STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366402	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Ridge of Mennonite Home Communities of Ohio	101 Willow Ridge Drive Bluffton, OH 45817

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review and staff interviews, the facility failed to ensure a thorough baseline care plan was created for one (Resident #172) of one reviewed for baseline care plans. The facility census was 20. Findings include: Review of the medical record for Resident #172 revealed an admitted [DATE]. The resident was admitted with diagnoses including aftercare following knee joint prosthesis, Parkinsonism, and hypertension. Review of the 07/01/24 admission skin assessment revealed documentation of a surgical wound with 31 staples and two sutures. Review of Resident #172's baseline care plan revealed no interventions or goals in place for the resident's surgical wound. Interview and observation on 07/08/24 at 10:47 A.M. revealed Resident #172 had thigh high compression hose on bilaterally. An Abdominal (ABD) pad was observed over his right knee. Upon questioning, Resident #172 stated he had right knee replacement surgery and was at the facility temporarily for therapy. Interview on 07/12/24 at 2:15 P.M. with the Director of Nursing verified there was no baseline care plan related to the surgical wound of Resident #172 and reported it was the expectation the base line care plan would have addressed the resident's surgical wound. Review of the 03/22 facility, Baseline Care Policy revealed any services and treatments to be administered on the behalf of the facility would be developed within the first 48 hours.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review and staff interview, the facility failed to ensure the advance directive code status in the Electronic Medical Record (EMR) matched the signed advanced directive form. This affected two (Resident #5 and #18) of three reviewed for advanced directives. The facility census was 20. Findings include: 1. Review of the medical record of Resident #5 revealed an admitted [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #5 had severe cognitive impairment. Review of a physician order in the EMR dated 04/27/24 revealed Resident #5's advanced code status was Do Not Resuscitate - Comfort Care (DNR-CC). Review of the DNR Order Form dated 04/29/24 revealed Resident #5's advanced code status was Do Not Resuscitate - Comfort Care Arrest (DNR-CCA). Interview on 07/11/24 at 2:16 P.M. with the Director of Nursing (DON) confirmed the advanced directive for Resident #5 was documented in the EMR as DNR-CC but should have been documented as DNR-CCA. 2. Review of the medical record of Resident #18 revealed an admitted [DATE] with diagnoses of fracture of other parts of pelvis, subsequent encounter for fracture with routine healing and essential (primary) hypertension. Review of the MDS dated [DATE] revealed Resident #18 was cognitively intact. Review of a physician order in the EMR dated 05/29/24 revealed Resident #18's advanced code status was DNR-CCA. Review of the DNR Order Form dated 06/11/24 revealed Resident #18'5 advanced code status was DNR-CC. Interview on 07/11/24 at 2:16 P.M. with the DON verified the advanced directive for Resident #18 was documented in the EMR as DNR-CCA but should have been documented as DNR-CC.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on review of Self Reported Incidents (SRI), staff interviews, record review, and review of facility policy, the facility failed to complete thorough investigations related to resident-to-resident sexual abuse. This affected three residents (#16, #15, #7) of three reviewed for abuse. The facility census was 20. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE]. The resident was admitted with diagnoses including dementia, stroke, type two diabetes mellitus, depression, and hypertension. The resident remained at the facility. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition and required extensive one person assistance for toileting and supervision for eating, bed mobility and transfers. Review of the care plan revealed Resident #16 had a history of being drawn to various females by doting affection, asking for dates and wanting companionship. Interventions included to educate family members regarding affectionate behavior and plans to divert, discourage, monitor displays and to offer alternative activities. Record review revealed Resident #16 had documented 15-minute checks from 03/10/24 at 9:30 P.M. until 03/18/24 at 3:15 P.M. Review of the progress note date 03/11/24 revealed Resident #16's daughter was called and notified of an incident with another resident which had occurred the previous day, and he remained on 15-minute checks. Review of the progress note dated 03/13/24 at 3:57 P.M. revealed activity staff requested an interview with Resident #16. Resident #16 began to rub activity staff's back and shoulders and staff attempted to redirect him. Resident #16 was documented to have told the activity staff he got lonely and would like to marry someone and leaned in to kiss her. Review of progress notes dated 03/14/24 and 03/15/24 reveled Resident #16 was observed on multiple occasions to hold hands, touch the leg, and put his arm around a female elder. Review of the progress note dated 03/16/24 revealed Resident #16 touched a staff member's breast two times and asked if someone could go to bed with him. 2. Review of the medical record for Resident #15 revealed an admitted [DATE]. The resident was admitted with diagnoses including Alzheimer's Disease, depression, aphasia and anxiety. The resident remained at the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed Resident #15 had impaired cognition and required extensive two person assistance for bed mobility, one person assistance for transfers and toileting, and supervision for eating. Review of a progress note dated 03/18/24 revealed Licensed Practical Nurse (LPN) #421 recieved a call from House #2 from State tested Nurse Aide (STNA) #238 that Resident #15 had been observed touching the shoulder and thigh of Resident #7 and kissing her on the lips and cheek. Resident #15 had been removed fromt the area. 3. Review of the medical record for Resident #7 revealed an admitted [DATE]. The resident was admitted with diagnoses including Alzheimer's Disease, unspecified psychosis, anxiety, depression and paranoid personality disorder. The resident remained at the facility. Review of the quarterly MDS assessment dated [DATE] revealed Resident #7 had severely impaired cognition and required extensive two-person assistance with bed mobility, transfers, and toileting, and supervision for eating. Review of the SRI dated 03/16/24 revealed Resident #16 had been observed by staff touching the arm of Resident #15. At a later time, Resident #16 was observed by State tested Nurse Aide (STNA) #492 touching the right breast of Resident #15. Resident #16 was removed from the area and a full body assessment of Resident #16 was completed with no concerns. The physician and families were notified. Review of the SRI dated 03/18/24 revealed Resident #16 was observed kissing Resident #7 by STNA #428. Resident #16 was removed and nursing staff were notified. A thorough skin assessment was completed of Resident #7 with no concern. The physician and families were notified and Resident #16 was admitted to a different facility for his behaviors. Interview on 07/10/24 at 10:42 A.M. with the Administrator, Director of Nursing (DON), and Clinical Services #505 while reviewing the SRI revealed a physical assessments of Resident #15 and Resident #7 was performed with no concerns, however no other residents were assessed. No interviews of residents were completed in regards of a concern for abuse. No staff statements were provided and no staff education had been given following the incident. The DON and Administrator stated they were not employed at the time of the incident and were unaware of the progress notes documenting behaviors prior to the sexual abuse, which had been substantiated at the time of either investigation. Review of the 10/22 facility policy, Abuse, Neglect and Expolitation, revealed allegations of abuse would be investigated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44076 Based on record review and staff interviews, the facility failed to ensure a thorough comprehensive care plan was completed for two (Residents #19, #5) of three reviewed for care plans. The facility census was 20. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE]. The resident was admitted with diagnoses including unspecified dementia, anxiety, depression and senile degeneration of the brain. She was admitted to hospice on 05/16/24. The resident remained at the facility. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had severely impaired cognition. She required moderate assistance with eating, substantial assistance for bed mobility, and was dependent for toileting, hygiene, and transfers. Review of the care plan revealed no goals or interventions in place for hospice care. An interview on 07/11/24 at 2:15 P.M. with the Director of Nursing (DON) verified there was no hospice care plan for Resident #19 and reported the expectation was for the care plan to include hospice care. 48570 2. Review of the medical record of Resident # 5 revealed an admitted [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the MDS assessment dated [DATE] revealed Resident #5 had severe cognitive impairment. Resident #5 required set-up assistance for eating and oral hygiene, supervision assistance for ambulation, and partial assistance for toileting hygiene, bathing, dressing, bed mobility, and transfers. Review of physician orders revealed an order dated 06/14/24 for Seroquel (antipsychotic) Oral Tablet 25 Milligrams (mg) (Quetiapine Fumarate) give 25 mg by mouth at bedtime related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #5's care plan revealed the care plan did not address Resident #5's use of antipsychotic medication. Interview on 07/11/24 at 2:16 P.M. with the DON confirmed Resident #5's care plan did not address use of antipsychotic medication.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48570 Based on record review, staff interview, and policy review, the facility failed to ensure a comprehensive care plan was developed and implemented. This affected two (Residents #5 and #18) of two residents reviewed for care planning. The facility census was 20. Findings include: 1. Review of the medical record of Resident #5 revealed an admitted [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had severe cognitive impairment and required set-up assistance for eating and oral hygiene, supervision assistance for ambulation, partial assistance for toileting hygiene, bathing, dressing, bed mobility, and transfers. Review of physician orders revealed an order dated 04/27/24 for an advance directive of Do Not Resuscitate - Comfort Care (DNR-CC), an order dated 04/27/24 for Apixaban (blood thinner) Oral Tablet 2.5 Milligram (mg) (Apixaban), give 1 tablet by mouth two times a day for blood thinner and an order dated 06/14/24 for Seroquel (antipsychotic) Oral Tablet 25 mg (Quetiapine Fumarate), give 25 mg by mouth at bedtime related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #5's care plan revealed the care plan did not address code status, use of a blood thinner, or the use of an anti-psychotic medication. 2. Review of the medical record of Resident #18 revealed an admitted [DATE] with diagnoses of fracture of other parts of pelvis, subsequent encounter for fracture with routine healing and essential (primary) hypertension. Review of the MDS assessment dated [DATE] revealed Resident #18 was cognitively intact. Resident #18 was independent for eating and required partial assistance for bed mobility, and substantial assistance for toileting hygiene, bathing, dressing, transfers, and for wheelchair mobility over 150 feet. Review of physician orders revealed an order dated 05/29/24 for Resident #18's advanced code status was DNR-CC Arrest, an order dated 06/13/24 for Aspirin Oral Tablet Delayed Release 81 mg (Aspirin), give 81 mg by mouth one time a day related to essential hypertension, an order dated 06/13/24 for Metoprolol Tartrate 25 mg two times daily for hypertension, an order dated 06/06/24 for Myrbetriq 25 mg extended release daily for urinary incontinence, and an order for Tramadol 50 mg every six hours as needed for pain. Review of Resident #18's care plan revealed the care plan did not address code status, hypertension, urinary incontinence, or pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/11/24 at 2:16 P.M. with the Director of Nursing (DON) confirmed Resident #5's care plan was not comprehensive and did not address code status, use of a blood thinner, or use of antipsychotic medication. The interview also confirmed that Resident #18's care plan was not comprehensive and did not address code status, hypertension, urinary incontinence, or pain. Review of the Care Plans policy dated 4/2022 revealed, It is the policy of the facility to develop and implement a person-centered care plan for each resident, consistence with resident rights, that included measurable objectives and timeframe's to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the residents comprehensive assessment.

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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** 44076 Based on record review and staff interviews, the facility failed to properly assess a surgical wound upon admission. This affected one (Resident #172) of one reviewed for wound assessments. The facility census was 20. Findings include: Review of the medical record for Resident #172 revealed an admitted [DATE]. The resident was admitted with diagnoses including aftercare following knee joint prosthesis, Parkinsonism, and hypertension. The resident remained at the facility. Review of the 07/01/24 admission skin assessment revealed documentation of a surgical wound with 31 staples and two sutures. There was no further description and no measurements of the surgical wound in the document. Interview and observation on 07/08/24 at 10:47 A.M. revealed Resident #172 had thigh high compression hose on bilaterally. An Abdominal (ABD) pad was observed over his right knee. Upon questioning, Resident #172 stated he had right knee replacement surgery and was at the facility temporarily for therapy. Interview on 07/10/24 at 1:59 P.M. with Registered Nurse (RN) #414 verified there were no measurements or description of the right knee surgical wound on the admission skin assessment. Review of the undated facility policy, Wound and Skin Care Treatment Program, revealed measurements of a wound would be completed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, observations, staff interviews, pharmacist interview, and policy review, the facility failed to ensure medications that should not be crushed were not crushed. This affected one (Resident #18) of one resident reviewed for medication administration. The facility census was 20. Findings include: Review of the medical record of Resident #18 revealed an admitted [DATE] with diagnoses of fracture of other parts of pelvis, subsequent encounter for fracture with routine healing and essential (primary) hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #18 was independent for eating and required partial assistance for bed mobility and substantial assistance for toileting hygiene, bathing, dressing, transfers, and for wheelchair mobility over 150 feet. Review of physician orders revealed an order dated 06/13/24 for Aspirin Oral Tablet Delayed Release 81 Milligrams (mg) (Aspirin), give 81 mg by mouth one time a day related to essential hypertension. Observation and interview on 07/10/24 at 7:54 A.M. with Registered Nurse (RN) #414 revealed the Aspirin Delayed Release was crushed and administered to Resident #18. RN #414 confirmed the medication was crushed. Interview on 07/10/24 at 10:28 A.M. with Pharmacist #510 confirmed Aspirin Delayed Release is what is supplied in the package for Resident #18's daily medication. Interview also confirmed the pharmacy was not aware of Resident #18 needing her medications crushed and that Aspirin Delayed Release should not be crushed and that she will be reaching out to the physician for a change in medications. Interview on 07/11/24 at 2:16 P.M. with the Director of Nursing (DON) confirmed the Aspirin Delayed Release for Resident #18 should not have been crushed. Review of the Standards for Medication Administration dated 08/15/12 revealed the policy does not address crushing medications that are not to be crushed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44076 Based on review of facility policy, documentation, and staff interviews, the facility failed to follow their Legionnaires policy. This had the potential to affect all 20 residents at the facility. Findings include: Review of the undated facility policy, Legionnaires Policy, revealed the policy applied to all water systems which included, but not limited to shower heads and hoses, ice machines and infrequently used equipment, cold water would be heated to 140 degrees Fahrenheit by water heaters in each house and relevant procedures and record keeping related to the program would be kept, maintained and reviewed as necessary. Interview on 07/11/24 at 2:59 P.M. with Maintenance Director #509 revealed the provided policy and water testing by an outside testing facility for Legionella and intermittent room water temperatures were the only documentation available for Legionella. He verified in the seven months he had been employed, he did not test the temperature of the water heaters and there was no documentation the shower heads had been treated or when a resident room was empty, stagnant water prevention was completed. Review of facility documentation revealed there was no documentation to show the facility was following their policy of checking water heaters.