STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366378	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covington Skilled Nursing & Rehab Center	100 Covington Drive East Palestine, OH 44413

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734 Based on record review and interview, the facility failed to ensure residents and or responsible parties received room change notifications in writing. This affected three residents (Resident #4, Resident #17, Resident #18) of six residents reviewed for room change notifications. The census was 56. Findings include: 1. Review of the medical record for Resident #4 revealed an admitted [DATE] with the diagnoses of adult failure to thrive, diabetes and spinal stenosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #4's medical record revealed a progress note dated 03/28/25 and 04/01/25 that the resident moved rooms. There was no indication the resident and/or representative received the notification in writing. Review of Resident #4's Room Change Notification Forms revealed the resident moved 03/28/25 and 04/10/25. There was no indication the resident and/or representative received the notification in writing. Interview on 04/28/25 at 10:26 A.M. with Resident #4 during initial screening revealed she had been in three different rooms since being at the facility and was not sure why she had been moved. Interview on 04/30/25 at 5:04 P.M. with Social Service Designee (SSD) #504 revealed she notified residents verbally of any room changes and put a note in the chart. She was not aware of any form that was completed or that notification should be in writing. 2. Review of the medical record for Resident #17 revealed an admitted [DATE] with the diagnoses of ventricular fibrillation, dementia and acute kidney failure. Review of Resident #17's Room Change Notification form revealed the resident moved rooms on 10/11/24. There was no indication the resident and/or representative received the notification in writing. Review of the quarterly MDS dated [DATE] revealed Resident #17's had cognitive impairment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/01/25 at 11:15 A.M. with Resident #17's son revealed the facility left a phone message but he did not receive anything in writing about a room notification. Interview on 04/30/25 at 5:04 P.M. with SSD #504 revealed she notified residents verbally of any room changes and put a note in the chart. She was not aware of any form that was completed or that notification should be in writing. 3. Review of the medical record for Resident #18 revealed an admitted [DATE] with the diagnoses of heart failure, diabetes and osteoarthritis. Review of the annual MDS dated [DATE] revealed the resident was cognitively intact. Review of Resident #18's medical record revealed no evidence Resident #18 received written notice of a new roommate. Review of Resident #16's Room Change Notification form revealed the resident moved into Resident #18's room on 04/02/25. Interview on 05/01/25 at 11:23 A.M. with Resident #18 revealed she was not notified in writing when receiving a new roommate, Resident #16. Interview on 04/30/25 at 5:04 P.M. with SSD #504 revealed she notified residents verbally of any room changes and put a note in the chart. She was not aware of any form that was completed or that notification should be in writing. Interview on 04/30/25 at 5:46 P.M. with Regional Nurse (REG) #599 revealed room notifications were in the progress notes. Interview on 04/20/25 at 6:06 P.M. with REG #599 revealed a copy of a blank room notification form and revealed nursing completed the form. REG #599 was not sure were the completed forms were kept. Interviews on 04/30/25 from 6:10 P.M. to 6:17 P.M. with floor nurses, Licensed Practical Nurse (LPN) #529, LPN #531 and LPN #560 revealed they were unaware of what the room change process was and denied completing any form for room notification. Interview on 04/30/25 at 7:09 P.M. with Assistant Director of Nursing (ADON) #501 revealed the team discussed room changes at their morning or afternoon meetings. She stated SSD #504 placed the phone call to responsible parties for notification of room changes. ADON #501 stated she gave her opinions on room changes but did not have anything else to do with it. She stated she thought SSD #504 kept the forms and believed SSD #504 started them during the morning or afternoon meetings. Interview on 04/30/25 7:15 P.M. at with SSD #504 revealed she had seen the form before after being shown a room notification form stating she thought the Director of Nursing (DON) and ADON filled them out. Interview on 05/01/25 at 12:40 P.M. with DON revealed prospective roommates were informed verbally. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled Transfers, Room to Room, revised December 20216 revealed no mention of written notification to the resident. Under the area of documentation it indicated the room change should be documented in the resident chart.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734 Based on review of the personnel files and interview with staff the facility failed to ensure the activities program was directed by a qualified professional. This had the potential to affect all 56 residents. Findings include: Review of the personnel file for Activity Director (AD) #505 revealed no evidence to support AD #505 had the appropriate qualifications for holding the position of activity director. AD #505 was hired as an activity assistant on 04/20/23 and was promoted to AD on 02/01/25. AD #505 signed the job description on 02/01/25. The checklist in the personnel file revealed AD #505 had a 90 day evaluation due for the Activity Director position on 05/01/25. Interview and record review on 04/30/25 at 4:07 P.M. with AD #505 and Administrator revealed AD #505 was initially hired as an activity assistant on 04/20/23. AD #505 stated she had no prior experience in an activity position. She was promoted to the activity director position on 02/01/25 after the position was unexpectedly vacated. Administrator stated Director of Clinical Services/Registered Nurse (DCS/RN) #592 oversaw the activity calendars and program. AD #505 stated she recently went to a training called Activity Director Bootcamp in March for 13.5 continuing education hours and provided the certificate. When asked what the requirements for an activity director were they could not provide the information except to say she had almost two years experience under a certified activity director. They verified AD #505 was not enrolled in any program to obtain her certification. Interview on 05/01/25 at 10:53 A.M. with DCS/RN #592 revealed she had been overseeing the activity programming since 2021 and communicated with AD #505 weekly. DCS/RN #592 verified she was not a certified activity director stating she had [AGE] years experience in healthcare field with about one and half years experience in an activity position years ago. When asked if AD #505 was enrolled in a program, DCS/RN #592 stated she needed to look up the information. She responded over an hour later by forwarding an email at 11:58 A.M. showing an email dated 05/01/25 and timed at 11:49 A.M. from Ohio Health Care Association (OHCA) acknowledging enrollment in a program. Interview on 05/01/25 at 12:25 P.M. with the OHCA representative in above email revealed she was not sure when the facility signed up for the certification program but it was either 04/30/25 or 05/01/25. She verified AD #505 was enrolled in the self-pace program which could be started immediately. She stated it consisted of 90 hours of training. She stated most people take the classes then take an exam to become certified. The OHCA representative stated the bootcamp training already done by AD #505 would not go toward the certification. Review of the job description for Activity Director dated 10/2017 revealed the applicant must be certified through an accredited source.

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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** 43063 Based on record review, observation and interview, the facility failed to ensure a physician's order for oxygen was in place for Resident #37. This affected one (Resident #37) of one resident reviewed for oxygen use. The facility had a total of nine residents who were on oxygen. The facility census was 56. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including respiratory failure, hypertension and diabetes mellitus. Review of the care plan dated 12/17/21 for Resident #37 revealed she had an alteration in respiratory function related to respiratory failure with hypoxia and oxygen use. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had oxygen therapy. Review of the physician's orders for April 2025 for Resident #37 revealed there were no oxygen orders in place after 04/22/25. There was an order for staff to change the oxygen tubing/cannula every week on night shift dated 02/29/24. Review of the nursing progress note dated 04/22/25 at 8:39 A.M. revealed Resident #37's oxygen saturation was stable with oxygen and the nurse practitioner provided an order to discontinue every shift checks of oxygen and to monitor oxygen monthly with routine vital signs. Observation on 04/28/25 at 12:54 P.M. of Resident #37 revealed she had oxygen on via nasal cannula at 2.5 liters. Observation on 04/29/25 at 9:19 A.M. revealed Resident #37 was wearing a nasal cannula, however, her oxygen concentrator was turned off. Observation on 04/29/25 at 9:22 A.M. with the Director of Nursing (DON) verified Resident #37 was ordered oxygen and the oxygen concentrator should be turned on. The DON stated Resident #37 would turn off the oxygen at times. Interview on 04/29/25 at 9:29 A.M. with the DON verified Resident #37 should have had an oxygen order in place for 2.5 liters via nasal cannula. She stated on 04/22/25 the nurse practitioner had discontinued oxygen saturation checks daily and ordered the checks monthly. The DON stated on 04/22/25 when the nursing staff discontinued the order for oxygen saturation checks, they also discontinued the oxygen order. Review of the facility policy titled, Oxygen Administration, revised October 2010, revealed the staff should verify there was a physician's order in place

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure the facility assessment was accurately completed. This had the potential to affect all 56 residents residing in the facility. Findings include: Review of the facility assessment dated [DATE] and signed by the Administrator, Regional Director of Operations #591 and the Director of Nursing (DON) revealed it was reviewed at the Quality Assurance Agency (QAA) in January 2025. The facility assessment did not have the facility's capacity or average daily census included in the assessment. Interview on 04/30/25 at 2:10 P.M. with the Administrator verified she had provided the facility assessment as noted above on 04/30/25 and this assessment was in the emergency preparedness book since the QAA meeting in January 2025. She verified the assessment did not have the capacity and average daily census listed. She stated the facility assessment she had provided was not the correct version. The Administrator then provided a second facility assessment dated [DATE] that was unsigned and did not match the original facility assessment. She verified she had just printed off the correct version.