STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Darby Glenn Nursing and Rehabilitation Center	4787 Tremont Club Drive Hilliard, OH 43026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on interview and observation, the facility failed to ensure Resident #65's bed was set to the proper setting to ensure comfort. This affected one resident (#65) of 18 reviewed for speciality mattresses. The facility census was 91. Findings include: Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses including cerebral infarction due to thrombosis of other cerebral artery, type 2 diabetes mellitus, need for assistance with personal care, anxiety, insomnia, lower back pain, hemiplegia, and major depressive disorder. Review of Resident #65's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she required maximal assistance for bed mobility. Review of Resident #65's medical record revealed an order dated 03/26/24 for a low air loss (LAL) mattress. Staff required to check placement and function every shift. Review of Resident #65's care plan dated 06/26/24 found she was at risk for alteration in comfort due to pain and hemiplegia. Interventions did not include a special air mattress. She was also at risk for alteration in skin integrity related to diabetes, hemiplegia, incontinence, mobility impairment and interventions included encourage resident to elevate heels, turn and reposition, and maintain low air loss mattress per physician order. Review of Resident #65's medical record revealed on 07/24/24 at 5:01 P.M. Resident #65 weighed 132.6 lbs. Interview and observation on 07/24/24 at 9:56 A.M. with Admin Nurse #113 in Resident #65's room confirmed the resident's bed was at an incorrect weight of 300 lbs. Admin Nurse #113 would reach out to bed company to ensure the weight was set correctly. Interview on 07/25/24 at 2:05 P.M. with Admin Nurse #55 said Resident #65 prefers her bed at a firmer setting that is why her bed is not set to the correct weight. Interview on 07/25/24 at 2:12 P.M. with Resident #65 said she does not like the pressure of the bed, it is too hard per her preference. (continued on next page)

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: 366387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 07/25/24 at 2:15 P.M. with Admin Nurse #113 and Resident #65 said her bed was hard and she was uncomfortable in it. Admin Nurse #113 confirmed Resident #65 correct weight was 132 pounds, Admin Nurse #113 adjusted Resident #65 bed to the correct weight. Interview on 07/25/24 at 2:29 P.M. with Maintenance Director #50 revealed Med-Aire Plus 8 Low Air Loss System (mattress) should be set to a minimum of 50 pounds higher than a residents weight. He confirmed if her weight is 132 pounds the bed should set to 200 pounds to prevent the bed from being too hard. Interview on 07/25/24 at 2:32 P.M. with Resident #65 confirmed after the bed weight was adjusted her bed was much more comfortable. Interview conducted on 07/25/24 at 5:50 P.M. with Admin Nurse #113 confirmed residents with special air mattresses are set per residents' comfort preference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on resident interview, family interview, staff interview, and policy review the facility failed to ensure care conferences were held quarterly. This affected four residents (#22, #68, and #79) of six residents reviewed for care conferences. The facility census was 91. Findings include: 1. Review of medical record for Resident #22 revealed admitted [DATE] with diagnoses including but not limited to paraplegia, congestive heart failure, cognitive communication deficit, and need for assistance with personal care. Review of Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. Review of social service note dated 02/28/23 revealed care conference was held on this date with the resident. Review of social service note dated 10/04/23 revealed spoke with the resident and offered care conference. The resident declined. Social Worker let her know we would offer quarterly, and they could request one at anytime. Further review of the medical record revealed no further notes or care conferences held since 02/28/23. 2. Review of medical record for Resident #68 revealed admitted [DATE] with diagnoses including but not limited to hydronephrosis, type two diabetes, chronic obstructive pulmonary disease, hypertension, hallucinations, anxiety, and sleep disorder. Review of Interdisciplinary Team (IDT) plan of care review summary dated 10/11/23 revealed daughter could not be present for care conference and needed to reschedule or have a phone care conference. Review of social service note dated 01/08/24 revealed the resident and/or responsible party offered care conference and they denied the care conference Proceed to care plan and monitor resident for social service needs. Review of social service note dated 03/22/24 revealed care conference was held with the IDT and the Power of Attorney (POA). No further care conferences were documented and no phone care conference was documented in October of 2023. Interview on 07/22/24 at 11:30 A.M. with family member of Resident #68 revealed the facility does not call her for care conferences. Family member stated that she always has to call the facility to get information and to set up meetings. (continued on next page)

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Note: The nursing home is disputing this citation.

Interview on 07/24/24 at 2:56 P.M. with the Director of Nursing (DON) verified the care conference was not held on 10/11/23 and phone care conference was not documented as being held. The DON verified there have been periods where the resident has not had care conferences quarterly. The DON stated the facility has been through several social workers in the past year.

3. Review of medical record for Resident #79 revealed admitted [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, type two diabetes, moderate protein-calorie malnutrition, dysphagia, kidney disease, hypertension, major depressive disorder, malignant neoplasm of unspecified part of right bronchus or lung, and acquired absence of lung.

Review of MDS dated [DATE] revealed the resident was cognitively intact.

Review of social service note dated 09/25/23 revealed resident and/or responsible party offered care conference. No response and no voicemail left due to voicemail not being set up. Social services to continue to follow.

Review of social service note dated 12/29/23 revealed social worker reached out to resident times two in regard to scheduled care conference on 12/28/23. The resident did not answer. Social worker left voicemail.

Review of IDT plan of care review dated 04/17/24 revealed the resident declined care conference at this time. IDT to review accordingly. Signed by social worker and therapy.

Interview on 07/25/24 at 11:12 A.M. with Resident #79 verified he has never attended a care conference. The resident stated that he was bed bound when he was admitted to the facility so he could not get out to attend meetings.

Interview on 07/24/24 at 1:47 P.M. with Social Services (SS #31) verified that prior to her coming to the facility the care conferences were not held quarterly for Resident #22, #68, and #79. SS #31 stated that in regards to setting up care conferences she would communicate with the resident and would call the families to schedule a date and time for care conference. SS #31 stated that the MDS triggers when the care conferences need to be held. SS #31 verified the care conferences are documented in point click care (PCC) under the social service note when held. SS #31 verified the social service summary is the MDS assessment that is completed.

Review of policy titled, Care Conference, revised on 03/20/24 revealed the facility shall inform the resident and, if applicable responsible party of the right to participate in the resident's plan of care in a manner that facilitates his/her participation which may include reminders posted in conspicuous locations in the facility, notices sent via mail and/or email, recorded phone messages, reminders during Resident Council, and reminders during routine communications and/or visits. The facility's IDT shall periodically review the resident's care plan and make necessary revisions based on the goals, preferences, and needs of the resident. At routine intervals and after significant changes, the resident and, if applicable the resident's representative shall be given an opportunity to participate in the plan of care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on interview, record review, and policy review, the facility failed to provide and offer Resident #65 activities per preference. This affected one resident (#65) of one resident reviewed for activities. The facility census was 91. Findings include: Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses including cerebral infarction due to thrombosis of other cerebral artery, type 2 diabetes mellitus, need for assistance with personal care, anxiety, insomnia, lower back pain, hemiplegia, and major depressive disorder. Review of Resident #65's activity assessment completed 03/11/24 revealed she prefers one-on-one (1:1) and small group activities. She enjoys bingo, television, pop music, and socializing. In line with her preferences, Resident #65 participates in bingo, crafts, happy hour/live music, and special events when she is up from bed. Activity staff will continue to invite, encourage, and assist her with activities as needed. Resident #65, who was recently admitted to hospice services, occasionally attends group activities but does not stay long due to pain. Listening to music she likes is very important to her. She finds it somewhat important to engage in group activities, pursue her favorite hobbies, and go outside. Review of Resident #65's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she was moderately cognitively impaired and dependent on staff for ambulation. Review of Resident #65's care plan dated 10/04/24 revealed the resident is a sociable person who enjoys participating in a variety of activities. Important activities for Resident #65 include arts and crafts, bingo, visits, reading, religious activities, and watching TV or movies. The goal is for her to participate in group activities twice per week. Interventions include assisting Resident #65 with sitting on the porch/courtyard/patio when weather permits and giving verbal reminders of activities before, they start. Review of Resident #65's medical record revealed that she was not invited to or did not attend arts and crafts, bingo, or party/social hour during June or July. Review of Resident #65's activity documentation from 06/01/24 to 07/23/24 revealed that she was not invited to or did not attend arts and crafts, bingo, or party/social hour. Interview on 07/23/24 at 9:30 A.M. with Resident #65 revealed that she did not have any activities scheduled. She expressed a desire to color or attend bingo on that day (07/23/24). Observation on 07/23/24 at 3:10 P.M. revealed that Resident #65 was not invited or taken to bingo. Interview on 07/24/24 at 9:56 A.M. with Admin Nurse #113 and Resident #65 confirmed she likes to go to bingo and staff can assist her with attending activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 07/24/24 at 2:00 P.M. with Resident #65 revealed that she was outside with a family friend. She said direct care staff rarely assist her in getting out of bed and taking her outside, despite her love for watching people from outside. Interview on 07/25/24 at 8:33 A.M. with Activity Director (AD) #24 confirmed Resident #65 is very sociable and used to attend group activities daily before transitioning to hospice care. Since the transition, she has faced limitations such as mobility and pain management. AD #24 acknowledged that her preferred group activities were not offered, and she did not attend them. AD #24 plans to communicate with direct care staff to ensure Resident #65 is offered and included in her preferred activities. Review of Program Planning/Scheduling policy dated 05/2007 revealed that the activity department is responsible for planning and scheduling an activity program that includes stimulating and therapeutic activities, diverse in focus, and consistent with the residents' wishes and needs.

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(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 Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, staff interviews, and record review, the facility failed to identify and assess new skin impairment timely. This affected one resident (#62) of four reviewed for skin. Facility census was 91. Findings include: Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, kidney disease, hypertension, pulmonary embolism, atrial flutter and delusion disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact and had no impairment in range of motion. The MDS revealed the resident was on an anticoagulant medication. Review of physician orders dated 06/25/23 for Eliquis (anticoagulant) 2.5 Milligrams (mg) tab with instructions to give one tab twice daily for atrial fibrillation. Facility had no orders for monitoring of bruising or bleeding. Review of the plan of care dated 05/14/24 revealed the resident was at risk of bleeding and bruising from anticoagulant medication with interventions to administer medications as ordered and monitor for adverse side effects of anticoagulant therapy and monitor for and report abnormal bruising or prolonged bleeding. Review of the progress notes dated 07/21/24 night shift assessment revealed no changes to skin. Review of the progress note dated 07/22/24 at 11:11 A.M. of assessment revealed no changes to skin. Review of the progress note dated 07/22/24 at 8:35 P.M. of assessment revealed no changes to skin. Interview and observation on 07/22/24 at 10:05 A.M. with Resident #62 revealed he noticed a bruise on his hand the previous evening (07/21/24). The bruise appeared to be about the size of hockey puck and was reddish purple in the middle with darker purple edges. Resident #62 revealed he told an aide about an hour ago and wanted the nurse practitioner to look at it as he was afraid due to the blood thinner he would have to go to the hospital. The resident stated staff were already at bedside several times including bringing his breakfast tray and when the nurse brought his morning medications and they were aware of his bruise. Interview on 07/22/24 at 10:14 A.M. with Licensed Practical Nurse (LPN) #107 revealed she was not informed by any aides of the bruise on the resident's hand. LPN #107 revealed she would assess the bruise and notify the nurse practitioner to evaluate the bruise per resident request. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 07/23/24 at 9:05 A.M. with Nurse Practitioner (NP) #206 confirmed the resident had a bruise and revealed the resident was anxious about going to the hospital after recent complications from eye surgery. He revealed the resident reported to him he hit his hand on the bedside table and appeared to be a bruise as a result from blood thinners. NP #206 revealed he would see the resident again today and revealed he would put in orders to monitor the bruise. NP #206 confirmed he did not document anything about the bruise in his visit note and confirmed nursing had no documentation of resident having a large bruise on his hand. Interview on 07/24/24 at 10:42 A.M. with the Director of Nursing (DON) revealed the facility did not have any documentation related to Resident #62's bruise. She revealed the expectation was for staff to document any skin impairments including bleeding or bruising and should include a description of the bruise including size location and appearance. The DON confirmed the skilled note written on 07/22/24 at 11:11 A.M. and 07/22/24 at 8:35 P.M. both stated no skin impairment. The DON also confirmed the nursing staff did not document any assessment or progress note acknowledging a large bruise on the resident's hand. Review of facility policy titled, Wound Assessment, dated 09/29/17 revealed wounds shall be assessed and monitored to determine if treatment plan was working or should be reevaluated.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, resident interview, and staff interview, the facility failed to ensure tube feed was labeled and dated. This affected one resident (#79) of one reviewed for tube feed. The facility census was 91. Findings include: Review of medical record for Resident #79 revealed admitted [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, type two diabetes, moderate protein-calorie malnutrition, dysphagia, kidney disease, hypertension, major depressive disorder, malignant neoplasm of unspecified part of right bronchus or lung, and acquired absence of lung. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. The resident was set up/supervision for meals. The resident rejected care one to three days during the seven day look back period. No weight loss or gain noted. Fifty one percent or more calories received from tube feeding and 501 milliliters a day or more average fluid intake per day provided by tube feeding. Review of current physician orders revealed diabetisource AC tube feed to run at 75 milliliters per hour for 22 hours via pump to provide 1650 milliliters per day to be on at 4:00 P.M. and off at 2:00 P.M. Observation on 07/22/24 at 10:27 A.M. revealed clear bag of tube feed hanging on a pole with no date or indication of what type of tube feed is in the bag. Interview on 07/22/24 at 10:34 A.M. with Nurse Manager (NM) #27 verified the tube feed bag was not labeled with tube feed solution or dated when it was hung. NM #27 stated she would discard the tube feed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48568 Based on observation, interview, and record review, the facility failed to ensure pests were not in the kitchen. This deficient practice had the potential to affect all residents. The census was 91. Findings include: Observation on 07/22/24 at 10:06 A.M. with Dietary Supervisor #104 revealed one flying insect around the clean dishware storage in the kitchen. Observation on 07/22/24 at 10:26 A.M. with Dietary Supervisor #104 revealed four flying insects located around the windowsill near the handsink in the kitchen. Interview on 07/22/24 at 10:27 A.M. with Dietary Supervisor #104 confirmed four flying insects around the windowsill and one flying insect around clean dishware storage in the kitchen. Dietary Supervisor #104 said they will call pest control. Observation on 07/23/24 at 11:09 A.M. revealed one flying insect flying around the handsink in the kitchen. Interview on 07/25/24 at 09:04 A.M. with Dietary Supervisor #104 confirmed the facility is aware of the pest issue and pest control should be on their way. Dietary Supervisor #104 also said pest control comes every month and as needed. Observation on 07/25/24 at 09:28 A.M. with [NAME] #29 revealed one flying insect by the handsink and stand mixer in the kitchen. Interview on 07/25/24 at 09:28 A.M. with [NAME] #29 confirmed the flying insect by the handsink and stand mixer in the kitchen. Observation on 07/25/24 at 09:29 A.M. with Dietary Supervisor #104 revealed one flying insect near the juice machine in the kitchen. Interview on 07/25/24 at 09:29 A.M. with Dietary Supervisor #104 confirmed one flying insect near the juice machine in the kitchen. Review of the, Infection Control - Dietary/Food Handling, policy dated March 2016 revealed a pest control plan must be in place. Review of the, Pest Control Program, policy dated 08/17/18 states The facility will maintain effective pest control that eradicates and contains common household pests and rodents . Review of the last 12 months of pest control service revealed the kitchen was not inspected or serviced in June. Further review revealed a call back order on 06/19/24 for flying ants.