STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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** 41526 Based on observation, record review and interview, the facility failed to provide privacy for urinary catheter drainage bags. This affected three residents (#25, #56 and #264) of four residents reviewed for urinary catheters. The facility census was 63. Findings include: 1. Observation on 05/28/24 at 9:29 A.M. from the hallway outside Resident #25's room revealed Resident #25 lying in bed with a urinary catheter drainage bag secured to the right bedside facing the room entrance door. There was no privacy covering over the urinary drainage bag. Interview on 05/29/24 at 9:31 A.M. with State tested Nursing Assistant (STNA) #630 verified there was no privacy covering over Resident #25's urinary catheter drainage bag or it was not placed on the opposite side of the bed out of public view. Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of bladder, urinary tract infection, multiple sclerosis, and diabetes mellitus type II. The plan of care dated 11/20/23 indicated Resident #25 had a suprapubic catheter for neuromuscular bladder. Interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door. 2. Observation on 05/29/24 at 7:13 A.M. from the hallway outside Resident #56's room revealed Resident #56 lying in bed with a urinary catheter drainage bag secured to the right bedside facing the room entrance door. There was no privacy covering over the urinary drainage bag. Interview at the time of the observation with Registered Nurse (RN) #640 verified there was no privacy covering over Resident #56's urinary catheter drainage bag or it was not placed on the opposite side of the bed out of public view. RN #640 indicated the privacy bag was still attached to Resident #56's wheelchair and was not moved over after being transferred to bed. Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included urinary tract infection, diabetes mellitus type II, and retention of urine. The plan of care revised 04/24/24 indicated Resident #56 had an indwelling urinary catheter for urinary retention. Interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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	3. Observation on 05/28/24 at 9:21 A.M. from the hallway outside Resident #264's room revealed Resident #264 lying in bed with a urinary catheter drainage bag secured to the left bedside facing the room entrance door. There was no privacy covering over the urinary drainage bag. Interview at the time of the observation with STNA #630 verified there was no privacy covering over Resident #264's urinary catheter drainage bag or it was not placed on the opposite side of the bed out of public view. STNA #630 indicated Resident #264 was recently admitted so a privacy bag was not in place but usually privacy bags were used. Review of the medical record for Resident #264 revealed an admitted [DATE]. Diagnoses included pneumonia, chronic kidney disease stage III, and diabetes mellitus. The baseline plan of care completed 05/24/24 indicated Resident #264 had an indwelling urinary catheter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 37095 Based on record review and interview, the facility failed to ensure they received signed and witnessed authorizations before managing resident funds. This affected three residents (#55, #39, and #61) of five residents reviewed for funds management. The facility census was 63. Findings include: 1. Record review of Resident #55 revealed he had $50.00 deposited in the facility's resident trust account. The facility furnished an authorization form that did not include any witness signature. 2. Record review of Resident #39 revealed she had $5.00 deposited in the facility's resident trust account. The facility could not furnish documented evidence of a signed or witnessed authorization form permitting them to manage her personal money. 3. Record review of Resident #61 revealed he previously had funds managed by the facility in a trust account closed on 10/12/23. The facility could not furnish documented evidence of a signed or witnessed authorization form permitting them to manage his personal money. Interview with Human Resources Director #663 on 05/29/24 at 1:50 P.M. confirmed the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 37095 Based on record review and interview, the facility failed to ensure all staff members received reference checks before hire. This affected four employees, Licensed Practical Nurse (LPN) #642, State-tested Nursing Aide (STNA) #604, STNA #614, and Maintenance Director (MD) #603, of six employees reviewed for completed employee files. This had the potential to affect all 63 residents residing in the facility. Findings include: Record review of the employee files for LPN #642, STNA #604, STNA #614, and MD #603 revealed no evidence the facility made reference checks or other attempts to check information from past or current employers before hiring the staff members. Interview with Human Resources Director #663 on 05/29/24 at 4:05 P.M. confirmed the above findings, and follow-up interview with her on 05/30/24 at 8:25 A.M. revealed the facility could not locate any documented evidence reference checks were attempted for the affected employees.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 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** 39973 Based on interview, observation, record review and review of the facility policy, the facility failed to ensure comprehensive care plans and/or Kardex's were complete for Residents #14, #16, #50, and #52. This affected four residents (#14, #16, #50, and #52) out of 22 resident's care plans reviewed. The facility census was 63. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including congestive heart failure, hypertension, and chronic obstructive pulmonary disease. Review of the care plan dated 08/11/21 revealed Resident #16 was on diuretic therapy due to edema. Interventions included administering diuretic medications as ordered, monitor, document and report any adverse effects, and apply TED hose/embolic stockings (tight stockings applied to lower extremities to reduce edema (swelling caused by fluid trapped in body's tissues) to her bilateral lower extremities as tolerated by donning in the morning and doffing at night. The comprehensive care plan for Resident #16 revealed nothing regarding Resident #16 having a midline (intravenous catheter inserted in the upper arm with the tip located just below the axilla area) intravenous catheter including monitoring and/or maintaining it. Review of quarterly the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition and was independent with dressing and applying footwear. She was not on intravenous therapy. Review of the May 2024 physician orders revealed Resident #16 had an order for embolic stockings to be on in the morning and off at night due to bilateral lower extremity edema. In addition, there was an order for an intravenous (IV) to be placed by an outside company. Resident #16 did not have any orders to maintain and monitor her midline IV catheter including no flush order, no dressing changes, and/or no orders to monitor for signs of infection. Review of the May 2024 Treatment Administration Record (TAR) revealed Agency Registered Nurse (RN) #665 signed off the TAR that Resident #16's embolic stockings were applied on 05/29/24. Review of the Midline Insertion Sheet dated 05/27/24 at 5:15 P.M. revealed the outside company (RN #901) inserted a midline IV line to Resident #16's left arm without any difficulty. The midline instruction sheet revealed Resident #16 received a Power Midline Catheter and the recommended guidelines given to the facility included to maintain according to protocol including to flush each lumen of the catheter with ten milliliter (ml) sterile water every 12 hours or after each use. Post insertion complications included catheter dislodgment, catheter infection, inflammation of vein wall, catheter occlusion, hematoma at catheter site, and blood clot inside the vein near the catheter wall. Interview and observation on 05/28/24 at 9:54 A.M. revealed Resident #16 was lying in bed with a midline IV catheter to her left arm and she was unable to provide any detailed information regarding her edema, use of embolic stockings and/or IV access. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Visual/ Bedside Kardex as of 05/29/24 revealed Resident #16 required supervision with dressing. There was nothing in her Kardex stating Resident #16 was to have embolic stockings applied to her bilateral feet. Observation on 05/29/24 at 7:09 A.M. revealed staff were in Resident #16's room assisting her with her activities of daily living (ADL), including getting her dressed and transferring her into her wheelchair with a mechanical lift. Observation on 05/29/24 at 7:23 A.M. revealed staff brought Resident #16 down to the dining room in a wheelchair without embolic stockings in place. Resident #16 was observed with a moderate amount of edema to her lower extremities. Observation on 05/29/24 at 9:49 A.M. revealed Resident #16 was sitting in the lounge area up in her wheelchair without embolic stockings in place. Observation on 05/29/24 at 10:57 A.M. revealed Resident #16 was up in her wheelchair in her room without embolic stockings in place, and her bilateral lower extremities continued to have moderate edema. Interview on 05/29/24 at 11:03 A.M. with State tested Nurse Aide (STNA) #616 revealed she was the aide assigned to Resident #16 and verified Resident #16 did not have embolic stockings on. She was not aware Resident #16 had a physician's order for the embolic stockings as she went by the Kardex, and the Kardex it did not identify that Resident #16 was to have embolic stockings. She revealed Resident #16 always had quite a lot of swelling in her lower extremities. She revealed Resident #16 had a significant decline over the last few weeks and now required assistance with most all her ADL including dressing. Interview on 05/29/24 at 11:05 A.M. with Agency RN #665 revealed it was the first time she worked at the facility. She verified that Resident #16 had an order for embolic stockings, and that she had signed off on 05/29/24 that Resident #16 had them on. She stated, I assumed the aide just applied and verified she had not checked that they were applied before signing it off on the TAR. She verified that Resident #16's order for embolic stockings was not on the Kardex and/or on the task bar in the electronic medical record. She verified Resident #16 was up in her wheelchair without embolic stockings in place as ordered. Interview on 05/30/24 at 8:52 A.M. with MDS/RN #605 revealed the facility did not have one specific staff person responsible for updating the resident's Kardex as either the Director of Nursing (DON), Assistant Director of Nursing (ADON)/ Licensed Practical Nurse (LPN) #601, staff nurses and/or herself all tried to keep them up to date the best that they could. MDS/RN #605 verified Resident #16's Kardex did not have embolic stockings to control her edema. MDS/ RN #605 verified that the STNA's utilize the Kardex to know what needs a resident required, including stockings. Also, she stated she did not know Resident #16 had a midline IV catheter as of 05/28/24. She verified there was no care plan regarding maintaining and/or monitoring her midline IV catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/30/24 at 9:23 A.M. with ADON/LPN #601 verified Resident #16 had a midline IV catheter that was inserted on 05/27/24. She verified that Resident #16 received one liter of IV fluids that were documented on 05/28/24. She verified after the IV fluids, there were no further orders to maintain the midline IV catheter, including flushing the catheter to ensure patency and checking the catheter site for signs of infection. She verified that usually a midline IV catheter not receiving IV medication and/or fluids through it, they maintain patency per their facility policy by flushing at least every 24 hours, and the nurse should be checking the IV site for signs of infection every shift. She verified there were no physician orders and/or documented evidence in the medical record that Resident #16's midline IV catheter was being monitored and/or maintained by flushing per the facility policy and/or the manufacturers guideline. 2. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including difficulty walking, hypertension, hemiplegia, and hemiparesis following cerebral infarction affecting right dominant side, and aphasia. Review of the care plan dated 11/06/22 revealed Resident #50 had an ADL self-care performance deficit related to traumatic subdural hemorrhage requiring surgical intervention leaving her with right sided hemiparesis. She required minimal staff assistance with dressing, personal hygiene, and transfers. There was nothing in the care plan regarding Resident #50's edema and that she was to wear embolic stockings every day. Review of the physician's order dated 03/07/24 revealed Resident #50 had an order to apply compression stockings in the morning and remove at night every shift for edema. Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 had impaired cognition as her Brief Interview Mental Status (BIMS) score was a four out of 15. She required partial to moderate staff assistance with lower body dressing and putting on and taking off footwear. Review of the May 2024 TAR revealed Agency RN #665 had signed off that Resident #50's embolic stockings were applied on 05/29/24. Observation on 05/28/24 at 9:48 A.M. revealed Resident #50 was up in her wheelchair in her room and had swelling to her bilateral lower legs. She was not wearing embolic stockings. Resident #50 was not interviewable due to cognitive ability. Review of the Visual/Bedside Kardex as of 05/29/24 revealed Resident #50 required minimal staff assistance with dressing. There was nothing in her Kardex regarding having embolic stockings applied to her bilateral feet. Observation on 05/29/24 at 7:57 A.M. revealed Resident #50 was up in her wheelchair in the dining room without embolic stockings in place. She had regular socks and tennis shoes on. Observation on 05/29/24 at 9:52 A.M. revealed Resident #50 was propelling herself in her wheelchair towards her room and continued to not have embolic stockings in place. Interview on 05/29/24 at 10:14 A.M. with Resident #50's brother revealed he had not ever seen Resident #50 wear embolic stockings and did not know she had an order to wear them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/29/24 at 11:00 A.M. revealed Resident #50 was sitting in her wheelchair in the activity room without embolic stockings in place. Her bilateral lower extremities were noted to have edema. Interview on 05/29/24 at 11:03 A.M. with STNA #616 revealed she was the aide assigned to Resident #50 and verified Resident #50 did not have embolic stockings on. She revealed she was not aware she had a physician order for the stockings as she went by the Kardex, and the Kardex did not identify that Resident #50 was to have embolic stockings. She verified that Resident #50 had some swelling to her lower extremities. Interview on 05/29/24 at 11:05 A.M. with Agency RN #665 revealed that it was the first time that she worked at the facility. She verified that Resident #50 had an order for embolic stockings and that she had signed off on 05/29/24 that Resident #50 had them on. She stated, I assumed the aide just applied and verified she had not checked that they were applied. She verified that Resident #50's order for embolic stockings were not on the care plan, Kardex and/or on the task bar in the electronic medical record. She verified Resident #50 was sitting in the activity room and did not have her embolic stockings in place as ordered. Interview on 05/30/24 at 8:52 A.M. with MDS/RN #605 verified Resident #50 did not have anything on her Kardex and/or her care plan anything regarding the need to have embolic stockings applied to control her edema. She verified that the STNA's utilize the Kardex to know what needs a resident requires, including stockings. 3. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including congestive heart failure, hypertension, and/or abnormalities with gait and mobility. Review of the undated comprehensive care plan revealed there was nothing in his care plan regarding Resident #52's use of oxygen. Review of the admission MDS assessment dated [DATE] revealed Resident #52 was cognitively impaired as his BIMS score was a six out of 15. He wandered one to three days during the seven-day assessment reference period. Review of the May 2024 physician orders revealed Resident #52 had an order for oxygen at two liters via nasal cannula as needed for shortness of breath and low oxygen saturation level. Observation on 05/27/24 at 9:34 A.M. revealed Resident #52 was lying in bed with two liters of oxygen being administered per his oxygen concentrator via nasal cannula. There was no sign on the outside of his room indicating oxygen was in use. Observation revealed next to his nightstand by his bed was a green E- cylinder (a cylinder containing oxygen that was combustible) not secured in a rack and/or proper holder to prevent from tipping over. Attempted interview revealed Resident #52 was cognitively impaired. Interview on 05/27/24 at 10:44 A.M. with the DON verified Resident #52 was wearing oxygen while lying in bed, and that there was no sign on the outside of his room indicating oxygen was in use. She also verified there was one E-cylinder that was free standing next to his nightstand not in a rack and/or proper holder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/30/24 at 8:52 A.M. with MDS/RN #605 verified there was nothing in Resident #52's care plan regarding his use of oxygen. 37097 4. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including diabetes, excoriation (skin-picking) disorder, anxiety disorder, and chronic kidney disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #14 had impaired cognition. Review of the physician's orders for Resident #14 revealed an order dated 08/10/23 for the resident to wear a right wrist hand orthotic during hours of sleep (HS) and remove for range of motion (ROM) and hygiene. Review of the current care plan for Resident #14 revealed no care plan was developed to address the resident's right-hand contraction. Review of the current Kardex revealed no mention of Resident # 14's order for a right-hand wrist orthotic. Review of the TAR for May 2024 revealed the order for Resident #14 to wear a right wrist hand orthotic during HS and remove for ROM and hygiene was not on the TAR. Interviews 05/29/24 at 2:56 P.M. with STNA #612 and STNA #618 revealed Resident 14's right hand was contracted, but he had never worn a splint that they were aware. Interview on 05/29/24 at 3:17 P.M. with LPN #639 revealed she had not heard anything about Resident #14's hand contraction. Interview on 05/30/24 at 12:49 P.M. with Certified Occupational Therapy Assistant (COTA)/ Director of Rehab #651 revealed Resident #14 had an order for a resting hand sprint, and he was given one. The resident usually refused to wear it. The splint was as needed. He could wear it anytime. There was not a set time frame. Interview on 05/30/24 at 1:00 P.M. with LPN #642 revealed she had never seen the splint or been instructed to use one for Resident #14. Interview on 05/30/24 at 1:04 P.M. with the Administrator verified she was unable to locate a care plan, TAR, or Kardex for Resident #14 that addressed the use of a hand splint. Review of the facility policy labeled, Care Plans, Comprehensive Person-Centered, dated March 2022, revealed a comprehensive person-centered care plan was to include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The comprehensive person-centered care plan included services that were to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 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** 39973 Based on interview, observation, record review and review of the facility policy, the facility failed to ensure Resident #16 and Resident #60's embolic stockings (tight stockings applied to lower extremities to reduce edema) were applied as ordered by the physician. This affected two residents (#16 and #50) out of two residents reviewed for edema. This had the potential to affect five additional residents (#3, #4, #7, #38, and #42) identified by the facility as residents who had orders for embolic stockings. The facility census was 63. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including congestive heart failure, hypertension, and chronic obstructive pulmonary disease. Review of the care plan dated 08/11/21 revealed Resident #16 was on diuretic therapy due to edema. Interventions included administering diuretic medications as ordered, monitor, document, and report any adverse effects, and apply TED hose (embolic stockings) to her bilateral lower extremities as tolerated by donning in the morning and doffing at night. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition and was independent with dressing and applying footwear. Review of the May 2024 physician orders revealed Resident #16 had an order for TED hose (embolic stockings) to be on in the morning and off at night due to bilateral lower extremity edema. Review of the May 2024 Treatment Administration Record (TAR) revealed Agency Registered Nurse (RN) #665 signed off that Resident #16's embolic stockings were applied on 05/29/24. Review of the Visual/ Bedside Kardex as of 05/29/24 revealed Resident #16 required supervision with dressing. There was nothing in her Kardex regarding embolic stockings applied to Resident #16's bilateral lower extremities. Interview and observation on 05/28/24 at 9:54 A.M. revealed Resident #16 was lying in bed and was unable to provide any detailed information regarding her edema and/or use of embolic stockings. Observation on 05/29/24 at 7:09 A.M. revealed staff were in Resident #16's room assisting her with her activities of daily living (ADL), including getting her dressed and transferring her to the wheelchair using a mechanical lift. Observation on 05/29/24 at 7:23 A.M. revealed staff brought Resident #16 down to the dining room in a wheelchair without embolic stockings in place. Resident #16 was observed with a moderate amount of edema to her lower extremities. Observation on 05/29/24 at 9:49 A.M. revealed Resident #16 was sitting in the lounge area up in her wheelchair without embolic stockings in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/29/24 at 10:57 A.M. revealed Resident #16 was up in her wheelchair in her room without embolic stockings in place, and her bilateral lower extremities continued to have moderate edema. Interview on 05/29/24 at 11:03 A.M. with State tested Nurse Aide (STNA) #616 revealed she was the aide assigned to Resident #16 and verified Resident #16 did not have embolic stockings on. She was not aware she had a physician's order for the embolic stockings as she went by the Kardex, and the Kardex did not identify that Resident #16 was to have embolic stockings. She revealed Resident #16 always had quite a lot of swelling in her lower extremities. She revealed Resident #16 had a significant decline over the last few weeks and now required assistance with most all her ADL, including dressing. Interview on 05/29/24 at 11:05 A.M. with Agency Registered Nurse (RN) #665 revealed that it was the first time that she worked at the facility. She verified that Resident #16 had an order for embolic stockings and that she signed off on 05/29/24 that Resident #16 had them on. She stated, I assumed the aide just applied and verified she had not checked that they were applied before signing it off. She verified that Resident #16's order for embolic stockings was not on the Kardex and/or on the task bar of the electronic medical record. She verified Resident #16 was up in her wheelchair without embolic stockings in place as ordered. Interview on 05/30/24 at 8:52 A.M. with MDS/RN #605 verified Resident #16's Kardex did not have instructions for applying embolic stockings to control her edema. MDS/RN #605 verified that the STNA's utilize the Kardex to know what care a resident requires, including stockings. 2. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including difficulty walking, hypertension, hemiplegia, and hemiparesis following cerebral infarction affecting right dominant side, and aphasia. Review of the care plan dated 11/06/22 revealed Resident #50 had an ADL self-care performance deficit related to traumatic subdural hemorrhage requiring surgical intervention leaving her with right sided hemiparesis. She required minimal staff assistance with dressing, personal hygiene, and transfers. There was nothing in the care plan regarding Resident #50's edema and that she was to wear embolic stockings every day. Review of the current physician's orders revealed an order dated 03/07/24 for Resident #50 to apply compression (embolic) stockings in the morning and remove at night every shift for edema. Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 had impaired cognition as her Brief Interview Mental Status (BIMS) score was a four out of 15. She required partial to moderate staff assistance with lower body dressing and putting on and taking off footwear. Observation on 05/28/24 at 9:48 A.M. revealed Resident #50 was up in her wheelchair in her room and had swelling to her bilateral lower legs. She was not wearing embolic stockings. Unable to interview Resident #50 due to cognitive ability. Review of the Visual/Bedside Kardex as of 05/29/24 revealed Resident #50 required minimal staff assistance with dressing. There was nothing in her Kardex regarding embolic stockings for Resident #50. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 TAR revealed Agency RN #665 signed off that Resident #50's embolic stockings were applied on 05/29/24. Observation on 05/29/24 at 7:57 A.M. revealed Resident #50 was up in her wheelchair in the dining room without embolic stockings in place. She had regular socks and tennis shoes on. Observation on 05/29/24 at 9:52 A.M. revealed Resident #50 was propelling herself in her wheelchair towards her room and continued to not have embolic stockings in place. Interview on 05/29/24 at 10:14 A.M. with Resident #50's brother revealed he had not ever seen Resident #50 wear embolic stockings and did not know she had an order to wear them. Observation on 05/29/24 at 11:00 A.M. revealed Resident #50 was sitting in her wheelchair in the activity room without embolic stockings in place. Her bilateral lower extremities were noted to have edema. Interview on 05/29/24 at 11:03 A.M. with STNA #616 revealed she was the aide assigned to Resident #50 and verified Resident #50 did not have embolic stockings on. She revealed she was not aware she had a physician's order for the stockings as she went by the Kardex, and the Kardex it did not identify that Resident #50 was to have embolic stockings. She verified that Resident #50 had some swelling to her lower extremities. Interview on 05/29/24 at 11:05 A.M. with Agency RN #665 revealed that it was the first time that she worked at the facility. She verified that Resident #50 had an order for embolic stockings and that she had signed off on 05/29/24 that Resident #50 had them on. She stated, I assumed the aide just applied and verified she had not checked that they were applied. She verified that Resident #50's order for embolic stockings was not on the care plan, Kardex and/or on the task bar in the electronic medical record. She verified Resident #50 was sitting in the activity room and did not have her embolic stockings in place as ordered. Interview on 05/30/24 at 8:52 A.M. with MDS/RN #605 verified Resident #50's Kardex and care plan did not have anything regarding Resident #50's order to have embolic stockings applied to control her edema. She verified that the STNA's utilize the Kardex to know what care a resident requires, including stockings. Review of the facility policy labeled, Applying Anti- Emboli Stockings (TED Hose), dated October 2010, revealed the purpose was to improve venous return to the heart, improve arterial circulation to the feet, to minimize edema to the legs and feet, and prevent complications associated with deep vein thrombosis (blot clot). The policy revealed staff were to verify there was an order for the stockings and review the care plan to assess any special needs of the residents. The policy revealed stockings should be applied in the morning prior to the resident getting out of bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0686 Level of Harm - 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** 41526 Based on observation, record review, facility policy review and interview the facility failed to provide comprehensive, individualized and necessary pressure ulcer assessment and care for Resident #56. This affected one resident (#56) of two residents reviewed for pressure related wound care. The facility census was 63. Actual harm occurred on 03/26/24 when the facility failed to adequately assess and implement pressure ulcer wound care for Resident #56, a new admission who had impaired cognition and bowel incontinence. On 03/28/24 the resident was transferred to the emergency room where hospital staff identified an extensive coccyx/sacral pressure ulcer with surrounding cellulitis and additional concern for osteomyelitis. The facility had not implemented any type of pressure ulcer wound care for the resident prior to the hospitalization . The resident was admitted for wound care intervention with intravenous antibiotic treatment due to the facility's lack of monitoring and adequate wound care following initial admission. Subsequently, Resident #56's was readmitted to the facility on [DATE] for continued wound care and treatment, however treatment was not initiated until 04/04/24. Findings include: Review of the medical record for Resident #56 revealed an initial admitted [DATE], discharge date of [DATE] due to hospitalization , and re-admission on 04/01/24. Resident #56 had diagnoses including diabetes mellitus type II, gastrostomy status, chronic obstructive pulmonary disease, encephalopathy, and protein calorie malnutrition. Review of the nursing progress note for admitted d 03/26/24 at 4:56 P.M. revealed Resident #56 was admitted for wound care and a new enteral feeding tube. Review of the admission assessment completed 03/26/24 indicated Resident #56 had a pressure ulcer (stage not identified) to the coccyx which measured 10 centimeters (cm) length, 8 cm width and 3 cm depth. There was no documented evidence of the resident's wound status or of a wound treatment being initiated or provided. Review of Resident #56's baseline plan of care completed 03/26/24 revealed there was a sacral pressure ulcer with treatment per physician orders and the functional goal was improvement of wound. Review of the hospital discharge information dated 03/25/24 revealed a coccyx wound with a treatment order to cleanse with wound cleanser, pat dry, apply Vashe (wound solution for cleansing, irrigating, moistening, debridement and removal of microorganisms and debris from exudating or dirty wounds) moistened gauze, cover with sacral foam daily and as needed if not intact, damp, moist or saturated. There was no documented evidence of a wound infection which required antibiotic treatment. Review of Resident #56's admission orders for March 2024 revealed no orders for wound related care or treatment, or antibiotic therapy required for a wound infection. Review of the medication and treatment administration records for March 2024 revealed no wound related care or treatments were provided for Resident #56 following the resident's admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress note dated 03/27/24 at 10:00 A.M. revealed Resident #56 had severe cognitive impairment, new onset of bowel incontinence, an indwelling urinary catheter in place to prevent soiling of a Stage III or IV pressure ulcer (wound that extends into deeper tissue reaching fat, muscle, tendon or bone) and a coccyx pressure ulcer (stage not identified) with slough (thick material in a wound bed made up of dead cells, pus and other accumulated debris). There was no documented evidence of wound infection, or wound treatment initiated or provided. Review of the nursing progress note dated 03/27/24 at 11:48 P.M. indicated Resident #56's enteral feeding tube was clogged by medications and after multiple attempts to clear the tubing was ineffective. The physician was notified. Review of the nursing progress note dated 03/28/24 at 10:30 A.M. revealed Resident #56's primary care physician (PCP) came to the facility to assist with the clogged enteral tube which was unsuccessful. The PCP ordered for transport to the emergency room for evaluation and treatment. Emergency services was contacted at 11:14 A.M. and provided transport. A nurse to nurse phone call was completed at 11:30 A.M. with the emergency room (ER). Information related during the phone call was not documented. Review of the nursing progress note dated 03/29/24 at 4:03 A.M. revealed the ER contacted the facility and informed staff the enteral feeding tube was replaced but when Resident #56 had an episode of bowel incontinence, a coccyx wound was then identified. The hospital physician determined the wound to be extensive and requested information from the facility on treatment orders. The facility explained there were no active orders in place regarding a coccyx wound so Resident #56's prior hospital records were checked and wound treatment orders were found which were ultimately relayed to the ER. The ER physician determined Resident #56 required hospitalization not for enteral tube replacement but for the coccyx wound due to being a candidate for intravenous antibiotic therapy. Review of the admission note dated 04/01/24 at 6:33 P.M. revealed Resident #56 was readmitted to the facility for wound care. There was no documented evidence of wound status, or wound treatment initiated or provided. Review of the hospital discharge information dated 04/01/24 revealed Resident #56 presented on 03/28/24 with a large sacral decubitus wound with concern for osteomyelitis. A computed tomography (CT) scan determined the wound measured up to 10 cm in length and had associated surrounding cellulitis without abscess or evidence of osteomyelitis. Physical examination indicated a sacral wound which measured 10 cm length and 5 cm width and had surrounding erythema (skin redness). Initially, the resident presented to the ER for an enteral tube malfunction but was found to have a sacral wound with cellulitis. Review of the admission assessment dated [DATE] revealed Resident #56 had a sacral pressure ulcer unstageable (the base of the ulcer was obscured by eschar (dead skin) or slough so the true depth of the wound was difficult to determine). The wound measurements included 10 cm length and 9.5 cm width. Review of the nursing progress notes from 04/01/24 to 04/03/24 revealed Resident #56 had a coccyx pressure ulcer (stage not identified) which measured 8 cm length, 10 cm width and 3 cm depth with slough present and received antibiotic therapy. There was no documented evidence of wound treatment initiated or provided at the time of the resident's re-admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the PCP progress note dated 04/04/24 revealed Resident #56 had a complicated medical history with frequent and prolonged hospitalization s and an enteral feeding tube was placed for nutrition. The resident was hospitalized from 02/28/24 until 03/26/24 at which time the resident was admitted to the facility. Upon examination, the resident had a clogged enteral feeding tube and attempt to clear it was unsuccessful so he was transferred to the ER for further evaluation and ultimately the enteral feeding tube was exchanged. Resident #56 was set for discharge back to the facility when he was found to have cellulitis around the sacral wound upon providing incontinence care. A CT scan revealed a large sacral decubitus ulcer with surrounding cellulitis and no evidence of abscess or osteomyelitis. The resident was admitted to the hospital and received intravenous antibiotics before being discharged back to the facility on [DATE] and continued antibiotics orally. The plan was to continue dressing changes per the wound team. Review of Resident #56's physician orders for April 2024 revealed a wound order initiated 04/04/24 to cleanse coccyx wound, pat dry, apply calcium alginate (a dressing used to treat moderate or heavily draining wounds) and cover with a foam border dressing daily and as needed for pressure injury. Review of the medication and treatment administration records for April 2024 revealed wound care was initiated on 04/04/24 and was completed daily thereafter. Review of the nursing progress note from 04/06/24 at 3:45 P.M. revealed Resident #56 received an antibiotic twice daily for wound infection. Review of the Admission and Medicare 5-day MDS (Minimum Data Set) assessment completed 04/08/24 revealed Resident #56 had severe cognitive impairment, an indwelling urinary catheter, was always incontinent of bowel and had one stage III pressure ulcer present upon admission. Review of the initial wound care evaluation completed 04/08/24 by the wound nurse practitioner indicated the facility requested Resident #56 be evaluated for a concerning area to Resident #56's bottom, a sacral pressure ulcer stage III which was present upon admission. The wound measured 8.8 cm length, 7.4 cm width and 2.2 cm depth. The wound treatment was updated to cleanse with normal saline, apply calcium alginate and cover with a clean dry dressing daily. Observation on 05/29/24 at 10:27 A.M. of wound care with Registered Nurse (RN) #640 revealed Resident #56 had a large coccyx/sacral wound which appeared as a deep crater and slough was present at the base of the wound. Wound drainage was moderate with an unpleasant odor, and the wound minimally bled upon removal of the old dressing. Interview on 05/29/24 at 11:23 A.M. with Assistant Director of Nursing (ADON) #601 indicated acting as the wound nurse and described wound orders being placed upon admission with regular wound rounds completed weekly. Additional interview on 05/30/24 at 12:36 P.M. with ADON #601 confirmed the above findings and verified no wound care or treatment was provided to Resident #56 from 03/26/24 to 03/28/24 before being admitted to the hospital for a wound infection, and then again upon re-admission on 04/01/24, until wound care was initiated on 04/04/24, and the wound nurse practitioner made an initial wound evaluation on 04/08/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/30/24 at 3:57 P.M. with Administrator and Regional Travel Director of Nursing (RTDON) #662 (after review of hospital discharge information printed 03/18/24) revealed Resident #56's wound was noted to be chronically infected however, RTDON #662 verified there was no evidence a wound infection was present including cellulitis at the time of facility admission on 03/26/24 until Resident #56 was transferred to the hospital on 03/28/24. In addition, RTDON #662 confirmed there remained no documented evidence that the facility provided wound care or treatment after initial admission on 03/26/24 and again on 04/01/24 to prevent infection until it was first initiated on 04/04/24. Review of the facility policy, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised April 2018 revealed nursing staff and practitioner would examine the skin of newly admitted residents for evidence of existing pressure ulcers and the physician would order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressing, and application of topical agents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview and record review, the facility failed to obtain physician's orders and provide sufficient care for an indwelling urinary catheter. This affected one resident (#264) of four residents reviewed for urinary catheters. The facility census was 63. Findings include: Observation on 05/28/24 at 9:21 A.M. from the hallway outside Resident #264's room revealed Resident #264 lying in bed with a urinary catheter drainage bag secured to the left bedside facing the room entrance door. Interview at the time of the observation with State tested Nurse Aide (STNA) #630 verified Resident #264 was recently admitted and had an indwelling urinary catheter. Review of the medical record for Resident #264 revealed an admitted [DATE]. Diagnoses included pneumonia, chronic kidney disease stage III, and diabetes mellitus. The baseline plan of care completed 05/24/24 indicated Resident #264 had an indwelling urinary catheter. Review of Resident #264's physician's orders for May 2024 revealed no evidence of orders to monitor, maintain, or care for the urinary catheter upon admission on 05/24/24. On 05/30/24 after surveyor intervention, orders were initiated to provide catheter care every shift, change the indwelling urinary catheter drainage bag every 48 hours as needed, document urinary catheter output every shift, and change the urinary catheter every 24 hours as needed if occluded. Review of Resident #264's medication and treatment administration records revealed no evidence of monitoring, maintaining, or caring for the urinary catheter from 05/24/24 to 05/29/24. Interview on 05/30/24 at 12:51 P.M. with Assistant Director of Nursing (ADON) #601 verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review and review of the facility policy, the facility failed to ensure Resident #16's midline (intravenous catheter inserted in the upper arm with the tip located just below the axilla area) catheter was appropriately monitored and maintained. This affected one resident (#16) out of one resident reviewed for intravenous (IV) access and had the potential to affect two residents (#16 and #313) identified by the facility with IV access. The facility census was 63. Findings included: Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including congestive heart failure, hypertension, and chronic obstructive pulmonary disease. Review of the undated comprehensive care plan for Resident #16 revealed nothing regarding Resident #16 having a midline IV catheter, including monitoring and/or maintaining it. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition and had no IV therapy. Review of the nursing note dated 05/26/24 at 8:04 P.M. and completed by Licensed practical Nurse (LPN) #643 revealed Nurse Practitioner (NP) #900 ordered Resident #16 to have one liter of IV fluids to run at 100 milliliters (ml) per hour. Review of the nursing note dated 05/26/24 at 8:05 P.M. and completed by LPN #643 revealed she had attempted to obtain IV access on Resident #16 but was unable. She contacted an outside company to have them come in to obtain IV access. The note revealed NP #900 was notified. Review of the nursing note dated 05/27/24 at 2:39 P.M. revealed RN #633 attempted twice to start IV access to administer Resident #16's IV fluids but was unable. She contacted the outside agency to obtain an update on the time they would be able to start IV access, and they were unable to provide a time due to the holiday weekend. NP #900 was updated. Review of the Midline Insertion Sheet dated 05/27/24 at 5:15 P.M. revealed the outside company (Registered Nurse (RN) #901) inserted a midline intravenous line to Resident #16's left arm without any difficulty. The midline instruction sheet revealed Resident #16 received a Power Midline Catheter and the recommended guidelines given to the facility included to maintain according to protocol including to flush each lumen of the catheter with ten ml sterile water every 12 hours or after each use. Post insertion complications included catheter dislodgment, catheter infection, inflammation of vein wall, catheter occlusion, hematoma at catheter site, and blood clot inside the vein near the catheter wall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 physician's orders revealed an order for a peripheral IV to be placed by outside company for one time that was signed off as completed by RN #633 on 05/27/24 at 5:27 P.M., and dextrose with sodium chloride one liter IV one time for dehydration that was signed off as administered by RN #633 on 05/28/24 at 10:32 A.M. Resident #16 did not have orders to maintain and monitor the midline IV catheter including no flush order, no dressing changes, and/or no orders to monitor for signs of infection. Interview and observation on 05/28/24 at 9:54 A.M. revealed Resident #16 had a midline IV intravenous catheter to her left arm with no signs of infection. Resident #16 was unable to provide any details regarding the IV access including how long she had it for and/or the reason for it. Interview on 05/30/24 at 8:52 A.M. with MDS/RN #605 revealed she did not know Resident #16 had a midline IV catheter as of 05/28/24. She verified there was no care plan regarding maintaining and/or monitoring her midline IV catheter. Interview on 05/30/24 at 9:23 A.M. with Assistant Director of Nursing (ADON)/ LPN #601 verified Resident #16 had a midline IV catheter that was inserted on 05/27/24. She verified that Resident #16 received one liter of IV fluids that was documented on 05/28/24. She verified after the IV fluids, there were no further orders to maintain the midline IV catheter, including flushing the catheter to ensure patency and checking the catheter site to ensure there were no signs of infection. She verified that usually if an IV catheter was not receiving IV medication and/or fluids through it, that they maintain patency per their facility policy by flushing it at least every 24 hours and the nurse should be checking the IV site for signs of infection every shift. She verified there were no physician orders and/or documented evidence in the medical record that Resident #16's midline IV catheter was being monitored and or maintained by flushing per the facility policy and/or the manufacturers guideline. Review of the facility policy labeled, Peripheral and Midline Intravenous (IV) Catheter Flushing and Locking, dated March 2022, revealed the purpose was to maintain catheter patency and function. The policy revealed for midline catheters used for intermittent infusion, flush the catheter and aspirate for blood return prior to each infusion and/or at least every 24 hours to assess catheter function. The policy revealed the nurse was then to document in the treatment administration record as well as note the condition of insertion site.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review and review of the facility policy, the facility failed to ensure residents had oxygen orders, oxygen was secured safely, and/or residents had oxygen signs indicating oxygen was in use. This affected two residents (#52 and #264) out of two residents reviewed for respiratory care. This had the potential to affect ten residents (#2, #9, #12, #25, #52, #56, #211, #264, #311, and #312) that were identified by the facility with oxygen. The facility census was 63. Findings include: 1. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including congestive heart failure, hypertension, and/or abnormalities with gait and mobility. Review of the undated comprehensive care plan revealed there was nothing in the care plan regarding Resident #52's use of oxygen. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively impaired. He wandered one to three days during the seven-day assessment reference period. Review of the May 2024 physician's orders revealed Resident #52 had an order for oxygen at two liters via nasal cannula as needed for shortness of breath and low oxygen saturation level. Observation on 05/27/24 at 9:34 A.M. revealed Resident #52 was lying in bed with two liters of oxygen being administered per his oxygen concentrator via nasal cannula. There was no sign on the outside of his room indicating oxygen was in use. Observation revealed next to his nightstand by his bed was a green E- cylinder (a cylinder containing oxygen that was combustible) not secured in a rack and/or proper holder to prevent from tipping over. Attempted interview revealed Resident #52 was cognitively impaired. Interview on 05/27/24 at 10:44 A.M. with the Director of Nursing (DON) verified Resident #52 was wearing oxygen while lying in bed and that there was no sign on the outside of his room indicating oxygen was in use. She also verified there was one E-cylinder that was free standing next to his nightstand not in a rack and/or proper holder. Interview on 05/30/24 at 8:52 A.M. with MDS/Registered Nurse (RN) #605 verified there was nothing in Resident #52's care plan regarding his use of oxygen. Review of the undated facility policy labeled, Oxygen Handling and Storage revealed the policy was to coordinate and manage the handling and storage of medical gas cylinders (oxygen only). The policy revealed to never leave an oxygen tank freestanding, not even for a moment. The policy revealed cylinders were to be in appropriate storage racks or cabinet. 41526 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #264 revealed an admitted [DATE]. Diagnoses included pneumonia, chronic respiratory failure with hypoxia (oxygen deficiency), and chronic obstructive pulmonary disease. Review of the baseline plan of care completed 05/24/24 indicated Resident #264 required continuous oxygen at three LPM (liters per minute), and oxygen at six LPM during CPAP (continuous positive airway pressure) machine use. Resident #264's physician's orders for May 2024 revealed no evidence of oxygen related orders including monitoring for blood oxygenation saturation. Observation on 05/28/24 at 11:16 A.M. revealed Resident #264 was sitting in a wheelchair with oxygen being administered via nasal cannula at three LPM. There was a CPAP machine at the bedside and no oxygen safety signage in place. Interview at the time of the observation with Licensed Practical Nurse (LPN) #637 confirmed Resident #264 received oxygen continuous at three LPM and used a CPAP with oxygen during the night hours. LPN #637 verified no oxygen related orders were in place including monitoring for blood oxygenation saturation, and there was no oxygen safety signage posted. Review of the facility policy, Oxygen Administration, revised October 2010, revealed to verify there was a physician's order before administering oxygen. While a resident receives oxygen, assess vital signs and oxygen saturation if applicable for signs and symptoms of hypoxia, and place an Oxygen in Use sign on the outside of the room entrance door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 37095 Based on record review and interview, the facility failed to ensure state-tested nursing aides (STNAs) received annual performance evaluations. This affected two STNAs (#604 and #614) of three reviewed for completed employee files. This had the potential to affect all 63 residents residing in the facility. Findings include: Record review of the employee files for STNA #604 revealed she was hired 12/21/22. Record review of the employee file for STNA #614 revealed she was hired 12/22/22. No documented evidence could be found in either employee file indicating they received annual performance evaluations. Interview with Human Resources Director #663 on 05/29/24 at 4:05 P.M. confirmed the above findings. She said the facility did not perform annual evaluations for their employees.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 Based on record review, interview and facility policy review, the facility failed to ensure pharmacy recommendations were addressed by the physician in a timely manner. This affected three residents (#15, #21, and #25) of five residents reviewed for unnecessary medications. The facility census was 63. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included vascular dementia with anxiety, gastrointestinal hemorrhage, insomnia, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident#15 had intact cognition. Review of the 06/12/23 Pharmacist Recommendation to Physician revealed Resident #15 had an order for trazadone 50 milligrams (mg) (antidepressant and sedative). Take a half tablet by mouth daily. The pharmacist recommended that due to multiple problems associated with administering half tablets, the physician consider an alternate dosing regimen so that whole pills were used. The form was unsigned. Review of the 07/17/23 Pharmacist Recommendation to Physician revealed Resident #15 had an order for trazadone 50 mg. Take a half tablet by mouth daily. The pharmacist recommended that due to multiple problems associated with administering half tablets, the physician consider an alternate dosing regimen so that whole pills were used. The form was unsigned. There was no change in medication until 10/17/23. Interview on 05/29/24 at 11:29 A.M. with Regional Travel Director of Nursing (DON) #662 verified the forms were not signed, and the requested action was not completed in a timely manner. 39973 2. Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including major depression, anxiety disorder, legal blindness, and hypothyroidism. Review of the pharmacy recommendation dated 06/12/23 and completed by Consultant Pharmacist #667 revealed he had reviewed Resident #21's medical record for indications to support the use of the patient's medication. Consultant Pharmacist #667 revealed Seroquel (anti-psychotic medication) lacked a proper diagnosis and could be considered unnecessary. He recommended to consider discontinuing the medication if the medication was no longer needed. The recommendation was unsigned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy recommendation dated 07/17/23 and completed by Consultant Pharmacist #667 revealed he had reviewed Resident #21's medical record for indication to support the use of the patient's medication. Consultant Pharmacist #667 revealed Seroquel lacked a proper diagnosis and could be considered unnecessary. He recommended to consider discontinuing the medication if the medication was no longer needed. The recommendation was unsigned. Review of the pharmacy recommendation dated 08/23/23 and completed by Consultant Pharmacist #667 revealed he had reviewed Resident #21's medical record for indication to support the use of the patient's medication. Consultant Pharmacist #667 revealed Seroquel lacked a proper diagnosis and could be considered unnecessary. He recommended to consider discontinuing the medication if the medication was no longer needed. The recommendation was unsigned. Review of the pharmacy recommendation dated 09/21/23 and completed by Consultant Pharmacist #667 revealed Resident #21 was receiving Seroquel but lacked an allowable diagnosis to support its use. Consultant Pharmacist #667 provided a list of appropriate diagnosis/ conditions that supported the use of the Seroquel. The recommendation was unsigned. Review of Medication Administration Records (MAR) April 2023 through October 2023 revealed Resident #21 received Seroquel 37.5 mg tablet by mouth at bedtime from 04/06/23 till 10/17/24 without a supporting diagnosis. Interview on 05/29/24 at 11:27 A.M. with Regional Travel Director of Nursing (DON) #662 verified Resident #21's pharmacy recommendations dated 06/12/23, 07/17/23, 08/23/23, and 09/21/23 all recommended to either have Resident #21's Seroquel discontinued and/or have a diagnosis added that would support the use of. Regional Travel DON #662 verified the recommendations were all unsigned and not addressed timely as Resident #21 had remained on Seroquel from 04/06/24 to 10/17/23 without a supporting diagnosis. 41526 3. Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, emphysema and diabetes mellitus type II. Review of the quarterly MDS assessment completed 02/28/24 indicated Resident #25 had no cognitive impairment and received opioid medication during the assessment period. Resident #25's physician orders specified an order dated 12/04/23 for acetaminophen 650 mg (milligrams) (analgesic and fever reducer) every eight hours PRN (as needed) for pain and an order dated 02/16/24 for Norco (hydrocodone-acetaminophen) 5-325 mg (opioid pain medication) every six hours PRN for pain. Review of the monthly pharmacist review recommendation dated 03/25/24 revealed the pharmacist indicated the PRN medications acetaminophen and Norco both had a diagnosis of pain but requested the physician be more specific when each medication should be used, i.e., mild pain for one and moderate/severe pain for the other, by type of pain, or consider using a pain scale for each medication. The recommendation was not completed. There was no documented evidence on the recommendation form that the physician was notified or addressed the recommendation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the monthly pharmacist review recommendation dated 04/28/24 revealed the pharmacist indicated the PRN medications acetaminophen and Norco both had a diagnosis of pain but requested the physician be more specific when each medication should be used, i.e., mild pain for one and moderate/severe pain for the other, by type of pain, or consider using a pain scale for each medication. The recommendation was not completed. There was no documented evidence on the recommendation form that the physician was notified or addressed the recommendation. Review of Resident #25's physician orders effective May 2024 revealed no changes were made to the PRN orders for acetaminophen and Norco to specify parameters for use. Review of the facility policy, Medication Therapy, revised April 2007, revealed all medication orders were supported by appropriate care processes and practices. The staff and practitioner reviewed an individual's current medication regimen to identify whether the frequency of administration and during use were appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37097 Based on observation and interview, the facility failed to puree all items in a manner that preserved nutrient value and taste. This had the potential to affect the five residents (#13, #18, #31, #46, and #213) identified by the facility as receiving pureed consistency foods. The facility census was 63. Findings include: Observation on 05/29/24 at 11:41 A.M. of the preparation of puree green beans revealed [NAME] #656 added green beans and their cooking water to a blender. There was a lot of cooking water. The green bean mixture was blended. [NAME] #656 checked the consistency and found it was too thin. The cook added food thicker and blended again. This was completed three times. The resulting puree green beans had an appropriate consistency but tasted diluted. This amount of water and thickener also diluted the nutrient density. [NAME] #656 verified there had been too much water in the mixture requiring additional thickener to be needed to reach the correct consistency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37097 Based on observation and staff interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner and the dish machine was monitored to ensure all service ware, cutlery, and utensils were sanitized effectively. This had the potential to affect 63 residents residing in the facility. The facility identified no residents received nothing by mouth. Findings include: An initial kitchen tour was conducted on 05/28/24 between 8:59 A.M. and 9:22 A.M. with Dietary Manager (DM) #655. Observation of the low temperature dish machine revealed the following: Dietary Worker/Cook #661 did not know what the temperature of dish machine should be or how to test the chemical level. DM #665 tested the dish machine rinse with a test strip usually used for testing Quaternary solutions used in the three compartment sinks and sanitizing buckets. Quaternary solutions should be maintained at 150 to 200 parts per million (ppm) concentration. The test strip did not show any results because it was the wrong type of strip. Low temperature dish washers use chemical sanitization. Wash temperature must hit 120 degrees Fahrenheit (F), and the chemical solution must be maintained at the correct concentration, based on periodic testing, at least once a shift. The Final Rinse must be 50 to 100 ppm hypochlorite (chlorine) on the dish surface in the final rinse. During the tour, Dietary Worker/Cook #661 was observed using the same gloved hands to scrape dirty dishes and pans as well as empty the clean dishes from the dish machine. The utensil drawer had crumbs and other greasy dirt inside, and the carts used in kitchen were very dirty with spills and food debris on them. This was verified by DM #655 at the time of observation. On 05/28/24 at 10:14 A.M. Dietary Workers #657 and #659, in the dish room, did not know how to test the chemical level of the dish machine, or what strips to use. On 05/28/24 at 10:19 A.M. review of the monthly record of the dish machine temperatures and chemical level for May 2024 revealed the record form had been filled out for the month as if the final rinse had been 50 to 100 ppm every shift. The facility did not have the correct test available to measure the chemical being used. On 05/28/24 at 10:19 A.M. interview with DM #655 verified they had not been testing the dish machine sanitization level correctly, and that the monthly record for May 2024 was inaccurate/falsified. On 05/29/24 at 3:47 P.M. interview with DM #655 verified they had been using the wrong test strips for a while, she was not sure how long.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, interview, record review, facility policy review, and review of the memorandum from the Department of Health and Human Services, the facility failed to initiate and use enhanced barrier precautions (EBP) when appropriate for Residents #56, #262, #264, and #313. This affected four residents (#56, #262, #264 and #313) of seven residents reviewed for infection prevention and control and had the potential to affect all 63 residents residing in the facility. Findings include: 1. Observation and interview on 05/28/24 at 9:08 A.M. with Resident #262 revealed a PICC (peripherally inserted central catheter) in the right arm. There was no EBP posted and no personal protective equipment (PPE) available at the room entrance. Review of the medical record for Resident #262 revealed an admitted [DATE]. Diagnoses included osteomyelitis, diabetes mellitus type II, and urinary tract infection. The physician orders and medication administration records from April 2024 to May 2024 indicated an intravenous (IV) antibiotic was infused daily via PICC from admission until 05/26/24. PICC line flushes were completed twice daily and continued after 05/26/24. Interview on 05/28/24 at 9:55 A.M. with Licensed Practical Nurse (LPN) #639 verified Resident #262 had a PICC line for IV antibiotic therapy. The antibiotic therapy was completed on 05/26/24, but the twice daily flushes continued. LPN #639 confirmed there were no EBPs in place for Resident #262. 2. Observation and interview on 05/28/24 at 9:21 A.M. with Resident #264 revealed an indwelling urinary catheter was in place with a urinary drainage bag secured to the left bedside. There was no EBP posted and no PPE available at the room entrance. Observation on 05/28/24 at 9:47 A.M. revealed State tested Nursing Assistants (STNA) #621 and #630 entered Resident #264's room and placed one opened package of gowns and one box of gloves onto the floor just inside the entrance door to the right. Each STNA obtained a gown and gloves from the supply which was placed onto Resident #264's floor and donned the PPE. Interview at the time of the observation with STNAs #621 and #630 verified there were no EBPs in place for Resident #264, so they put the gowns and gloves on the floor for use until it was set up. Review of the medical record for Resident #264 revealed an admitted [DATE]. Diagnoses included pneumonia, chronic kidney disease stage III, and diabetes mellitus. The baseline plan of care completed 05/24/24 indicated Resident #264 had an indwelling urinary catheter. 3. Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included urinary tract infection, diabetes mellitus type II, atrial fibrillation, hypertension, chronic obstructive pulmonary disease, and gastrostomy status. The plan of care revised 04/08/24 indicated Resident #56 required an enteral feeding tube related to dysphagia (difficulty swallowing). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366326	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Center for Rehabilitation and Nursing	1140 South Broadway Geneva, OH 44041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/29/24 at 8:15 A.M. of medication administration for Resident #56 revealed Registered Nurse (RN) #640 prepared 12 medications for enteral administration. There was a sign posted for EBP and PPE located just inside Resident #56's room to the left of the doorway. RN #640 entered the room, donned gloves and administered the medications via Resident #56's enteral feeding tube. RN #640 did not wear a gown during the medication administration procedure. Interview at the time of the observation with RN #640 confirmed no gown was worn for EBP as required. 4. Review of the medical record for Resident #313 revealed an admitted [DATE]. Diagnoses included cellulitis of the left lower limb, necrotizing fasciitis, and diabetes mellitus type II. The baseline plan of care completed 05/20/24 indicated a right arm PICC line for IV antibiotic administration. Observation on 05/29/24 at 11:48 A.M. of medication administration for Resident #313 revealed Assistant Director of Nursing (ADON) #601 obtained one IV antibiotic medication for administration. ADON #601 entered Resident #313's room. There was a sign posted for EBP and PPE located just inside the room to the right of the doorway. ADON #601 donned gloves and administered the IV medication into Resident #313's right arm PICC line. ADON #601 did not wear a gown during the medication administration procedure. Interview at the time of the observation with ADON #601 confirmed no gown was worn for EBP as required. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO). The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. Review of the facility policy, Policy on Disease-Specific Isolation/Precautions, initiated 04/01/24, revealed EBP were used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities. EBP was indicated for residents with indwelling medical devices even if the infectious status was unknown. Indwelling medical devices include central lines and urinary catheters.