

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>39333</p> <p>Based on record review and staff interview the facility failed to ensure residents personal funds accounts with balances greater than 100 dollars were deposited into an interest-bearing account as required. This affected four (Residents #33, #47, #55, and #69) of five residents reviewed for personal funds. The facility census was 91.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of the statement for Resident #33 revealed month ending account balance of \$154.15 for the month of May 2024, \$141.15 for the month of June 2024 and \$289.99 for the month of July 2024. No interest was noted credited to Resident #33's account during these three months. Review of the statement for Resident #47 revealed month ending account balance of \$1,285.30 for the month of May 2024, \$1,327.30 for the month of June 2024 and \$1,373.30 for the month of July 2024. No interest was noted credited to Resident #47's account during these three months. Review of the statement for Resident #55 revealed month ending account balance of \$11,990.95 for the month of May 2024, \$10,802.20 for the month of June 2024 and \$10,400.59 for the month of July 2024. No interest was noted credited to Resident #55's account during these three months. Review of the statement for Resident #69 revealed month ending account balance of \$129.84 for the month of May 2024, no interest was noted credited to Resident #55's account for the month of May 2024. Resident #69's account balances for June and July 2024 were under \$100.00. <p>Interview on 08/06/24 at 8:34 A.M. with Business Office Manager (BOM) #837 verified Residents #33, #47, #55 and #69 did not receive interest for the year of 2024. BOM #837 stated he completed an audit in January 2024, and it was discovered that the facility's original bank, which held the resident fund accounts, did not pay interest to the residents. He found out that the interest that was accrued on the resident fund monies was absorbed back to the bank because their fees were higher than the interest accrued. BOM #837 stated that a new bank account was opened, and social security checks started to be deposited on 04/01/24 and continued to be deposited. BOM #837 stated that he will give interest when all the accounts are transferred.</p> <p>Interview on 08/07/24 at 1:26 P.M. with Administrator revealed he was the former Business Office Manager before being promoted and he didn't notice that the residents were not getting interest.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>Based on record review and staff interview the facility failed to ensure resident funds were conveyed timely upon resident discharge from the facility. This affected one (Resident #242) of five residents reviewed for resident funds. The facility census was 91.</p> <p>Findings Include:</p> <p>Resident #242 was admitted to the facility on [DATE] and expired on [DATE].</p> <p>Review of the business records for Resident #242 revealed a check for \$2,169.85 was dispersed to the Treasurer of Ohio State on [DATE].</p> <p>Interview on [DATE] at 8:34 A.M. with Business Office Manager (BOM) #837 verified that Resident #242's funds were dispersed on [DATE] and Resident #242 expired on [DATE]. BOM #837 stated that he thought he had up to 90 days after the resident's death. BOM #837 stated that according to the Revised Ohio Code that the 90 days was because of an open application for release filed. BOM #837 could not provide documentation of any open application, and it was explained that the federal regulations are more stringent, and funds must be conveyed within 30 days.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure residents were provided a facility phone they could use timely and in a private area. This affected two residents (Resident #31 and #21) out of 20 residents reviewed for right to forms of communication with privacy. The facility census was 91.</p> <p>Findings include:</p> <p>1. Record review for Resident #31 revealed an admitted [DATE]. Diagnosis included chronic obstructive pulmonary disease.</p> <p>Review of the Admissions Minimum Data Set (MDS) 3.0 assessment for Resident #31 dated 05/08/24 revealed Resident #31 was cognitively intact. Resident #31 had clear speech, was able to make self-understood and was able to understand others.</p> <p>Interview on 08/08/24 at 9:11 A.M. with Social Worker Designee (SWD) #803 and SWD Assistant #841 revealed if a resident wanted to make a phone call, and they did not have a personal cell phone, they would have to be put on a phone call waiting list to make a call which would be done at the nurses station. The residents that get on the list wait until the nurses were not busy, then they can use the phone.</p> <p>Interview on 08/08/24 at 10:56 A.M. with Resident #31 revealed her personal cell phone was broken. Resident #31 revealed if she wanted to make a phone call, she had to fill out a form and then wait for the staff. Resident #31 revealed she made out two papers (forms) at two different times to use the phone. Resident #31 stated, That's what they told me, oh you got to make out a paper, they still have not let me use their phone. Resident #31 revealed she never gets to make a call in private.</p> <p>Interview on 08/08/24 at 10:58 A.M. with Licensed Practical Nurse (LPN) #920 and Unit Manager LPN #836 revealed when a resident wanted to make a call, they needed to fill out a form. Unit Manager LPN #836 revealed once the form is filled out, the nurse will make the call for them at the nurses station and the nurse must stay right there with them while the resident is on the phone. Unit Manager LPN #836 revealed there was a pay phone available for the residents to use if they had money. Unit Manager LPN #836 confirmed the pay phone was not in a private area and the residents would not be able to make a private phone call.</p> <p>Interview and observation on 08/08/24 at 11:05 A.M. with Activity Director #807 of the pay phone made available for resident use confirmed the pay phone was in a public area. Activity Director #807 confirmed the pay phone also did not work. Activity Director #807 confirmed if a resident wanted to make a phone call, and they did not have a personal cell phone, they would need to fill out a phone call request form and turn it into the nurses station. The nurses or State tested Nursing Assistant (STNA) would let the resident know when they had time to allow the resident to make their call.</p> <p>Record review of the Phone Call Request Form revised 03/2024 revealed the form to be completed included Resident name, date, Person you are requesting to call, day you would like to make the call, phone number, circle a time 8:00 A.M. - 12:00 P.M., 1:00 P.M. to 4:00 P.M., and 6:00 P.M. - 9:00 P.M.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review for Resident #21 revealed an admitted [DATE]. Diagnosis included metabolic encephalopathy.</p> <p>Review of the quarterly MDS 3.0 assessment for Resident #21 dated 06/28/24 revealed Resident #21 had moderate cognitive impairment. Resident #21's speech was clear, made self-understood and was able to understand others.</p> <p>Interview on 08/08/24 at 11:10 A.M. with Resident #21 revealed the staff refused to let her use the phone in the past telling her they need the phones for incoming calls. Resident #21 revealed the staff did not want residents using their phones.</p> <p>Interview on 08/08/24 at 11:15 A.M. with STNA #894 revealed she helped residents in the past to make phone calls. STNA #894 revealed the resident must first fill out a form then they have to wait until the STNA, or nurse had time to help them with the call. STNA #894 revealed the residents phone calls were made from the nurses station and staff had to stay with the resident during the call. STNA #894 revealed there was also a phone located at the end of the hall the resident could use but that phone was also not a private area.</p> <p>Interview on 08/08/24 at 11:18 A.M. with Registered Nurse (RN) #801 revealed when a resident wanted to use a facility phone, someone had to help them. The resident must fill out a paper first. RN #801 revealed the nurse would place the call from the nurses station then they could transfer the call to the phone in the hall. Observation of the phone located at the end of the hall revealed three residents sitting in the hall within hearing distance of the phone RN #801 referred to. RN #801 confirmed the phone in the hall would not allow outgoing calls, only incoming calls and confirmed the phone in the hall would not be a private phone call.</p> <p>Interview on 08/08/24 at 11:36 A.M. with Administrator confirmed the pay phone was currently not accepting coins. To allow opportunity for all residents to make outgoing calls, the facility created the phone call request form. The form was to be used if the payphone was unavailable or the resident did not have money. Once the form was filled out, it would be provided to the nurse, then at the nurses earliest available opportunity, the nurse would provide use of facility phone either at the nurses station or transfer the call to the hall phone. Administrator confirmed the hall phone would not allow outgoing calls. Administrator confirmed the residents have the right to make a call in privacy, and it would be either at the nurses station or in the hall.</p> <p>Interview on 08/08/24 at 1:03 P.M. with DON revealed residents have the right to use a phone in privacy and at the time of request.</p> <p>Review of the facility policy titled, Telephones, Resident Use of undated revealed Residents shall have easy access to telephones. Designated telephones are available to residents to make and receive private phone calls. The telephones at the nurses stations are reserved for staff use, unless no other alternative is available.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>Based on medical record review, review of a fall incident report and related facility investigation, interviews with staff and review of facility policy, the facility failed to timely notify Resident #41's primary care physician of a fall. This affected one (Resident #41) of two residents reviewed for accidents/hazards. The facility census was 91.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including schizophrenia, sarcoidosis, epilepsy, legal blindness, cachexia, muscle weakness, unspecified abnormalities of gait and balance and alcohol induced persisting dementia.</p> <p>A physician order dated 11/21/23 revealed Resident #41's primary physician was Medical Director #874.</p> <p>Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #41 revealed the resident had severe cognitive impairment, no functional limitation in range of motion (ROM) of the lower extremities (hip, leg, ankle, foot), he used a walker and wheelchair for mobility, required substantial/maximum assist to walk ten feet and walking 50 feet with two turns was not attempted due to medical condition or safety concerns so the resident would require a wheelchair with substantial/maximum assistance of a helper to wheel 50 feet with two turns.</p> <p>Review of Resident #41's care plan (dated 04/20/17) with revisions on 02/07/24 revealed Resident #41 was at risk for falls related to his well-documented poor balance, unsteady gait, post seizure, and noncompliance with staff assistance. Intervention dated 03/30/21 revealed to encourage resident to utilize walker to aid with mobility and safety.</p> <p>Review of nursing progress note dated 01/24/24 timed at 2:29 P.M. revealed Resident #41 was ambulating unassisted without a walker and fell in the 100-hall lounge area. There was no head involvement per witness. Resident was assisted to bed. Neurological checks, pain and skin assessments were performed. Resident determined to be at baseline post fall. ROM was within normal limits per baseline. Resident reported no pain at the time of the incident. Parties notified included Hospice, the guardian and the Assistant Director of Nursing (ADON). Immediate action taken was to have the resident use a wheelchair for ambulation. There was no evidence Resident #41's primary care physician was notified of the incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the document titled #2811 Fall dated 01/24/24, timed 10:25 A.M. and prepared by LPN #898 revealed the resident (#41) was ambulating without walker and assistance of one and he fell in the 100hall/lounge. He did not hit his head, and he was unable to give a description. Immediate action taken was the resident was assisted to bed and would be given a wheelchair for further ambulation. There were no injuries noted. He was not taken to a hospital. A bruise was noted on his left front thigh. His pain level was seven (severe). He was alert and oriented to person. Predisposing factors included recent medication change and ambulating without assistance. Other info included non-compliance with walker and assistance, fixation on cigarettes and seizure history. There were unspecified staff witnesses at the time of the fall. Under the section titled agencies/people notified there were no notifications documented.</p> <p>Interview on 08/08/24 at 2:03 P.M. with the Director of Nursing (DON) confirmed if a resident had a fall, the resident was not to be moved until after the nurse assessed the resident and if there was a change in condition, the nurse was to notify hospice and update the physician of any changes. The DON confirmed according to the review of the fall investigation report dated 01/24/24 for Resident #41, Resident #41 was helped up off the floor and assisted back to his room before the nurse assessed him. The DON confirmed the resident was experiencing worsening pain post-fall and bruising to the left leg had been identified by LPN #898 on 01/24/24 and the primary care physician was not notified.</p> <p>Review of the March 2018 revised facility policy called; Assessing Falls and Their Causes revealed if a resident had just fallen, notify the attending physician in an appropriate time frame. When a fall results in a significant injury or change of condition, notify the physician immediately by phone. If the fall does not result in a significant injury or change of condition, notify the physician routinely by fax or phone the next office day.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on record review and staff interview the facility failed to ensure the state ombudsman was notified of a residents transfer to the hospital. This affected four residents (#41, #43, #59, #242) of four reviewed for hospitalization . The facility census was 91.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Review of the medical record for Resident #43 revealed an admitted [DATE] with medical diagnoses including schizoaffective disorder, cellulitis of right lower limb, and morbid obesity. Review of the medical record revealed Resident #43 required hospitalization from [DATE] through [DATE] for right leg cellulitis. 2. Review of the closed medical record for Resident #242 revealed an admitted [DATE] with diagnoses including dementia, type two diabetes, major depressive disorder, and chronic obstructive pulmonary disease. Review of the medical record revealed Resident #242 discharged to the hospital on [DATE] for transient ischemic attack and cerebral vascular accident. Resident #242 expired at the hospital on [DATE]. 3. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including schizophrenia, sarcoidosis, epilepsy, and anxiety disorder. Review of the medical record revealed Resident #41 required hospitalization from [DATE] through [DATE] for left hip repair. 4. Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses of dementia, type two diabetes, major depressive disorder, and anxiety disorder. Review of the medical record revealed Resident #59 required hospitalization from [DATE] through [DATE] for cellulitis of right great toe. <p>Interview on [DATE] at 3:00 P.M. with the Director of Social Services (DOSS) #803 and Social Services Assistant (SSA) #841 revealed no notification to the ombudsman had been provided since [DATE], and no notification regarding Resident's #41, #43, #59, and #242 discharge and/or transfer to the hospital had been sent.</p> <p>An interview with the Director of Nursing (DON) on [DATE] at 8:28 A.M., verified the lack of ombudsman notification regarding Resident's #41, #43, #59, #242, discharge and/or transfer to the hospital. The DON also noted the local ombudsman had not been notified of any hospitalization s since [DATE]. The DON confirmed and verified the above findings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on medical record review, facility bed hold policy and staff interviews, the facility failed to ensure four (#41, #43, #59, #242) of four residents reviewed for hospitalization were provided bed hold notification. The facility census was 91.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the medical record for Resident #43 revealed an admitted [DATE] with medical diagnoses including schizoaffective disorder, cellulitis of right lower limb, and morbid obesity. Review of the medical record revealed Resident #43 required hospitalization from [DATE] through [DATE] for right leg cellulitis. Review of the medical record identified no written evidence was provided to the legal guardian regarding the facility's bed hold policy and bed hold days remaining. Review of the closed medical record for Resident #242 revealed an admitted [DATE] with diagnoses including dementia, type two diabetes, major depressive disorder, and chronic obstructive pulmonary disease. Review of the medical record revealed Resident #242 discharged to the hospital on [DATE] for transient ischemic attack and cerebral vascular accident. Resident #242 expired at the hospital on [DATE]. Review of the medical record revealed no evidence Resident #242's legal guardian was given information regarding bed hold days remaining prior to his death. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including schizophrenia, sarcoidosis, epilepsy, and anxiety disorder. Review of the medical record revealed Resident #41 required hospitalization from [DATE] through [DATE] for left hip repair. Review of the medical record identified no written evidence was provided to the legal guardian regarding the facility's bed hold policy and bed hold days remaining. Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses of dementia, type two diabetes, major depressive disorder, and anxiety disorder. Review of the medical record revealed Resident #59 required hospitalization from [DATE] through [DATE] for cellulitis of right great toe. Review of the medical record identified no written evidence was provided to the legal guardian regarding the facility's bed hold policy and bed hold days remaining. <p>An interview with the Director of Nursing (DON) on [DATE] at 8:28 A.M , verified the lack of bed hold notice given to Resident's #41, #43, #59, #242, or their legal guardian. The DON also noted no notices had been provided since [DATE], and no staff person had been assigned to or making sure that residents were receiving required bed hold notices upon discharge to the hospital.</p> <p>Review of the facility document titled Bed-Holds and Returns revised [DATE], revealed the facility had a policy in place that residents and/or representatives would be informed in writing of bed-hold policies, procedures, and detailed information as it related to their bed-hold status.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442</p> <p>Based on interview, record review and facility policy review, the facility failed to complete a baseline care plan within 48 hours after admission as required. This affected one (Resident #342) of 20 residents reviewed for care plans. The facility census was 91.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #342 revealed an admitted [DATE]. Diagnoses included but were not limited to schizoaffective disorder, generalized anxiety disorder, unspecified dementia, type II diabetes mellitus, chronic respiratory failure, and neuromuscular dysfunction of bladder. No evidence was found of a baseline care plan following admission.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #342 had severe cognitive impairment, required maximum assistance of one for dressing and was dependent upon staff for toileting and transfers.</p> <p>Interview on 08/07/24 at 4:17 P.M. with the Director of Nursing confirmed she was unable to provide evidence of a baseline care plan or comprehensive care plan developed within 48 hours of admission for Resident #342.</p> <p>Review of undated facility policy called; Care Plan-Baseline revealed a comprehensive care plan may be used in place of a baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</p> <p>Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #82 received routine showers/bathing to meet his care needs. This affected one (Resident #82) of three residents reviewed for showers/bathing. The facility census was 91.</p> <p>Findings include:</p> <p>Record review for Resident #82 revealed an admitted [DATE]. Diagnoses included encephalopathy and adult failure to thrive.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #82 was severely cognitively impaired. Resident #82 required substantial/maximum assistance for toileting, personal hygiene and dependent for showers.</p> <p>Review of the care plan revealed Resident #82 had a self care performance deficit related to impaired cognition, needs assistance with dressing and grooming. Interventions included to encourage resident to participate in activities of daily living.</p> <p>Review of the shower record for Resident #82 for June and July 2024 revealed Resident #82 was to receive showers on Tuesdays and Thursdays per Hospice.</p> <p>Review of the shower sheet for June 2024 revealed Resident #82 received one shower between the date of 06/13/24 and 06/25/24 (received 06/19/24). Resident #82 received the next shower in July 2024 on 07/03/24. From 07/04/24 through 07/16/24, Resident #82 received one shower (07/10/24). From 07/20/24 through 07/30/24, Resident #82 received one shower (07/24/24).</p> <p>Observation and interview on 08/05/24 at 1:31 P.M. revealed Resident #82 had very oily hair with multiple white particles throughout his hair. Resident #82 had a strong body odor. Resident #82 revealed he would like more showers.</p> <p>Observation and interview on 08/05/24 1:32 P.M. with State tested Nursing Assistant (STNA) #886 confirmed Resident #82 had very oily hair with multiple white partials throughout his hair and confirmed Resident #82 had a strong body odor. STNA #886 revealed hospice gave Resident #82 showers two times a week. If a resident received hospice services, the facility would not schedule routine showers any longer for the resident, that would be the responsibility of hospice.</p> <p>Observation and interview on 08/06/24 at 2:05 P.M. with Licensed Practical Nurse (LPN) #805 confirmed Resident #82 had very oily hair with multiple white partials throughout his hair. Resident #82 had strong body odor, and LPN #805 revealed she could not smell it.</p> <p>Interview 08/06/24 at 4:45 P.M. with DON revealed she would expect staff to give or offer each resident a minimum of two showers a week even if they received hospice services. DON revealed a resident may refuse showers, but the facility should still offer the showers and if they received hospice services, hospice would then also offer two additional showers a week.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/07/24 at 9:35 A.M. with Registered Nurse (RN) #930 from Hospice #931 confirmed Resident #82 received Hospice services through her company. RN #930 revealed the hospice aid would visit Resident #82 two times a week and offer a shower or bath. The Hospice Aid would not consistently come the same two days a week. RN #930 revealed hospice provided additional care to the residents in facilities. The expectations would be hospice would provide two showers/baths a week and the facility would continue to provide their two showers/baths a week unless the resident refused.</p> <p>Interview on 08/07/24 at 9:41 A.M. with Unit Manager #836 revealed the STNA's assumed if a resident received hospice services, they dont have to do that residents showers anymore because hospice does them. Unit Manager #836 revealed sometimes hospice doesn't show up on scheduled shower days so they make up the shower when they show up.</p> <p>Interview on 08/07/24 at 1:28 P.M. with DON confirmed there was no further documentation of any showers Resident #82 received, all showers were documented on the shower sheet by hospice aids. DON confirmed there was no documentation of Resident #82 refusing showers.</p> <p>Review of the facility policy titled, Bath, Shower/Tub revised February 2018 revealed the purpose of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>Based on medical record review, review of a fall incident report and related facility investigation, review of hospital documentation, interviews with staff and review of facility policy, the facility failed to provide timely and necessary medical intervention to Resident #41 following a fall with injury and severe pain.</p> <p>Actual harm occurred on 01/24/24 when Resident #41, who had moderate cognitive impairment, muscle weakness, and was known by the facility to be a safety risk for falls with injury, fell to the floor while ambulating in a common area, and was picked up off the floor by Speech Therapist (ST) #899 and walked back to his room prior to completion of a thorough nursing assessment by Licensed Practical Nurse (LPN) #898. Upon assessment by LPN #898 on 01/24/24, Resident #41 was noted to have severe pain (seven out of 10 with 10 being the worst pain), a bruise to his left front thigh yet his physician was not notified. The resident began experiencing increased leg pain with facial grimacing with left leg movement on 01/26/24, faded bruising to the left inner thigh was noted on 01/30/24, and the resident began experiencing left hip pain on 02/03/24. The resident was sent to the hospital on 02/07/24 (14 days after the fall) upon request of his legal guardian where he was diagnosed with a left hip fracture requiring palliative hip fracture surgical repair and remained in the hospital until 02/09/24. This affected one (Resident #41) of two residents reviewed for accidents/hazards. The facility census was 91.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including schizophrenia, sarcoidosis, epilepsy, legal blindness, cachexia, muscle weakness, unspecified abnormalities of gait and balance and alcohol induced persisting dementia.</p> <p>A physician order dated 11/21/23 revealed Resident #41 was admitted to Gentiva Hospice for alcohol induced persistent dementia. Resident #41's primary physician was Medical Director #874.</p> <p>Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #41 revealed the resident had severe cognitive impairment, no functional limitation in range of motion (ROM) of the lower extremities (hip, leg, ankle, foot), he used a walker and wheelchair for mobility, required substantial/maximum assist to walk ten feet and walking 50 feet with two turns was not attempted due to medical condition or safety concerns so the resident would require a wheelchair with substantial/maximum assistance of a helper to wheel 50 feet with two turns.</p> <p>Review of Resident #41's care plan (dated 04/20/17) with revisions on 02/07/24 revealed Resident #41 was at risk for falls related to his well-documented poor balance, unsteady gait, post seizure, and noncompliance with staff assistance. Intervention dated 03/30/21 revealed to encourage resident to utilize walker to aid with mobility and safety.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 01/23/24 from psychiatric services for Resident #41 revealed Resident #41 was seen via telehealth for medication evaluation. Resident #41 was noted to still be having problems with his vision, pain, and was given Morphine to treat pain. It was also noted he was a safety risk as far as falling and injuring himself. A recommendation was made to decrease his total daily (anti-psychotic medication) Haldol from 18 mg to 15 mg to allow him to be more active. It was noted he could ambulate independently.</p> <p>Review of nursing progress note dated 01/24/24 timed at 2:29 P.M. revealed Resident #41 was ambulating unassisted without a walker and fell in the 100-hall lounge area. There was no head involvement per witness. Resident was assisted to bed. Neurological checks, pain and skin assessments were performed. Resident determined to be at baseline post fall. ROM was within normal limits per baseline. Resident reported no pain at the time of the incident. Parties notified included Hospice, the guardian and the Assistant Director of Nursing (ADON). Immediate action taken was to have the resident use a wheelchair for ambulation. There was no evidence Resident #41's physician was notified of the incident.</p> <p>Review of the document titled #2811 Fall dated 01/24/24, timed 10:25 A.M. and prepared by LPN #898 revealed the resident (#41) was ambulating without walker and assistance of one and he fell in the 100hall/lounge. He did not hit his head, and he was unable to give a description. Immediate action taken was the resident was assisted to bed and would be given a wheelchair for further ambulation. There were no injuries noted. He was not taken to a hospital. A bruise was noted on his left front thigh. His pain level was seven (severe). He was alert and oriented to person. Predisposing factors included recent medication change and ambulating without assistance. Other info included non-compliance with walker and assistance, fixation on cigarettes and seizure history. There were unspecified staff witnesses at the time of the fall. Under the section titled agencies/people notified there were no notifications documented.</p> <p>Review of the facility document titled Pain assessment dated [DATE] at 2:39 P.M. revealed the resident was having severe, almost constant pain. The location of the pain was not specified. Pain management included administer as-needed morphine and acetaminophen and encourage repositioning. In the comment section no new pain indicated by patient post fall was written.</p> <p>Review of the facility investigation dated 01/24/24 revealed a witness statement dated 01/24/24 from Housekeeper #887 revealed she observed Resident #41 walking down the hall without his walker, lost his balance and fell . Housekeeper #887 notified the nurse. ST #899 came and helped Resident #41 up from floor and took him to his room.</p> <p>Review of the witness statement dated 01/24/24 from Dietary Manager (DM) #885 revealed she saw Housekeeper #887 running towards 100 hall and tell an unidentified resident not to pick Resident #41 up. DM #885 yelled for LPN #898 and LPN #898 was giving care and finished providing care before coming to assist Resident #41. Resident #41 told DM #885 he was okay, and DM #885 instructed him not to move. DM #885 went to get Resident #41's walker and ST #899 helped Resident #41 up from the floor.</p> <p>Review of the witness statement dated 01/24/24 from ST #899 revealed she was walking out of the therapy room and DM #885 and Housekeeper #887 notified her Resident #41 had a fall. LPN #898 was providing care and did not come for over one minute and ST #899 assisted Resident #41 up from the floor and walked him back to his room. ST #899 notified the nurse she assisted Resident #41 back to his room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the witness statement dated 01/24/24 from LPN #898 revealed she was providing resident care when she received the radio call that Resident #41 had fallen. Upon completion of care, she found Resident #41 in his bed in his room. The statement included LPN #898 performed skin, neurological, and pain assessment on Resident #41 in his room.</p> <p>Review of the witness statement from State tested Nursing Assistant (STNA) #810 revealed she was in the shower room with another resident and heard ST #899 yell for the nurse. STNA #810 opened the door and witnessed Housekeeper #887 and ST #899 lifting Resident #41 off the floor.</p> <p>Review of nursing progress note dated 01/26/24 timed at 7:30 A.M. revealed 0.5 milliliter (mL) of morphine sulfate (MS) oral solution 20 milligrams (mg) mg/5 mL was given for pain. Resident was noted to have new complaint of leg pain. States started with his fall last week. Resident #41 was unable to tell nurse where the pain was on his legs but grimaced when left leg was moved.</p> <p>Review of nursing progress note for Resident #41 dated 01/28/24 timed at 8:40 P.M. revealed MS oral solution 20 mg/5mL was given for leg pain rated a nine out of ten (on a scale of zero to 10).</p> <p>Review of nursing progress dated 01/29/24 timed at 7:02 P.M. revealed Resident #41 complained to the hospice nurse of pain and pain medication was administered.</p> <p>Review of nursing progress noted dated 01/30/24 timed at 1:32 P.M. revealed Resident #41 was noted to have a purple/red partially faded area on his left inner thigh area. Resident #41 was noted to cry out and complain of pain when repositioned to observe the area.</p> <p>Review of the 01/24 Medication Administration Record (MAR) for Resident #41 revealed as needed MS oral solution 20 mg/5 mL was given on the following dates and times but location of pain was not specified in the correlating MAR nursing progress note:</p> <p>01/26/24 at 7:30 A.M. with noted pain level of 8 out of 10</p> <p>01/26/24 10 :14 A.M. with noted pain level of 6 out of 10</p> <p>01/26/24 at 8:10 P.M. with noted pain level of 7 out of 10</p> <p>01/28/24 at 8:40 P.M. with noted pain level of 9 out of 10</p> <p>01/29/24 at 5:55 P.M. with noted pain level of 6 out of 10</p> <p>01/31/24 at 7:40 A.M. with noted pain level of 7 out of 10</p> <p>01/31/24 at 9:16 P.M. with noted pain level of 5 out of 10</p> <p>Review of nursing progress note dated 02/03/24 timed at 1:25 P.M. revealed MS 20 mg/5 mL was given for left hip pain and was noted to require maximal assist of one to transfer.</p> <p>Review of nursing progress note dated 02/04/24 timed at 8:03 A.M. revealed MS 20 mg/5 mL was given for left leg/hip pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of 02/24 MAR for Resident #41 revealed as needed MS oral solution 20 mg/5 mL was given on the following dates and times, but location of pain was not specified in the correlating MAR nursing progress note:</p> <p>02/02/24 at 3:53 A.M. with noted pain level of 7 out of 10</p> <p>02/02/24 at 9:49 A.M. with noted pain level of 5 out of 10</p> <p>02/02/24 at 2:00 P.M. with noted pain level of 4 out of 10</p> <p>02/03/24 at 1:25 P.M. with noted pain level of 8 out of 10</p> <p>02/04/24 at 4:31 A.M. with noted pain level of 5 out of 10</p> <p>02/04/24 at 8:03 A.M. with noted pain level of 8 out of 10</p> <p>02/05/24 at 5:39 A.M. with noted pain level of 6 out of 10</p> <p>02/05/24 at 2:50 P.M. with noted pain level of 7 out of 10</p> <p>02/06/24 at 3:32 A.M. with noted pain level of 8 out of 10</p> <p>02/06/24 at 6:06 P.M. with noted pain level of 7 out of 10</p> <p>Review of nursing progress note dated 02/07/24 timed at 9:55 A.M. revealed follow up with hospice related to Resident #41 having continued pain on left hip area. Observation of left hip/groin area swollen with asymmetrical body alignment.</p> <p>Review of nursing progress note dated 02/07/24 timed at 10:30 A.M. revealed Resident #41 continued to complain of pain with facial grimacing and inability to bear weight on left foot and was medicated. Hospice nurse noted swelling and asymmetry with resident hip/groin area. Order given for hip/pelvic x-ray for Resident #41 with two views and ultrasound to left extremity.</p> <p>Review of nursing progress note dated 02/07/24 timed at 10:45 A.M. revealed x-ray performed, hospice aware of results, ordered morphine 20 mg (1 mL) every two hours for severe pain/prevention. Guardian requested Resident #41 be sent to hospital for evaluation and treatment.</p> <p>Review of nursing progress note dated 02/07/24 timed at 11:30 A.M. revealed Resident #41 went to the hospital.</p> <p>Review of nursing progress note dated 02/08/24 timed at 7:37 A.M. Resident #41 scheduled to have palliative hip repair.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review for Resident #41's hospital discharge record from [NAME] Health dated 02/09/24 at 1:38 P.M. authored by Hospital Physician #903 revealed Resident #41 had an admitted to the hospital of 02/07/24. The discharge diagnosis from the hospital for Resident #41 included closed left hip fracture, initial encounter with an active problem of left displaced femoral neck fracture. Hospital course included Resident #41 was brought to the emergency room with complaints of left hip pain after a fall on 01/24/24. Resident #41 stated he usually walked with a walker but not since his fall. Resident #41 had been having pain in his left hip which is new. Chronically Resident #41 had no pain other than occasional headaches which get better with Tylenol. He was found to have a left hip fracture and underwent left hemiarthroplasty. Pain was well controlled post-operatively.</p> <p>Interview was conducted on 08/07/24 at 8:24 A.M. with State tested Nursing Assistant (STNA) #843 who revealed Resident #41 was on hospice, was able to make his needs known to staff, required staff to push him in his wheelchair, was legally blind and frequently tried to self-transfer. STNA #843 said he gets reminders to call for staff assistance and had been getting better with asking the staff for help. STNA #843 was familiar with the resident but was not present at the time of the fall on 01/24/24.</p> <p>Interview via phone was attempted with former employee STNA #810 on 08/08/24 at 9:41 A.M. and 08/14/24 at 1:10 P.M. and a voice mail message with request for a call back was left. No return contact was made.</p> <p>Telephone interview on 8/08/24 at 9:56 A.M. with LPN #898 revealed she was in a resident room providing care and she was notified by the walkie talkie Resident #41 had fallen. LPN #898 stated she looked out the door and saw three staff assisting him (no specific staff identification provided) and finished providing care to the resident she was assisting. LPN #898 stated when she finished</p> <p>Resident #41 was already in his room. LPN #898 stated she was told by Speech Therapist (ST) #899 she had assisted Resident #41 back to his room with the assistance of Dietary Manager (DM) #885. ST #899 told her Resident #41 did not have any complaints of pain and did not have any signs of injury. LPN #898 confirmed Resident #41 was taken back to his room before he was assessed by the nurse.</p> <p>Telephone interview was attempted on 08/08/24 at 10:15 A.M. and 08/14/24 at 1:26 P.M. with ST #899. A voice mail message with call back phone number was left on the voice mail. No return contact was made.</p> <p>Interview was conducted on 08/08/24 at 10:18 A.M. with Resident #41 who was alert but unable to answer any simple or open-ended questions due to cognitive impairment.</p> <p>Interview on 08/08/24 at 10:20 A.M. with DM #885 stated she observed Resident #41 on the floor by his walker and ST #899 was walking towards him. DM #885 stated she did not assist as she knew she needed to wait for the nurse to assess him. DM #885 stated ST #899 notified LPN #898 of his Resident #41's fall and told DM #885 she was okay to leave.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/08/24 at 10:27 A.M. with Housekeeper #887 revealed she was walking by the 100 hall nurses' station and saw Resident #41 fall. Housekeeper #887 stated he was standing using his walker in the common area by the nurse's station and fell . Housekeeper #887 stated there were no staff near him when he fell so she radioed LPN #898. LPN #898 stated she was in the middle of med pass and would be there as soon as possible. Housekeeper #887 stated she did not recall if other staff assisted him back to his room. Housekeeper #887 was not allowed to assist and did not help Resident #41 get up.</p> <p>Interview on 08/08/24 at 2:03 P.M. with the Director of Nursing (DON) confirmed if a resident has a fall, the resident was not to be moved until after the nurse assessed the resident and if there was a change in condition, the nurse was to notify hospice and update the physician of any changes. The DON confirmed according to the review of the fall investigation report dated 01/24/24 for Resident #41, Resident #41 was helped up off the floor and assisted back to his room before the nurse assessed him. The DON confirmed the resident was experiencing worsening pain post-fall and bruising to the left leg had been identified by LPN #898 on 01/24/24.</p> <p>Interview on 08/08/24 at 3:02 P.M. with Registered Nurse (RN) #801 revealed after Resident #41's fall on 01/24/24, he was still trying to attempt to walk but was unable to bear weight due to pain.</p> <p>Review of the March 2018 revised facility policy called; Assessing Falls and Their Causes revealed if a resident had just fallen, evaluate for possible injuries. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying or standing position. Notify the attending physician and family.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333</p> <p>Based on observation, interview, record review and review of facility policy, the facility failed to maintain appropriate hand hygiene during the tracheostomy (trach) care. This affected one (Resident #15) of one resident who was identified by the facility as having a trach. The facility census was 91.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic obstructive pulmonary disease, major depressive disorder, schizophrenia, and dependence on supplemental oxygen.</p> <p>Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 05/06/24, revealed the resident had moderately impaired cognition. The resident required supervision for activities of daily living (ADLs).</p> <p>Review of the physician's order for August 2024 revealed Resident #15 revealed an order for trach care every shift.</p> <p>Observation of trach care on 08/06/24 at 2:37 P.M. with Licensed Practical Nurse (LPN) #892 revealed he did don personal protective equipment (PPE) correctly. LPN #892 removed the trach necktie and removed the split gauze and took a fresh gauze to clean the area. The area was red. LPN #892 then removed his gloves and put on a new pair of gloves. LPN #892 did not wash or sanitized his hands before putting on new gloves. LPN #892 verified that he did not wash hands prior to putting on the new pair of gloves and stated that Resident #15 usually does his own trach care.</p> <p>Review of the undated facility policy titled Tracheostomy Care revealed hand hygiene should be performed prior to putting on clean gloves.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>42011</p> <p>Based on observation, interview, and review of the facility policy, the facility failed to ensure stock medications used for residents were not expired. This had the potential to affect 15 residents (Resident #57, #2, #65, #9, #79, #84, #74, #30, #45, #61, #342, #76, #49, #43, and #10) the facility identified as receiving stock medications out of 91 residents residing in the facility.</p> <p>Findings include:</p> <p>Observation on 08/06/24 at 11:54 A.M. with Unit Manager (UM) Licensed Practical Nurse (LPN) #836 of the west hall medication stock room revealed a partially used bottle of ducosate sodium 250 milligrams (mg) with an expiration date of 06/2024. An additional bottle of ducosate sodium 250 mg with an open date of 05/05/23 expired on 06/2024. A bottle of aspirin 81 mg expired 07/2024. A bottle of cranberry tabs 450 mg expired 05/2024. A bottle of vitamin D 25 micrograms expired 02/2024. The expired medications were verified by UM LPN #836.</p> <p>Observation on 08/06/24 at 12:10 P.M. with UM LPN #836 of the north hall medication stock room revealed a bottle of magnesium oxide 400 mg expired 04/2024. The expired medication was verified by UM LPN #836.</p> <p>Interview on 08/07/24 at 2:00 P.M. with DON confirmed expired medications should be disposed of from the stock medications. Record review provided by DON revealed Resident #57, #2, #65, #9, #79, #84, #74, #30, #45, #61, #342, #76, #49, #43, and #10 received facility stock medications from the stock medication rooms and had the potential to receive the expired medications.</p> <p>Review of the facility policy titled, Storage of Medications dated 11/2020 revealed discontinued, outdated, or deteriorated drugs or biological's are returned to the dispensing pharmacy or destroyed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Wayside Farm Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4557 Quick Rd Peninsula, OH 44264	

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 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>39333</p> <p>Based on observation, interview, and policy review, the facility failed to serve pureed foods at a smooth consistency for safe swallowing. This had the potential to affect nine residents (#10, #16, #18, #23, #27, #39, #45, #50, #62) the facility identified as receiving pureed diets of 91 residents who consumed meals from the facility's kitchen. No residents were identified as nothing by mouth (NPO). The facility census was 91.</p> <p>Findings include:</p> <p>Observation of puree preparation on 08/06/24 from 3:45 P.M. through 4:00 P.M. revealed [NAME] #881 pureed pepper steak. [NAME] #881 portioned a sample of the puree pepper steak into a souffle cup. A taste test of pureed pepper steak revealed there were intact pieces of the beef that was not smooth in consistency.</p> <p>A taste test on 08/06/24 at 4:00 P.M. with Dietary Manager (DM) #885 verified that the puree pepper steak was not a smooth consistency. DM #885 told [NAME] #881 to puree the pepper steak more. As [NAME] #881 was pureeing the pepper steak, the robot coupe (mechanical chopper) was making a noise. DM #885 stated that the bearings were starting to go on it and the backup robot coupe was just sent out for repair.</p> <p>Review of the undated facility's policy titled, Texture Modified Diets, revealed pureed foods should be of a mashed potato consistency.</p>