

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation of Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 345 East Boundary Street Perrysburg, OH 43551	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation, record review, resident and staff interview, and review of the facility policy, the facility failed to ensure residents were provided a bed long enough to accommodate their height. This affected one (#107) of one resident reviewed for bed length. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #107 revealed an admitted [DATE] with diagnoses of osteoarthritis, anxiety, and gout.</p> <p>Review of the Admission Evaluation/Observation dated 09/03/24 revealed Resident #107 was alert and oriented to person, place, time, and event.</p> <p>Review of the Resident #107's height, documented 09/03/24, revealed he was 78 inches tall (six feet, six inches tall).</p> <p>Review of a nurses progress note dated 09/03/24 revealed a tall bed was ordered for Resident #107.</p> <p>Observation and interview on 09/16/24 at 9:33 A.M. revealed Resident #107 in bed with the head of the bed elevated to allow him to sit up in bed. Resident #107's head was at the same height as the top of the mattress and he had pillows under each knee keeping his knees bent. A flat footboard was flush against the end of the mattress and extended approximately one-and-one-half feet above the mattress. Resident #107 stated he was not comfortable in the bed and stated he was given the extended bed but it was still too short. Resident #107 stated he was six feet, six inches tall.</p> <p>Observation on 09/17/24 at 1:58 P.M. revealed Resident #107 in bed with the head of bed elevated and both legs propped up at the knees with pillows in such a way to keep both legs bent.</p> <p>Observation and interview on 09/17/24 at 5:16 P.M. with Resident #107 and his daughter revealed Resident #107 again with the head of bed elevated and both legs bent at the knee with pillows under them. Resident #107 stated he had not slept well the previous evening and again confirmed the bed was too short.</p> <p>(continued on next page)</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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/18/24 at 10:22 A.M. with the Assistant Director of Nursing (ADON) #319 stated she was aware Resident #107 had a long bed. ADON #319 stated she did not know whether Resident #107's height was considered when the facility requested a long bed from the contracted supplier. ADON #319 stated she was not aware Resident #107's bed was too short for him; however, she was aware his bed had a very high footboard.</p> <p>Interview on 09/18/24 at 10:34 A.M. with State tested Nurse Aide (STNA) #359 revealed he was familiar with Resident #107 and was aware the bed seemed a little short for Resident #107. STNA #359 stated there were a few techniques, such as bending his legs and sliding Resident #107 to the very top of the bed, to keep Resident #107 from being so tight in the bed. STNA #359 stated he reported his concern regarding the length of Resident #107's bed to the nurse but could not recall which nurse he reported it to.</p> <p>Follow up interview on 09/18/24 at 11:10 A.M. with ADON #319 revealed she spoke with the bed supplier and learned Resident #107's bed was 80 inches (six feet, eight inches) long and further stated she ordered a longer bed for Resident #107 and was told by the contracted supplier the bed would be delivered later in the day.</p> <p>Interview on 09/18/24 at 12:16 P.M. with ADON #319 revealed she did not visualize Resident #107 in his bed before calling to order a longer bed. ADON #319 stated she spoke with Licensed Practical Nurse (LPN) #362, who was the floor nurse for Resident #107, and LPN #362 told ADON #319 Resident #107 looked uncomfortable in his bed.</p> <p>Observation on 09/18/24 at 12:18 P.M. revealed Resident #107 lying in the newly delivered bed. Resident #107 was able to fully extend his legs without his feet pressing against the footboard.</p> <p>Interview on 09/19/24 at 8:18 A.M. with Resident #107 stated the longer bed was much better. Resident #107 stated he slept for seven hours the previous night due to the comfort of his bed.</p> <p>Review of the policy, Accomodation of Needs, dated October 2023, revealed the resident's individual needs and preferences, including the need for modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. Additionally, the resident's individual needs and preferences shall be accommodated to the extent possible.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>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.</p> <p>44815</p> <p>Based on observation, resident and staff interview, review of the floor plan, and review of the facility policy, the facility failed to ensure adequate window coverings were available in the dining rooms to prevent glare. This affected three residents (#37, #41 and #108) and had the potential to affect eleven residents (#13, #14, #24, #38, #42, #44, #48, #103, #104, #106, #107) who ate meals in the dining room on the second floor. The facility census was 55.</p> <p>Findings include:</p> <p>Interview on 09/16/24 at 10:00 A.M. with Resident #108 revealed she liked to eat her noon and evening meals in the dining room and the dining room was too bright. Resident #108 stated there were sheer curtains over the windows, but no blinds or heavier curtains. Resident #108 stated residents were blinded and all tried to sit with their backs to the windows.</p> <p>Observation on 09/16/24 at 12:10 P.M. of the third floor dining room revealed a large room with windows along one wall. The sunlight was very bright and coming in through the windows. Observation of the window coverings revealed only sheer curtains were available. No blinds or heavier curtains were available to cover the windows.</p> <p>Continued observation on 09/16/24 at 12:11 P.M. revealed State tested Nurse Aide (STNA) #359 pushing Resident #108 in her wheelchair into the dining room on the third floor. Resident #108 stated she did not want to sit with her eyes in the sun. Resident #108 further stated the sun was very bright. STNA #359 seated Resident #108 with her back to the window.</p> <p>Interview on 09/17/24 at 5:09 P.M. with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #362 revealed they were not aware of any resident concerns regarding the brightness of the dining room. Concurrent observation of the second floor dining room with the (DON) confirmed no window coverings were available except sheer curtains.</p> <p>Interview on 09/17/24 at 5:25 P.M. with STNA #417 revealed Resident #37 and Resident #41 reported concerns about the brightness of the dining room. STNA #417 stated she filled out a concern form and turned it in to Human Resources.</p> <p>Interview on 09/18/24 at approximately 3:00 P.M. with Human Resources Manager (HRM) #413 revealed she did not receive concern forms and she believed all concern forms were given to the Administrator.</p> <p>Interview on 09/18/24 at approximately 3:15 P.M. with the Administrator revealed she did not recall receiving a concern form regarding the brightness of the dining room.</p> <p>Interview on 09/19/24 at 9:21 A.M. with Resident #41 revealed the sunlight in the dining room during the dinner meal to be blinding and terrible. Resident #41 reported the sheer curtains were pulled but the sunset came straight through and made it uncomfortable for residents in the dining room. Resident #41 further stated residents preferred to sit with their backs to the sun but there were not enough seats. Resident #41 reported verbal complaints had been made but there had been no changes.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's floor plan revealed the dining rooms on the second and third floors were in the same location on the floor and the windows faced west.</p> <p>Review of the policy, Homelike Environment, dated 10/2023, revealed comfortable lighting is provided in all areas of the facility, including reduction in glare (through use of light filters).</p>

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<p>F 0606</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>31638</p> <p>Based on personnel file review and staff interview, the facility failed to complete reference checks for new hires. This had the ability to affect all residents. The facility census was 55.</p> <p>Findings include:</p> <p>Review of State tested Nursing Aide (STNA) #359, Registered Nurse #428, and Environmental Services Manager #320's personnel files revealed they were hired on 01/08/24 and no reference checks were completed.</p> <p>Review of Activity Director #310's personnel file revealed she was hired on 02/26/24 and no reference checks were completed.</p> <p>Review of STNA #435's personnel file revealed a hire date of 04/01/24 and no reference checks were completed.</p> <p>Review of STNA #417's personnel file revealed a hire date of 06/10/24 and no reference checks were completed.</p> <p>Review of Licensed Practical Nurse (LPN) #361's personnel file revealed a hire date of 08/05/24 and no reference checks were completed.</p> <p>Review of Maintenance Manager #349's personnel file revealed a hire date of 08/28/24 and no reference checks were completed.</p> <p>Interview with Human Resource Manager #413 on 09/19/24 at 11:45 A.M. revealed on 02/24/24 the corporate office informed the facility that reference checks were no longer required by law so the checks were failed to be completed.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528</p> <p>Based on medical record review, resident interview, staff interview, and review of policy, the facility failed to ensure care conferences were offered quarterly. This affected two (#13 and #41) of three residents reviewed for care plan conferences. The facility census was 55.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #13 was admitted on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertensive heart disease without heart failure, major depressive disorder recurrent, and mixed hyperlipidemia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was not assessed for cognition. The previous MDS assessment, dated 04/04/24, revealed Resident #13 was cognitively impaired.</p> <p>Review of the social service progress note dated 11/02/23 revealed a care conference was held.</p> <p>Further review of the medical record revealed no additional care conferences were completed.</p> <p>Interview on 09/19/24 at 10:54 A.M. with Licensed Social Worker (LSW) #460 verified a care conference had not been held for Resident #13 since the documented care conference on 11/02/23. LSW #460 reported Resident #13's resident representative did not want to meet over the summer due to personal reasons. LSW #460 reported the interdisciplinary team met but did not attempt to include the resident and did not document meeting as a care conference.</p> <p>2. Review of the medical record revealed Resident #41 was admitted on [DATE]. Diagnoses included other incomplete lesion at C1, C2, C3, and C4 level of cervical spinal cord, acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, pressure ulcer of sacral region stage four, and pressure ulcer of other site stage four.</p> <p>Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact.</p> <p>Review of the social service progress notes dated 04/10/24 revealed a care conference was held.</p> <p>Further review of the medical record revealed no other documented care conferences taking place.</p> <p>Interview on 09/16/24 at 2:37 P.M. with Resident #41 revealed she could not recall having a care conference.</p> <p>Interview on 09/18/24 at 11:10 A.M. with LSW #460 verified Resident #41 has not had a documented care conference since April 2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of policy, Care Update Meeting, approved 03/06/19, verified care update meeting will be held every 90 days on all residents. If the resident or representative cancels or does not come to the scheduled meeting the medical record should reflect this.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on observation, resident interview, staff interview, and policy review, the facility failed to assist dependent male residents with shaving. This affected two (Residents #22 and #157) of two reviewed for activities of daily living. The facility census was 55.</p> <p>Findings include:</p> <p>1. Review of Resident #22's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia, hemiparesis, and diabetes mellitus.</p> <p>Review of Resident #22's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required substantial assistance for showering and bathing.</p> <p>Review of Resident #22's most recent care plan revealed the resident required assistance with activities of daily living related to weakness. He required assistance with dressing and grooming.</p> <p>Observation of Resident #22 on 09/16/22 revealed he had a full beard which was uneven and approximately 1.5 inches long.</p> <p>Interview with Resident #22 on 09/16/24 at 1:23 P.M. revealed he wanted his beard shaved off, but staff were unable to do so due to not having the proper equipment. The resident required assistance with shaving due to the inability to lift his left arm.</p> <p>Review of Resident #22's progress note dated 09/18/24 revealed the resident voiced he would like to have his beard shaved off. The nurse informed the resident that the beautician does provide beard trims, but the resident stated he wanted it shaved all of the way. The nurses informed the resident that staff could assist with shaving and Resident #22 agreed and asked the nurse to assist and she stated she didn't have time, but staff would assist him in the morning.</p> <p>Interview with Occupational Therapy Assistant #356 on 09/18/24 revealed she did assist Resident #22 with trimming his neck area with a razor, but the facility did not have a trimmer to shave off the beard. She stated he would have to wait to get home to shave where he owned the proper equipment.</p> <p>2. Review of Resident #157's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia, hemiparesis, dysphasia, aphasia, and congestive heart failure.</p> <p>Review of Resident #157's admission MDS dated [DATE] revealed he had was cognitively intact. The resident required set up for personal hygiene including shaving.</p> <p>Review of Resident #157's most recent care plan revealed he required assistance with ADL care related to left hemiplegia and dysphasia. The resident should receive appropriate assistance for ADLs through next review.</p> <p>Observation on 09/16/24 at 9:50 A.M. revealed Resident #157 had approximately 1/2 inch of beard growth and stated he was unable to get assistance from staff for shaving.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #157 on 09/16/24 at 9:50 A.M. revealed he wanted to have his beard trimmed, but could not receive assistance from staff.</p> <p>Interview with State tested Nursing Aides (STNA) #316 and #359 on 09/17/24 between 8:10 A.M. and 8:32 A.M. revealed the residents usually brought their electric razors on admission, but the facility did supply disposable razors. Once the resident's beards were longer the disposable razors were ineffective.</p> <p>Review of the facility policy titled, Shaving the Resident, dated 01/2024 revealed the purpose of this procedure is to promote cleanliness and to provide skin care. Notify the supervisor if the resident refuses the procedure document the reasons why and interventions taken.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of policy, the facility failed to ensure pressure ulcer reducing interventions were implemented as ordered. This affected one (#41) of one residents reviewed for pressure ulcers. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #41 was admitted on [DATE]. Diagnoses included other incomplete lesion at C1, C2, C3, and C4 level of cervical spinal cord, acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, pressure ulcer of sacral region stage four, and pressure ulcer of other site stage four.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and had range of motion impairment on the upper and lower extremities. Resident #41 required substantial/maximal assistance with toileting, bathing and was dependent for transfers.</p> <p>Review of physician orders dated 03/25/24 revealed Resident #41 to off-load heels when in bed if the resident tolerates or will allow.</p> <p>Review of physician orders dated 04/02/24 revealed Resident #41 had an order for a pressure relieving aircushion to the wheelchair to promote skin integrity. With an additional note to plug in at nighttime.</p> <p>Review of the most recent care plan revealed Resident #41 was care planned for impaired skin integrity due to coccyx pressure wound, right posterior leg (calf), and pressure injury right heel. Interventions included offloading boots on while in bed, elevate heels when in bed, and pressure relieving aircushion to the wheelchair.</p> <p>Review of pressure injury review dated 09/13/24 revealed Resident #41 had coccyx wound currently at a stage three measuring 1.4 centimeter (cm) x 0.5 cm x 0.1 cm., a right posterior leg stage 4 measuring 4.6 cm x 1.7 cm x 0.9 cm, and a deep tissue pressure injury of the right heel measuring 0.6 cm x 1.5 cm x 0.0. Review of wound documentation revealed no worsening of the pressure wounds from the previous week.</p> <p>Observation on 09/16/24 at 2:19 P.M. of Resident #41 revealed the resident laying in bed with no heel boots applied and heels not elevated. Resident was observed to be wearing thin slippers on her feet.</p> <p>Interview on 09/16/24 at 2:21 P.M. with Resident #41 revealed the heel boots and elevating the heels was typically only done at nighttime. Resident #41 stated she had not refused to have her heels elevated.</p> <p>Interview on 09/16/24 at 2:59 P.M. with the Administrator verified Resident #41 did not have the heel boots applied and the heels were not elevated while Resident #41 was in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 09/17/24 at 8:58 A.M. revealed Resident #41 sitting up in her wheelchair in the resident room. Observation of the alternating pressure wheelchair seat cushion was turned off.</p> <p>Interview on 09/17/24 at 9:01 A.M. with Licensed Practical Nurse (LPN) #407 verified the alternating pressure wheelchair seat cushion was off stating it needed to be plugged in and turned on.</p> <p>Review of policy Pressure Injury: Assessment and Prevention, approved 06/09/22, verified the facility will identify residents at risk for developing pressure injuries and implement interventions to prevent the development of pressure injuries. Interventions include to encourage and assist residents to assist to float/offload heels to keep the heels off the bed and use pillows, wedges, and/or other devices for repositioning.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation, staff interview, medical record review, review of maintenance documents, and review of the facility's policies, the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE) when providing care for residents who were infected with COVID-19. This affected one (Resident #114) of one resident observed for droplet precautions. Additionally, the facility failed to complete weekly water flushes of equipment at risk for developing Legionella pneumophila (the cause of Legionnaire's Disease). This had the potential to affect all 55 residents in the facility.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #114 revealed an admitted [DATE] with a diagnosis of COVID-19 on 09/12/24.</p> <p>Review of modified 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #114 had intact cognition.</p> <p>Review of a physician order dated 08/27/24 revealed Resident #114 received occupational therapy (OT) five times weekly for 60 days.</p> <p>Review of a physician order dated 09/12/24 revealed Resident #114 was positive for COVID-19.</p> <p>Review of a physician order dated 09/17/24 revealed Resident #114 should remain in droplet precautions in single room isolation due to COVID-19 through 09/22/24.</p> <p>Review of the Matrix provided by the facility on 09/16/24 revealed Resident #114 tested positive for COVID-19 and was in droplet isolation.</p> <p>Observation on 09/16/24 at approximately 10:00 A.M. revealed Resident #114's door was closed. Upon the door was a yellow apron with several pockets containing PPE. Additionally, a sign indicated Resident #114 was in droplet precautions.</p> <p>Interview on 09/16/24 at approximately 3:15 P.M. with the Director of Nursing (DON) confirmed residents in droplet precautions require staff to wear PPE prior to entering the resident's room. Required PPE included an N95 mask, a gown, gloves, and eye protection.</p> <p>Observation on 09/18/24 at 2:59 P.M. revealed a housekeeper in the doorway of Resident #114's room removing PPE and placing it in the appropriate disposal bin. As the housekeeper exited the room and pulled the door closed, an observation was made of a person not wearing a yellow disposable gown and sitting in a chair inside Resident #144's room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation of Perrysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 345 East Boundary Street Perrysburg, OH 43551	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview and concurrent observation on 09/18/24 at 3:00 P.M. with Occupational Therapist (OT) #437 revealed he was putting on a yellow disposable gown when he came to Resident #114's doorway to answer the surveyor's knock at the door. OT #437 confirmed he was sitting in Resident #114's for a moment, setting his things down, and was just putting on the gown. OT #437 was wearing an N-95 mask. Continued interview and observation confirmed OT #437 was not wearing eye protection or gloves. OT #437 continued to tie on the disposal gown during the interview.</p> <p>Review of OT #437's Daily Treatment Log for 09/18/24, printed 09/19/24, revealed Resident #114 was the last person OT #437 treated for the day.</p> <p>Review of the policy, Resident COVID-19 Quarantine Guidance, revised 01/05/24, revealed residents who tested positive for COVID-19 must be placed in transmission-based precautions and full PPE must be worn, including face mask, gloves, eye protection and a gown. Further review revealed an N95 mask was required to be worn by all staff providing direct patient care to residents in transmission based precautions.</p> <p>2. Review of the maintenance document titled, Weekly Fixture Exercise Log, revealed each device must be exercised 30 seconds weekly minimum revealed the log identified several locations throughout the facility, including (but not limited to) trash chutes, the salon, the Bistro restroom, restrooms, housekeeping closets, and the education room.</p> <p>Review of the Weekly Fixture Exercise Logs dated January 2024 through May 2024 revealed the exercise occurred only the first week of the month. Further review revealed no logs were available for June 2024 through August 2024.</p> <p>Interview on 09/19/24 at 1:33 P.M. with Maintenance Manager (MM) #349 revealed he began working at the facility 12 days prior. MM #349 confirmed the facility identified the areas on the Weekly Fixture Exercise Log as areas at risk for growing Legionella pneumophila and therefore, the areas needed to be flushed by letting water run for at least 30 seconds weekly. MM #349 could provide no evidence the areas were flushed weekly since January 2024.</p> <p>Review of the policy Water Management Protocol, dated 08/2019, revealed the policy was established to provide appropriate monitoring and proactive intervention relative to the skilled nursing facility potable water systems. Further review revealed fixtures will be exercised and allowed to flush with a moderate or better flow for 30 seconds weekly. The exercise would be documented on the Weekly Fixture Exercise Log.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation and staff interview, the facility failed to ensure the gap between mattresses and bed rails were safe and appropriate. This affected one (#32) of two residents reviewed for bed rails. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses of acute and chronic respiratory failure and quadriplegia.</p> <p>Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was rarely/never understood and was dependent on staff for all Activities of Daily Living (ADLs).</p> <p>Review of the Bed Rail Safety assessment dated [DATE] revealed Resident #32 was appropriate for bed rails to assist in alerting staff when unsafe transfers were attempted.</p> <p>Review of the current care plan for Resident #32 revealed bed rails were in place to provide a feeling of comfort/security, increase mobility, and act as a bed perimeter reminder.</p> <p>Interview on 09/16/24 at 9:25 A.M. with Licensed Practical Nurse (LPN) #362 revealed Resident #32 was quadriplegic and had no function of his arms and legs.</p> <p>Observation on 09/17/24 at 5:25 P.M. revealed Resident #32 lying in bed on an air mattress. A large gap was identified between Resident #32's mattress and the bed rails.</p> <p>Interview and observation on 09/18/24 at 10:15 A.M. with the Director of Nursing (DON) confirmed the gap between Resident #32's mattress and bed rail was 5.25 inches on his left side, measured at the narrowest point, and 3.25 inches on his right side, measured at the narrowest point.</p> <p>Interview on 09/18/24 at 4:47 P.M. with the DON revealed she was unable to obtain manufacturers guidelines for Resident #32's bed regarding the acceptable distance between the mattress and bedrails; however, the DON confirmed the gaps Resident #32's were too large and were potentially unsafe.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</p> <p>Based on observation and staff interview, the facility failed to ensure residents had access to a call light. This affected one (#32) of one resident reviewed for call light accessibility. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses of acute and chronic respiratory failure and quadriplegia.</p> <p>Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was rarely/never understood and was dependent on staff for all Activities of Daily Living (ADLs).</p> <p>Review of the current care plan for Resident #32 revealed he had a communication problem, Resident #32 was unable to communicate and had been working with speech language pathology (SLP) therapy, outpatient, to use eye gaze device. Interventions included keeping Resident #32's call light in reach.</p> <p>Interview on 09/16/24 at 9:25 A.M. with Licensed Practical Nurse (LPN) #362 revealed Resident #32 was quadriplegic and had no function of his arms and legs.</p> <p>Observation on 09/16/24 at 2:29 P.M. revealed Resident #32 lying in bed with a standard push-call light button clipped to his bed near his left upper arm. Resident #32 had an electronic communication board in front of his face propped up by a metal stand. Observation of Resident #32's communication board revealed he requested help and wanted the head of his bed lowered. The ODH surveyor pressed the call light and LPN #362 entered the room. LPN #362 confirmed Resident #32 could not use the call light and staff would frequently check on him. LPN #362 did not believe Resident #32's communication board was connected to the call light system.</p> <p>Interview on 09/17/24 at 2:31 P.M. with SLP #410 revealed she was familiar with Resident #32 who used the electronic communication board and stated Resident #32 was able to use the device well to communicate and answer questions. SLP #410 explained Resident #32 used his eyes to focus on a word or letter and the device would detect what his eyes focused on and would type the letter or word on the monitor. SLP #410 stated Resident #32's computer also had an audible button that would speak and say I need the nurse or I need help. SLP #410 stated his device was not connected the call light system. Further interview revealed SLP #410 was not aware if the facility had access to a breath-activated call light device but thought Resident #32 could be able to use one.</p> <p>Observation on 09/17/24 at 1:52 P.M. revealed Resident #32 lying in bed. Resident #32's electronic communication board was backed against the wall on Resident #32's right side and was not within visual range for him.</p> <p>Observation on 09/17/24 at 3:08 P.M. revealed Resident #32 lying in bed. Resident #32's electronic communication board remained backed against the wall on Resident #32's right side and was not within visual range for him.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continuous observation on 09/17/24 from 3:08 P.M. until 4:35 P.M. revealed State tested Nurse Aide (STNA) #417 providing care to Resident #37, Resident #104, and Resident #105. STNA #417 was not seen providing care to Resident #32 during the observation.</p> <p>Interview on 09/17/24 at 4:35 P.M. with STNA #417 stated she began her shift at 1:50 P.M. and the STNA from first shift left the floor when STNA #417 arrived. STNA #417 confirmed she had not yet provided care for Resident #32 since beginning her shift. STNA #417 confirmed Resident #32's electronic communication board was placed out of range for him to use it. STNA #417 confirmed she observed Resident #32 effectively use the electronic communication board.</p> <p>Interview and observation on 09/17/24 at 5:25 P.M. with STNA #417 confirmed Resident #32 was repositioned; however, his electronic communication board remained out of range. STNA #417 stated it took time to reposition the electronic communication board and had not returned to his room to place it in range.</p> <p>Review of the policy, Answering the Call Light, dated 02/2023, revealed the use of call lights should be explained and demonstrated to residents and staff should ensure the resident can use the call system.</p>		