

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Wayne County Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 876 S Geyers Chapel Road Wooster, OH 44691	

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 - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>36650</p> <p>Based on interview and record review the facility failed to ensure residents who wanted the facility to manage resident funds had a signed authorization for the facility to manage their resident funds. This affected two residents (#19 and #37) out of 24 residents with resident funds.</p> <p>Findings Include:</p> <p>Review of the Resident Funds for Resident #19 revealed the current balance of \$2,210.05 in the Resident funds account, There was no documentation that Resident #19 signed authorization for the facility to manage his resident funds.</p> <p>Review of the Resident Funds for Resident #37 revealed the currant balance of \$3,716.61 in the Resident funds account. There was no documentation that Resident #37 signed authorization for the facility to manage his resident funds.</p> <p>Interview on 11/12/24 at 3:01 P.M. with Fiscal Specialist #300 verified there were no resident funds authorizations forms for Resident #19 and Resident #37.</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: 366341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Wayne County Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 876 S Geyers Chapel Road Wooster, OH 44691	

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>36650</p> <p>Based on interview and record review the facility failed to ensure residents receive a spend down notice prior to reaching the maximum allowed limit for Medicaid benefits. This affected two residents (Resident #4 and #19) out of 24 residents with resident funds.</p> <p>Findings Include:</p> <p>Review of the Resident Funds for Resident #19 revealed a balance of \$3,716.61 in the Resident Funds account. The facility is to notify the resident when their account reaches \$200 below the allotted amount (\$2000), which could cause the resident to lose their Medicaid benefits.</p> <p>Review of the Resident Funds for Resident #4 revealed a balance of \$4,814.47 in the Resident Funds account. The facility is to notify the resident when their account reaches \$200 below the allotted amount (\$2000), which could cause the resident to lose their Medicaid benefits.</p> <p>Interview on 11/12/24 at 3:01 P.M. with Fiscal Specialist #300 verified Resident #4 and #19 did not receive written notification that their accounts were over the allotted amount and could affect residents Medicaid benefits. Residents are to be notified that they are getting close to the limit so that they can use their funds or the funds need to be returned to Medicaid.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Wayne County Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 876 S Geyers Chapel Road Wooster, OH 44691	
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>Based on review of the medical record, review of therapy assessments, and staff interview, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) to Resident #41. This affected one resident (#41) of two reviewed for beneficiary notification. The facility census was 37.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #41 revealed an admitted [DATE] with diagnoses including cerebral infarction, hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting non-dominant left side, muscle wasting and atrophy to bilateral lower extremities, and unspecified abnormalities of gait and mobility. Resident #41 was discharged on [DATE].</p> <p>Review of the physician's orders for June 2024 identified orders for occupational therapy five to seven times per week for four weeks (ordered 05/08/24) and physical therapy five to seven times per week for four weeks (ordered 05/06/24).</p> <p>Review of the progress note, dated 05/10/24 at 1:08 P.M., revealed Social Services Designee (SSD) #245 met with Resident #41 and his daughter to discuss discharge planning, a discharge meeting was scheduled for 05/22/24, and Resident #41's therapy discharge date was set for 06/03/24.</p> <p>Review of the discharge Minimum Data Set (MDS) Assessment, dated 06/04/24, revealed Resident #41 had no cognitive impairment. The assessment indicated Resident #41 required partial or moderate assistance for showering, dressing, sit to stand, transfers, and walking, and supervision or touching assistance for oral hygiene, toileting hygiene, personal hygiene, and bed mobility. Resident #41 received 894 minutes of speech therapy over 24 days, 2,797 minutes of occupational therapy over 56 days, and 2,887 minutes of physical therapy over 57 days.</p> <p>Review of the physical therapy recertification assessment, dated 05/08/24, revealed Resident #41 was certified for physical therapy services through 06/01/24. Review of the occupational therapy recertification assessment, dated 05/08/24, revealed Resident #41 was certified for occupational therapy services through 06/03/24.</p> <p>On 11/13/24 at 2:56 P.M., an interview with SSD #245 confirmed a Notice of Medicare Non-Coverage (NOMNC) was not provided to Resident #41 because he was not managed care and it was not an involuntary discharge. SSD #245 was unaware that a NOMNC was supposed to be provided to individuals receiving skilled services covered under Medicare Part A.</p> <p>On 11/14/24 at 8:09 A.M., an interview with Certified Occupational Therapy Assistant (COTA) #303 confirmed the recertification dates for therapy services were the dates Resident #41 was approved for therapy services covered by insurance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Wayne County Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 876 S Geyers Chapel Road Wooster, OH 44691	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/14/24 at 9:00 A.M., an interview with the Director of Nursing (DON) verified the progress note dated 05/10/24 indicated Resident #41 would be discharged from therapy on 06/03/24 with a discharge planning meeting scheduled with Resident #41's family on 05/22/24. The DON stated a NOMNC should have been issued to Resident #41.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Wayne County Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 876 S Geyers Chapel Road Wooster, OH 44691	
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** 44808</p> <p>Based on observation, interview, and review of facility policy, the facility failed to change the oxygen tubing in a timely manner for Resident #8. This affected one resident (#8) of one reviewed for oxygen use. The facility census was 37.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including cerebral infarction, type two diabetes mellitus, anxiety, ovarian cancer, hypertension, depression, and hemiplegia and hemiparesis following cerebral infarction.</p> <p>Review of the respiratory care plan, revised 01/18/24, revealed Resident #8 had the potential for altered breathing patterns related to shortness of breath, anxiety, decreased energy, fatigue, and hypoxia. Interventions included administer oxygen via nasal cannula as per orders and observe effects (revised 07/05/23) and change oxygen tubing as per physician's orders (revised 07/05/23).</p> <p>Review of the significant change Minimum Data Set (MDS) Assessment, dated 10/02/24, revealed Resident #8 had severe cognitive impairment and utilized oxygen therapy.</p> <p>Review of the physician's orders for November 2024 identified orders for change oxygen tubing, bag and aerosol set-up every Saturday (ordered 06/10/23).</p> <p>Review of the treatment administration record (TAR) for November 2024 indicated Resident #8's oxygen tubing was changed on 11/09/24, signed as administered by Licensed Practical Nurse (LPN) #503.</p> <p>On 11/12/24 at 9:05 A.M., an observation of Resident #8 revealed she was laying in bed with eyes closed, not responsive to verbal stimuli, and was receiving oxygen via nasal cannula. The oxygen tubing was dated 11/02/24.</p> <p>On 11/12/24 at 9:10 A.M., an observation and interview with Certified Nurse Aide (CNA) #229 verified Resident #8's oxygen tubing was dated 11/02/24.</p> <p>On 11/12/24 at 3:11 P.M., an interview with the Director of Nursing (DON) stated the facility's policy was to change the oxygen tubing at least every seven days or as needed.</p> <p>On 11/13/24 at 9:17 A.M., an attempt to interview LPN #503 via phone was unsuccessful.</p> <p>Review of the facility's policy titled Departmental (Respiratory Therapy) - Prevention of Infection, dated November 2011, indicated the oxygen cannula and tubing would be changed every seven days or as needed.</p>		