

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Als Mount Vernon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Gambier Road Mount Vernon, OH 43050	

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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008</p> <p>Based on observation, medical record review, staff interviews, review of the facility assessment, and review of facility policy, the facility failed to provide adequate nursing supervision to assure safety for residents that were identified as a choking risk, while the residents were eating in the dining room. This had the potential to affect two residents who were identified as a choking risk (Resident #11 and Resident #20) out of four residents observed eating in the dining room without supervision.</p> <p>Findings include:</p> <p>Review of Resident #11's medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, multiple sclerosis, need for assistance with personal care and dysphagia.</p> <p>Review of Resident #11's physician orders dated 11/19/24 revealed that she was prescribed a regular diet with pureed texture consistency.</p> <p>Review of Resident #11's care plan dated 12/20/23 revealed that she was at risk of alteration in her nutrition and hydration status related to using a mechanically altered diet and a loss of food and fluids from her mouth according to the Speech and Language Pathologist.</p> <p>Review of Resident #20's medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included Huntington's disease, need for assistance with personal care and dysphagia.</p> <p>Review of Resident #20's physician orders dated 06/21/24 revealed that she was ordered to have a regular diet with pureed textures.</p> <p>Review of Resident #20's care plan dated 06/21/24 revealed that she was at risk for potential of alteration in nutrition and hydration related to dysphagia, mechanically altered diet, history of chewing difficulty and leaving residue in mouth.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Als Mount Vernon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Gambier Road Mount Vernon, OH 43050	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/26/25 from 7:45 A.M. to 7:50 A.M. revealed that there was no staff member in the dining room while Resident #7, Resident #11, Resident #12, and Resident #20 were eating food. During this time, Resident #20 coughed on three occasions and was observed with food dripping down her chin. Certified Nursing Aide #64 and Licensed Practical Nurse (LPN) #84 were observed passing meal trays in the hall, out of the line of sight from the dining room.</p> <p>Interview with LPN #84 on 03/26/25 at 6:44 A.M. revealed that it was her opinion that there was not enough nursing staff on day shift to take care of the resident's needs.</p> <p>Interview with LPN #84 on 03/26/25 at 7:50 A.M. confirmed that there was no nursing staff present in the dining room from 7:45 A.M. to 7:50 A.M. LPN #84 confirmed that to her knowledge, at least Resident #20 was a choking risk. She confirmed that a member of the nursing staff should be present in the dining room at all times.</p> <p>Interview with the Director of Nursing on 03/26/25 at 10:27 A.M. revealed that at least one nursing aide or nurse should be present in the dining room at all times while residents are consuming meals. Further interview confirmed that Resident #11 and Resident #20 were identified as at risk for choking.</p> <p>Review of the facility assessment revealed that there was no facility assessment available for review to determine the level of sufficient staff needed pertaining to the severity of conditions and limitations of the residents, and the services that the facility must provide.</p> <p>Interview with the Administrator on 03/26/25 at 12:41 P.M. confirmed that a completed facility assessment was not available for review.</p> <p>Review of an undated policy titled Dining Room Observation- Meal Time revealed that when it is meal time in the dining room, one staff member should be in the dining room while residents are eating their meal. If a staff member is unavailable when trays arrive, the room trays should be served first and then the dining room service should start.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163661.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Als Mount Vernon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Gambier Road Mount Vernon, OH 43050	
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 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>50008</p> <p>Based on review of the facility assessment and staff interview, the facility failed to have documented evidence of a completed facility assessment for review. This had the potential to affect all 19 residents living in the facility.</p> <p>Findings include:</p> <p>Review of the facility assessment revealed that there was no facility assessment available for review to determine the level of sufficient staff needed pertaining to the severity of conditions and limitations of the residents, and the services that the facility must provide.</p> <p>Interview with the Administrator on 03/26/25 at 12:41 P.M. confirmed that a completed facility assessment was not available for review.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Als Mount Vernon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Gambier Road Mount Vernon, OH 43050	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008</p> <p>Based on resident record review and staff interview, the facility failed to ensure resident medical records were complete. This affected five of five residents (#4, #7, #11, #12, and #20) reviewed for the administration of treatments, side effect monitoring, and behavior monitoring. The facility census was 19.</p> <p>Findings include:</p> <p>1. Review of Resident #4's medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included Huntington's disease, major depressive disorder, and dementia.</p> <p>Review of Resident #4's physician orders revealed that she had an order dated 03/06/25 to have her weight taken daily in the morning, an order on 03/01/25 to have skin preparation (prep) to her left knee during the day shift, an order on 03/03/25 to monitor for signs and symptoms of depression for each shift, an order on 03/03/25 to monitor for side effects of her sedative medication for each shift, and an order on 03/03/25 to monitor for side effects of her antidepressant medication on each shift.</p> <p>Review of Resident #4's treatment administration record revealed no documented evidence that the 03/07/25 morning nursing shift documented that the residents weight was obtained, that her skin prep was completed to her left knee, or that she was monitored for signs of depression, side effects of her sedative medication or side effects of her antidepressant medication.</p> <p>Interview with the Director of Nursing on 03/26/25 at 10:20 A.M. confirmed that there was no evidence in the medical record that the treatments for Resident #4 had been administered and/or signed off by the nurse on the morning of 03/07/25.</p> <p>2. Review of Resident #7's medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included dementia, type two diabetes mellitus, hypertension, chronic kidney disease, peripheral vascular disease, major depressive disorder and nail dystrophy.</p> <p>Review of Resident #7's physician orders revealed that effective 09/08/23 she was to have her behaviors monitored and documented on every shift, and effective 09/08/23 she was to be monitored for pain and non-pharmacological interventions were to be documented on each shift.</p> <p>Review of Resident #7's treatment administration record revealed no documented evidence that the 03/07/25 morning nursing shift documented that the residents behaviors were monitored or that she was monitored for pain and non-pharmacological interventions.</p> <p>Interview with the Director of Nursing on 03/26/25 at 10:20 A.M. confirmed that there was no evidence in the medical record that the treatments for Resident #7 had been administered and/or signed off by the nurse on the morning of 03/07/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Als Mount Vernon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Gambier Road Mount Vernon, OH 43050	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of Resident #11's medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, multiple sclerosis, dementia, depression, dysphagia, and the need for assistance with personal care.</p> <p>Review of Resident #11's physician orders revealed that effective 12/21/23 she was to be monitored for pain and non-pharmacological interventions were to be documented on each shift, effective 11/19/24, she was to have her head of bed elevated at 45 degrees or higher at all times on each shift, effective 01/06/25 she was to be monitored for side effects of her antidepressant medication on each shift, effective 02/10/25 she was to be monitored for signs and symptoms of a cough or fever for a respiratory screening on each shift, effective 02/14/25 she had orders to cleanse the area to her left great toe with wound cleanser and apply betadine twice daily, and effective 02/28/25 she was to be monitored for signs of depression on each shift.</p> <p>Review of Resident #11's treatment administration record revealed there was no documented evidence that the 03/07/25 morning nursing shift documented the residents area to her left great toe was cleansed and that betadine was applied, that her head of bed was elevated at 45 degrees or higher, that she was monitored for pain and non-pharmacological interventions were attempted, that she was monitored for side effects of her antidepressant medication, that she was monitored for signs of depression or that she was monitored for signs and symptoms of a cough or fever.</p> <p>Interview with the Director of Nursing on 03/26/25 at 10:20 A.M. confirmed that there was no evidence in the medical record that the treatments for Resident #11 had been administered and/or signed off by the nurse on the morning of 03/07/25.</p> <p>4. Review of Resident #12's medical record revealed that he was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia, need for assistance with personal care, congestive heart failure, cardiac pacemaker, inflammatory disorder of scrotum, obstructive sleep apnea, and depression.</p> <p>Review of Resident #12's physician orders revealed that he had orders effective 03/22/24 to monitor and document his behaviors on each shift, effective 03/22/24 he was to have his pain and non-pharmacological interventions documented on every shift, effective 02/28/25 he was to be monitored for side effects of his antidepressant medication on each shift, effective 02/28/25 he was to be monitored for signs of depression on each shift, and effective 02/28/25 he was to be monitored for side effects of a sedative on each shift.</p> <p>Review of Resident #12's treatment administration record revealed there was no documented evidence that the 03/07/25 morning nursing shift documented he had his behaviors monitored and/or documented, that he was monitored for pain and non-pharmacological interventions were attempted, that he was monitored for side effects of his antidepressant medication, that he was monitored for signs of depression, or that he was monitored for side effects of a sedative.</p> <p>Interview with the Director of Nursing on 03/26/25 at 10:20 A.M. confirmed that there was no evidence in the medical record that the treatments for Resident #12 had been administered and/or signed off by the nurse on the morning of 03/07/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Als Mount Vernon Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Gambier Road Mount Vernon, OH 43050	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Review of Resident #20's medical record revealed that she was admitted to the facility on [DATE] with diagnoses that included Huntington's disease, muscle weakness, depression, dysphagia, and need for assistance with personal care.</p> <p>Review of Resident #20's physician orders revealed that there was an order effective 05/14/24 she was to be monitored on every shift for pain and non-pharmacological interventions were to be documented on each shift, effective 05/14/24 her behaviors were to be monitored on every shift, effective 05/15/24 she was to be monitored for side effects of her antipsychotic medication on every shift, effective 05/15/24 she was to be monitored for side effects of her antidepressant medication on each shift, effective 05/28/24 she was to be monitored for side effects of her sedative on each shift, effective 01/22/25 she was to have her left dorsal foot cleansed and skin preparation (prep) was to be applied on every shift, effective 02/26/25 for her to have her right dorsal foot cleansed and silver alginate applied on every day shift, and effective 02/28/25 she was to be monitored for signs of depression on each shift.</p> <p>Review of Resident #20's treatment administration record revealed there was no documented evidence that the 03/07/25 morning nursing shift documented her right dorsal and left dorsal feet were cleansed and the treatments completed, that she was monitored for side effects of her sedative, antidepressant or her antipsychotic medication, or that she was monitored for pain or behaviors.</p> <p>Interview with the Director of Nursing on 03/26/25 at 10:20 A.M. confirmed that there was no evidence in the medical record that the treatments for Resident #20 had been administered and/or signed off by the nurse on the morning of 03/07/25.</p>		