #91 had bladder and bowel incontinence, and enterocolitis related to C. diff. Resident # 91 required moderate to complete assistance from staff for activities of daily living (ADLs) including toileting, dressing, and transferring.</p> <p>Review of laboratory results finalized on 03/29/24 revealed positive finding of C. diff for Resident #91. Review of Resident #91's progress note dated 03/29/24 revealed Resident #91 was positive for C. diff and that contact precautions were started and all departments were notified.</p> <p>Review of Resident #91's care plan dated 04/16/24 revealed diagnoses of C. diff with risk of complications related to C. diff, bowel incontinence related to loose stools, urinary incontinence related to physical weakness, potential for functional status deficit related to physical deconditioning, and risk for falls. Interventions included following the principles of infection control, placing resident in private room on contact precautions, assessing quality and consistency of diarrhea, avoiding unnecessary diagnostic or therapeutic procedures and devices, following the facility's policies and procedures when cleaning and disinfecting room, equipment and linens, using the least restrictive isolation, practicing good handwashing, having adequate personal protective equipment (PPE), and providing incontinent care.</p> <p>Review of Resident #91's progress notes 03/28/24 to 4/17/24 revealed the resident had loose stools indicating continued active C. diff on 03/28/24, 04/01/24, 04/02/24, 04/08/24, 04/10/24, 04/11/24, 04/13/24, 04/14/24, and 4/15/24.</p> <p>Observation on 04/17/24 at 9:20 A.M. revealed State tested Nursing Aide (STNA) #214 grabbed gloves and entered the room of Resident #91, without performing hand hygiene or donning a gown. STNA #214 exited the room of Resident #91 at 9:35 A.M., without personal protective equipment (PPE) on and placed bags with dirty linens and trash into their designated containers located outside of resident's room. STNA #214 performed hand hygiene using alcohol-based hand sanitizer after dispensing of bags.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 04/17/24 at 9:35 A.M. with STNA #214 confirmed STNA #214 provided care to Resident #91 with only gloves being worn in room. STNA #214 confirmed Resident #91 was on Contact Precautions and signage was posted on door. STNA #214 stated they thought only gloves were needed for care but was not sure and would need to double check. STNA #214 stated gloves, gown, mask, hair covers, and booties should be worn in a room requiring contact precautions. STNA #214 confirmed they were told to wash hands using soap and water but used hand sanitizer instead.</p> <p>Interview on 04/17/24 at 12:25 P.M. with Director of Nursing (DON) confirmed Resident #91 was on Contact Precautions due to C. diff .</p> <p>Interview on 04/17/24 at 12:26 P.M. with Licensed Practical Nurse (LPN) #279 confirmed Resident #91 was on contact precautions until testing comes back negative for C. diff . LPN #279 confirmed the resident has been on Contact Precautions the entire stay. LPN #279 stated they did not remember when their last training on transmission-based precautions was and identified the needed personal protective equipment for care of a resident in contact precautions is gown, gloves and face shield.</p> <p>Subsequent interview on 04/18/24 at 12:04 PM with the DON confirmed the expected personal protective equipment needed to provide care for a resident on contact precautions would be gown, and gloves and the expected order to donning PPE would be gown, then gloves. The DON confirmed the expectation would be for staff to use soap and water for hand hygiene after removing PPE.</p> <p>Review of the staffing assignments for 04/17/24 revealed STNA #214 was assigned to provide care and services to Residents #1, #6, #8, #9, #16, #17, #18, #19, #20, #23, #25, #28, #30, #31, #33, #34, #90, #91, #92, #93, #94, #95, #96, #240, #241, #242, #243, and #244.</p> <p>Review of facility's Infection Control- Contact Precautions policy, revised on 09/13/22, revealed residents with Clostridioides difficile (C. diff), formerly known as Clostridium difficile, should be in contact precautions for the duration of their illness. Contact precautions include using a private room or cohorting with a resident actively infected with the same organism, using gloves and gown when providing care, and completing hand hygiene prior to putting on gloves and after taking them off.</p> <p>Review of the CDC recommended steps to prevent the spread of C. diff in healthcare facilities, found at https://www.cdc.gov/cdiff/clinicians/faq.html#prevent included the use of gowns and gloves when providing care and the use of isolation with contact precautions.</p>		