STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366388	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonespring of Vandalia	4000 Singing Hills Bvld Dayton, OH 45414

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	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, staff interview, and review of the facility policy the facility failed to ensure call lights were accessible to two (Residents #428 and #439) of 28 sampled residents. The facility census was 134. Findings include: 1. Review of medical record for Resident #428 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes mellitus, dementia, and atrial fibrillation. Review of the Minimum Data Set (MDS) assessment for Resident #428 dated 08/19/23 revealed that the resident was cognitively impaired and was dependent on staff assistance for activities of daily living (ADLs.) Review of plan of care for Resident #428 dated 04/13/24 revealed the resident was at risk for an ADL self-care performance deficit related to atrial fibrillation, COPD, chronic kidney disease, glaucoma, and DM. Interventions included the following: assist with positioning to help maintain proper body alignment, encourage rest periods, keep call light within reach while in room. Observation on 04/17/24 at 7: 40 A.M. revealed Resident #428 was lying in bed and was awake. Resident #428's call light was on the right side of the bed on the floor, covered in the blanket and falling off the bed. Interview on 04/17/24 at 7:47 A.M. with Registered Nurse (RN)#154 confirmed Resident #428's call light was not in reach. RN #154 further confirmed Resident #428 was able to use her call light and the resident's call light should be kept within the resident's reach at all times. 2. Review of the medical record for Resident #429 revealed an admitted [DATE] with diagnoses including hemiplegia, hemiparesis, DM, cognitive deficit, and hypertension. Review of plan of care for Resident #429 revealed the resident was at risk for an ADL self-care performance deficit related to hemiplegia, left side weakness, gastric tube, pulmonary embolism, DM, dysphagia, and dysarthria. Interventions included the following: assist with ADLs, encourage rest periods, provide privacy, keep resident's call light within reach while in room. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/17/24 at 8:14 A.M. of Resident #429 revealed the resident was up in her reclining geri chair in her room with the call light on the bed and out of the resident's reach. Interview on 04/17/24 at 8:14 A.M. with RN #154 confirmed Resident #429 was able to use the call light to summon assistance but the call light was out of reach. RN #154 confirmed Resident #429's call light should be accessible to the resident while in the room. Review of the facility policy titled Call Lights dated August 2016 revealed the facility maintained a functioning communication system that registered residents' calls from rooms, toilet, and bathing facilities. It was the responsibility of each nurse to ensure the residents' call lights were working and within reach.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure carpet in resident rooms was maintained in a clean and sanitary manner. This affected one (Resident #421) of 28 sampled residents. The facility census was 134. Findings include: Review of medical record for Resident #421 revealed an admitted [DATE] with diagnoses including skin cancer, atrial fibrillation, and post-traumatic stress disorder (PTSD.) Review of the Minimum Data Set (MDS) assessment for Resident #421 dated 03/26/24 revealed the resident was cognitively intact and was dependent on staff for assistance with activities of daily living (ADLs.) Observation on 04/15/24 at 11:00 A.M. of Resident #421's room revealed there were six large dark red stains on the carpet next to television and dresser stand. Interview on 04/15/24 at 11:00 A.M. with Resident #421 confirmed the stains on the carpet were made when he had fallen, and his blood had dripped all over the floor. Interview on 04/15/24 at 2:30 P.M. with State tested Nursing Assistant (STNA) #250 confirmed Resident #421's carpet had six large stains due to the resident had bled on the floor when he fell . Observation on 04/16/24 at 1:40 P.M. revealed the stains to Resident #421's carpet were present and unchanged from the observation on 04/15/24. Interview on 04/18/24 at 1:40 P.M. with the Administrator confirmed Resident #421 had bled from a skin tear on 03/30/24 which had resulted in the blood stains to the resident's carpet. The Administrator further confirmed the facility had not removed the blood stains from Resident #421's carpet. Review of the facility policy titled Residents Rights dated 1987 revealed that residents at a nursing home had the right to provide a safe, and clean-living environment.

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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 0686 Level of Harm - Minimal harm or potential for 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** 44080 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff followed physician's orders for treatment of pressure ulcers. This affected one (Resident #429) of 17 facility-identified residents with pressure ulcers. The facility census was 137. Findings include: Review of medical record for Resident #429 revealed an admitted [DATE] with diagnoses including hemiplegia, hemiparesis, type two diabetes, and hypertension. Review of physician's order for Resident #429 dated 04/12/24 revealed an order for State tested Nursing Assistant (STNA) to apply Remedy barrier cream after each incontinent episode. Review of physician's orders for Resident #429 dated 04/17/24 revealed an order to cleanse the pressure ulcer to the resident's sacrum with normal saline, pat dry with sterile gauze, cover with collagen, cover with gauze or abdominal pad, then secure with tape every day and night shift. Observation on 04/17/24 at 11:10 A.M. revealed Unit Manager (UM) #240 removed an old dressing that was saturated with urine and blood from Resident #429's sacral pressure ulcer. UM #240 performed hand hygiene, then donned gloves and used a peri wipe to clean the peri wound area to sacral pressure ulcer. UM #240 did not clean the wound bed. UM #240 then performed hand hygiene, donned clean gloves and applied Remedy barrier cream to a border gauze dressing which she placed over the resident's sacral pressure ulcer. Interview on 04/17/24 at 11:12 A.M. with UM #240 confirmed Resident #429 had an order to cleanse the sacral pressure ulcer with normal saline, pat dry with sterile gauze, cover with collagen, cover with gauze or abdominal pad, then secure with tape every day and night shift. UM #429 confirmed she cleansed the peri wound to the resident's sacrum with a peri wipe and she applied Remedy barrier cream to the peri wound and covered the pressure ulcer with a gauze dressing. UM #240 confirmed she did not follow Resident #429's physician's orders for care of the resident's sacral pressure ulcer. Review of the facility policy titled Skin Integrity Team-Skin Monitoring Process dated January 2023 revealed the facility team would provide care and services to promote healing of pressure ulcers or other skin related issues in accordance with professional standards of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, observation, and staff interview, the facility failed to ensure non-edible products were secured and not accessible to residents with cognitive impairments. This affected one (Resident #94) of two residents reviewed for accidents. The facility census was 134. Findings include: Review of the medical record for Resident #94 revealed an admitted [DATE] with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #94 dated 04/02/24 revealed the resident had severely impaired cognition and required supervision for eating, moderate assistance for oral hygiene, maximal assistance for personal hygiene, and was dependent on staff for toileting, bathing, dressing, bed mobility, and transfer. Review of the plan of care for Resident #94 dated 10/26/22 revealed the resident had impaired cognition and decision-making skills related to dementia. Interventions included the following: administering medications as ordered, ask yes/no questions to determine the resident's needs, cue, reorient, and supervise as needed. Review of the progress note for Resident #94 dated 03/24/24 revealed the nurse was alerted by the aide that Resident #94 had ingested about two fluid ounces of no-rinse foam cleanser for cleansing and conditioning hair and skin. The facility staff contacted Poison Control and were informed the cleanser was non-toxic, but could cause gastrointestinal issues. Observation on 04/15/24 at 11:39 A.M. of Resident #94 revealed the resident was lying in bed. There was a bedside table next to the bed, and on the top of the table were various personal care items, including clinical no-rinse foam cleanser. Interview on 04/15/24 at 11:39 A.M. with Licensed Practical Nurse (LPN) #169 confirmed clinical no-rinse foam cleanser was on the bedside table next to Resident #94.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44080 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure gastrostomy tube (g-tube) feedings were administered in a safe and proper manner. The affected one (Resident #86) of seven facility-identified residents with g-tubes. The facility census was 134. Findings include: Review of medical record for Resident #429 revealed an admitted [DATE] with diagnoses including hemiplegia, hemiparesis, type two diabetes, cognitive deficit, and hypertension. Review of plan of care for Resident #429 dated 04/12/24 revealed the resident was at nutritional risk. Interventions included the following: administer tube feeding and flush per orders, maintain the head of the bed elevated 30 degrees during and thirty minutes after tube feeding, monitor and report signs and symptoms of aspiration. Review of plan of care for Resident #429 dated 04/12/24 revealed the resident required tube feeding related to dysphagia. Interventions included the following: administer tube feed and flush per orders, head of bed elevated 30 degrees during and thirty minutes after tube feed, verify tube placement, monitor for signs and symptoms of aspiration. Review of physician's orders for Resident #429 revealed an order dated 04/12/24 for the resident to have nothing by mouth. Review of physician's orders for Resident #429 revealed an order dated 04/17/24 for Glucerna 1.2 per g-tube via continuous pump at 60 milliliters (ml.) per hour. Observation on 04/17/24 revealed Resident #429 was lying flat in the bed and receiving care with the g-tube pump continuously running at 60 ml per hour. Interview on 04/17/24 at 11:20 A.M. with Unit Manager (UM) #240 confirmed Resident #429 was lying flat with the tube feeding running. UM #240 confirmed the tube feeding should have been placed on hold while the resident was receiving care which required the head of the bed to be lowered. Review of facility policy titled Gastric Tube dated March 2012 revealed that a resident who had a gastric tube should have the head of bed elevated at least 30 degrees while the tube feeding was infusing. Staff should turn the pump to the hold position while providing care that required the head of bed to be lowered.