STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366412	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Als Mount Vernon Inc	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)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on record review, interview, and facility policy review the facility failed to ensure residents and/or their representatives were invited to participate in initial and quarterly care plan meetings. This affected four residents (#10, #9, #13, and #15) of five residents reviewed for care plan meetings. The facility census was 19. Findings include: 1. Review of Resident #10's medical record revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease, unsteadiness on feet, and muscle weakness. Resident #10 was hospitalized from 04/29/24 to 05/03/24. Review of Resident #10's Minimum Data Set (MDS) 3.0 significant change assessment, dated 05/14/24, revealed a brief interview for mental status (BIMS) score of 02, indicating severely impaired cognition. The resident was recorded to have an impairment on one side of his upper extremities. Resident #10 required set up assistance for eating and substantial/maximum assistance for other activities of daily living and mobility tasks. An additional review of the MDS 3.0 discharge return anticipated, dated 04/29/24, revealed the resident had one fall with a minor injury. Review of Resident #10's interdisciplinary progress notes revealed a note dated 05/06/24 which indicated the resident had pain, edema, and bruising to his right upper extremity. An additional note dated 05/06/24 indicated the facility Nurse Practitioner had ordered an x-ray examination of his right clavicle. The interdisciplinary progress notes revealed no mention of a care plan meeting being held, scheduled, or Resident #10's family being invited to such a meeting since the resident admitted to the facility on [DATE]. Review of an x-ray report, completed at the facility on 05/07/24, revealed Resident #10 had an acute fracture of the right mid clavicle, with moderate displacement and fracture overlap. Review of Resident #10's physician's orders revealed orders dated 05/07/24 for the resident to wear a sling to his right upper extremity and for the resident to be referred to an orthopedic specialist. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's Interdisciplinary Plan of Care (IPOC) Summary form, dated 05/04/24, revealed the reason the IPOC meeting was held was Annual, Admission and Significant Change. The form indicated Resident #10 recently had a fall which resulted in injury with the family choosing to not see an orthopedic specialist. The summary of the meeting indicated Resident #10's child and Social Services Designee (SSD) #412 were the only two attendees. Resident #10's child's name was handwritten on the form which did not include a signature. A telephone interview conducted on 06/20/24 at 9:00 A.M. with a family member of Resident #10 revealed knowledge of Resident #10's fall and resulting clavicle fracture at the facility. The family member of Resident #10 denied ever being informed or refusing an orthopedic consult and indicated the family had previously transported the resident to all outside appointments via their personal vehicles. The family member of Resident #10 stated they had never been offered, nor attended, a care conference since the resident admitted to the facility approximately a year and a half ago. An interview conducted on 06/20/24 at 10:18 A.M. with SSD #412 revealed she coordinated the care plan meetings at the facility. SSD #412 stated only she and the daughter of Resident #10 were present for the care conference dated 05/04/24 and the date on the form indicated the date the care conference was held. The surveyor informed SSD #412 that the documentation on the form stated the family refused an orthopedic consult days before Resident #10's x-ray examination was ordered, completed, or revealed a fracture. SSD #412 verified the documentation was incorrect and stated that the correct date for the care plan meeting was 05/24/24. SSD #412 confirmed there was no documentation of scheduling or notices provided to coordinate a care plan meeting, and the IPOC Summary dated 05/04/24 contained no evidence that a nurse or other department representative was present at the care plan meeting. SSD #412 stated documentation should be completed in the resident's electronic medical record reflecting a care conference was scheduled, held and afterwards, a summary contained in the resident's electronic medical record. 47569 2. Review of Resident #9's medical record revealed admitted [DATE] with diagnoses including Huntington's Disease, chronic obstructive pulmonary disease (COPD), depression, and anxiety. Resident #9 required assistance from staff to complete activities of daily living (ADL) and had severely impaired cognition. Review of Resident #9's IPOC summary dated 02/01/23 revealed the IPOC summary was marked for an annual review and a quarterly review care conference. The only people in attendance for the care conference included Resident #9's power of attorney (POA) and the SSD designee #412. There were no completed IPOC summary review care conferences available to review from 03/01/23 to 06/24/24. Review of Resident #9's progress notes dated 02/01/23 to 02/20/23 revealed no documentation reflecting the IPOC care conference completed on 02/10/23. Further review of progress notes dated 03/01/23 to 06/24/24 revealed no documentation for any type of care conference, annual or quarterly, since the care conference completed on 02/10/23. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/20/24 at 10:20 A.M. with SSD #412 confirmed there were no completed IPOC summary review care conferences since the IPOC summary care conference dated 02/10/23. SSD #412 further confirmed the only people in attendance for the care conference dated 02/10/23 was Resident #9's POA and SSD #412. SS #412 stated there should at least be a nurse, dietary representative, and therapy representative in attendance for a care conferences. SSD #412 confirmed there should be documentation in the progress notes to reflect the completion of care conferences. 3. Review of Resident #13's medical record revealed admitted [DATE] with diagnoses including traumatic brain injury (TBI), stroke, and hemiplegia to left side. Resident #13 required assistance from staff for ADL tasks and had moderately impaired cognition. Review of Resident #13's IPOC summary review care conference form dated 04/20/23 revealed the care conference marked as a quarterly IPOC summary review care conference. The attendees included Resident #13's family members, the Director of Nursing (DON), the Assistant Director of Nursing (ADON) #402, and SSD #412. There were no completed annual or quarterly IPOC summary review care conferences dated from 05/01/23 to 06/24/24 available to review. Review of Resident #13's progress notes dated 04/01/23 to 05/01/23 revealed no documentation to reflect the completion of the IPOC summary review care conference dated 04/20/23. Further review of Resident #13's progress notes dated 05/01/23 to 06/24/24 revealed no documentation was available for review to reflect an annual or quarterly IPOC summery review care conference completion. Interview on 06/20/24 at 10:20 A.M. with SSD #412 confirmed Resident #13 only had a quarterly care conference completed on 04/20/23, and there were no further care conferences completed from 05/01/23 to 06/24/24. SSD #412 stated Resident #13's family requested to only have annual care conferences instead of quarterly care conferences. SSD #412 confirmed there should be documentation in the progress notes to reflect the completion of care conferences. 4. Review of Resident #15's medical record revealed admitted [DATE] with diagnoses including high blood pressure, anxiety, and bipolar disorder. Resident #15 required minimal assistance from staff for ADL tasks and had intact cognition. Resident #15 was receiving therapy services in anticipation for discharge to previous living conditions. Review of Resident #15's IPOC summary review care conference form dated 06/13/24 revealed the care conference was marked as a discharge care conference. There was no previous IPOC summary review care conference forms to review or reflect the completion of an initial care conference completed for Resident #15. Review of Resident #15's progress notes dated 05/21/24 to 06/24/24 revealed no documentation available to review for completed IPOC review care conferences. Interview on 06/20/24 at 10:20 A.M. with SSD #412 confirmed Resident #15 did not have an initial IPOC summary review care conference completed upon admission to the facility. SSD #412 stated Resident #15 should have had an initial care conference completed within seven days of admission to the facility. SSD #412 confirmed there should be documentation in the progress notes to reflect the completion of care conferences. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Nursing Home Resident's Rights revealed, Nursing home residents have the right to participate in planning your care and treatment or changes in your care and treatment.

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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. 47569 Based on observation, interview, and facility policy review the facility failed to maintain a clean home like environment in resident rooms. This deficient practice affected one resident (#17) out of 19 residents reviewed for environment. The facility census was 19. Findings include: Observation on 06/17/24 at 8:45 A.M. revealed Resident #17's outer doorframe was noted to have missing paint and dry wall covering. The area was observed on the wall surrounding the doorframe. The appearance of having had plastic covering taped around the doorframe and doorway was evident. The largest area was approximately four inches wide with paint and dry wall covering missing exposing the dry wall backing paper. Further observation inside Resident #17's room revealed the wall to the left side of the bed with multiple vertical large, long (approximately 12 inches long) gouges running the length of the bed. The gouges were deep enough for the dry wall material to be visible, approximately one-half inch deep, with torn dry wall covering hanging loosely on the wall. Resident #17's bed was against the wall with Resident #17's left side being towards the damaged wall. Interview on 06/24/24 at 9:35 A.M. with Maintenance Staff #416 confirmed the gouges being deep enough for the dry wall material to be visible, approximately one-half inch deep, with torn dry wall covering hanging loosely on the wall to the left side of the bed and the outer doorframe areas of missing dry wall and non-painted areas. Review of the facility's policy titled Resident Environmental Quality, dated 08/22, revealed, It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff interview, and record review the facility failed to accurately code the Minimum Data Set (MDS) 3.0 assessment for Residents #10 and #11. This affected two residents (#10 and #11) of 11 residents reviewed for accuracy of assessments. The facility census was 19. Findings include: 1. Review of Resident #10's medical record revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease, unsteadiness on feet, and muscle weakness. Review of Resident #10's MDS 3.0 significant change assessment, dated 05/14/24, revealed a brief interview for mental status (BIMS) score of 02, indicating severely impaired cognition. The resident was recorded to have an impairment on one side of his upper extremities. Resident #10 required set up assistance for eating and substantial/maximum assistance for other activities of daily living (ADL) and mobility tasks. An additional review of the MDS 3.0 discharge return anticipated assessment, dated 04/29/24, revealed the resident had one fall with a minor injury, and no falls with a major injury. Review of Resident #10's progress notes revealed a note dated 04/29/24 at 12:25 A.M. indicating a thud was heard from the resident's room. When staff entered the room, the resident was observed on the floor underneath his bedside table. The resident reported he had been attempting to change clothes when he fell . The resident complained of pain to his right arm and head, with a knot noted near his right clavicle. Resident #10 was transferred and admitted to a local hospital. Review of a facility incident report, dated 04/29/24, revealed Resident #10 sustained a fall and was noted with a quarter sized knot near his right clavicle. The report indicated that Resident #10 was transferred and admitted to a local hospital. Review of hospital records for Resident #10, dated 04/29/24, revealed an x-ray examination of the right humerus was completed on 04/29/24 which showed no definitive fracture. The hospital records revealed no indication that a right clavicle x-ray examination had been completed while the resident was at the hospital. Review of Resident #10's vitals and pain assessment, dated 05/07/24, revealed the resident complained of pain rated at 7/10 on a 01-10 scale. The pain was described as aching and stiffness, worse with movement. Resident #10 was additionally observed to have edema (swelling) to his right upper extremity. Review of an x-ray report, completed at the facility on 05/07/24, revealed Resident #10 had an acute fracture of the right mid clavicle, with moderate displacement and fracture overlap. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 06/18/24 at 2:12 P.M. with the Director of Nursing (DON) revealed Resident #10 sustained a fall resulting in injury on 04/29/24 and was transported to the hospital, where he was admitted . The injury was a knot on his right clavicle, and the resident complained of arm pain. The DON stated she believed the hospital would have completed an x-ray examination of the clavicle, but the hospital only x-rayed the humerus (upper arm bone) which was not fractured. After the resident returned to the facility and was still having pain, the facility obtained an order to x-ray the clavicle. The DON confirmed the fracture to Resident #10's clavicle was a result of the fall sustained on 04/29/24. An interview conducted on 06/18/24 at 10:21 A.M. by phone with MDS Nurse #250 revealed she was unaware of Resident #10's fall on 04/29/24 resulted in a fractured clavicle. MDS Nurse #250 stated although the fracture was not noted at the time of the hospital transfer, she should have modified the MDS assessment once it was determined Resident #10 sustained a fracture, as that would be considered a major injury. MDS Nurse #250 stated the assessment was incorrect and stated she would complete a modification of Resident #10's MDS assessment to reflect one fall with major injury. Review of the Resident Assessment Instrument (RAI) Manual, revised October 2023, revealed an injury related to a fall included any documented injury that occurred as a result of, or was recognized within a short period of time after the fall and attributed to the fall. The RAI Manual identified a major injury included bone fractures and joint dislocations. 47569 2. Observation on 06/17/24 at 9:05 A.M. revealed Resident #11 sitting in a recliner chair receiving continuous two liters of oxygen therapy from an oxygen concentrator via a nasal canula tubing. Review of Resident #11's medical record revealed an admitted [DATE] with diagnoses including pneumonia, high blood pressure, heart failure, and rib fractures. Resident #11 required assistance from staff to complete ADL tasks and had moderately impaired cognition with a score of seven out of fifteen on Brief Interview of Mental Status (BIMS) score. Review of Resident #11's at risk for altered respiratory status care plan dated 05/14/24 revealed an intervention for the use of oxygen as ordered. Review of Resident #11's admission MDS 3.0 assessment, dated 05/07/24, revealed Section O - Special Treatments, Procedures, and Programs C1 Oxygen therapy was marked as being used on admission and while being a resident. Review of Resident #11's significant change MDS 3.0 assessment, dated 05/15/24, revealed Section O Special Treatments, Procedures, and Programs C1 Oxygen therapy was marked as not being used while being a resident. Interview on 06/24/24 at 10:25 A.M. with the MDS Registered Nurse (RN) #450 confirmed Resident #11's significant change MDS 3.0 assessment, dated 05/15/24, was coded incorrectly to reflect Resident #11 did not use oxygen therapy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the RAI 3.0 User's Manual, dated October 2023, revealed the steps for assessment include, Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the assessment period defined for each column.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to complete a physician-ordered orthopedic consult for Resident #10, and failed to ensure dressings were changed as ordered for Resident #5. This affected two residents (#10 and #5) of 11 residents reviewed for quality of care. The facility census was 19. Findings include: 1. Review of Resident #10's medical record revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease, unsteadiness on feet, and muscle weakness. Resident #10 was hospitalized from 04/29/24 to 05/03/24. Review of Resident #10's Minimum Data Set (MDS) 3.0 significant change assessment, dated 05/14/24, revealed a brief interview for mental status (BIMS) score of 02, indicating severely impaired cognition. The resident was recorded to have an impairment on one side of his upper extremities. Resident #10 required set up assistance for eating and substantial/maximum assistance for other activities of daily living (ADL) tasks and mobility tasks. An additional review of the MDS 3.0 discharge return anticipated, dated 04/29/24, revealed the resident had one fall with a minor injury. Review of an x-ray report, completed at the facility on 05/07/24, revealed Resident #10 had an acute fracture of the right mid clavicle, with moderate displacement and fracture overlap. Review of Resident #10's physician's orders revealed orders dated 05/07/24 for the resident to wear a sling to his right upper extremity, and for the resident to be referred to an orthopedic specialist. Review of Resident #10's interdisciplinary progress notes revealed a note dated 05/06/24 which indicated the resident had pain, edema, and bruising to his right upper extremity. An additional note dated 05/06/24 indicated the facility Nurse Practitioner had ordered an x-ray examination of his right clavicle. Subsequent progress notes contained no evidence that Resident #10's referral to an orthopedic specialist had been completed or that a discussion had taken place with Resident #10's family regarding the orthopedic consultation. An observation and interview on 06/18/24 at 8:38 A.M. with Resident #10 revealed him seated on the edge of the bed. The resident denied pain when asked and denied any recent falls or hospitalization s, stating he could not remember. The resident was not wearing a sling and was observed to feed himself breakfast. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/18/24 at 2:12 P.M. with the Director of Nursing (DON) revealed Resident #10 had a fall on 04/29/24 with a documented injury to his right clavicle, described as a quarter-sized knot. The DON stated the resident was transported to the hospital and admitted , and upon the return to the facility, the facility obtained an x-ray of the resident's clavicle as he was having ongoing pain. The resident's x-ray indicated a fracture to the right clavicle on 05/07/24, which the DON stated she attributed as being related to the fall on 04/29/24. The DON stated she thought the hospital would have x-rayed the resident's clavicle, but they only obtained x-ray imaging for the humerus (upper arm bone). The DON stated the facility Nurse Practitioner ordered an orthopedic consultation and a sling on 05/07/24 and verified there was no evidence in the medical record of the orthopedic consult being completed. The DON stated the resident's family possibly refused the orthopedic consult but verified there were also no refusals recorded in Resident #10's medical record but there should have been. An interview on 06/18/24 at 3:54 P.M. with Registered Nurse (RN) #413 revealed Resident #10 recently had a fracture identified to his right clavicle. Nursing staff had provided pain management, and over a few weeks the pain decreased, and the resident was gradually able to regain his range of motion. RN #413 stated he believed the family possibly did not want the resident to go to any outside providers. A telephone interview on 06/20/24 at 9:00 A.M. with a family member of Resident #10 revealed knowledge of the resident's recent fall at the facility on 04/29/24 and his return to the hospital. The family member indicated the fall on 04/29/24 resulted in a broken collarbone that the facility identified upon the resident's return from the hospital. The family member stated they were never notified of the resident being referred to an orthopedic specialist, and stated she would have been aware as they previously transported the resident to all outside appointments. Review of the facility policy titled Provision of Physician Ordered Services, dated 10/2023, revealed qualified nursing personnel will submit timely requests for physician ordered services (including consultations) to the appropriate entity. Documentation of consultations will be maintained in the resident's clinical record. 2. Review of Resident #5's medical record revealed an admitted [DATE]. Medical diagnoses included diabetes mellitus, a history of a myocardial infarction, and dementia with unspecified severity. Review of Resident #5's MDS 3.0 quarterly assessment, dated 04/17/24, revealed a BIMS score of 09, indicating moderately impaired cognition. Review of Resident #5's incident report revealed the resident sustained a fall on 06/15/24 when he was ambulating without his assistive device. The fall resulted in a skin tear to the resident's left outer forearm. The listed intervention included education on the use of proper footwear. Review of Resident #5's physician's orders revealed an order dated 06/18/24 to treat a recently obtained skin tear. The order called for staff to replace border foam to the resident's left outer forearm every three days, and check steri-strip placement. The order instructed staff to not remove steri-strips, as they will fall off on their own. The order was scheduled to be completed on day shift between 7:00 A.M. and 7:00 P.M. on the designated days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's June 2024 Treatment Administration Record (TAR) revealed the dressing was documented as being completed on 06/18/24 and 06/21/24. An observation on 06/24/24 at 8:06 A.M. revealed Resident #5 seated at the dining room table. He had eaten all of his breakfast and was observed coloring. The resident was observed with a dressing on his left elbow dated 06/18/24. An interview on 06/24/24 at 8:59 A.M. with the DON verified Resident #5's dressing was still dated 06/18/24 and was not completed as documented on 06/21/24. The DON stated the dressing needed to be changed. Review of the facility policy titled Wound Care, dated 08/2023, revealed treatments should be completed per physician's orders. Following the completion of the treatment, the nurse should document in the resident's electronic medical record.

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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** 47569 Based on observation, record review, interview, and facility policy review the facility failed to ensure safety interventions were implemented and were appropriate for residents assessed to be at high risk for falls. This deficient practice affected two residents (#6 and #9) out of five residents reviewed for accidents. The facility census was 19. Findings include: Observation on 06/24/24 at 8:07 A.M. revealed Resident #9 sitting at the dining room table eating breakfast. Resident #9 was wearing light blue non-skid socks on his feet. The right foot sock was halfway on the foot with the toe of sock was folded under the foot and dragging on the floor. Resident #9's four wheeled walker was located behind the dining room chair approximately two feet out of Resident #9's reach. Resident #9 stood up from the table when State tested Nursing Assistant (STNA) #421 came over to the table to assist Resident #9. Resident #9 reached for the four wheeled walker, grabbed hold of the handles and then lost balance tipping the walker over to the left side, Resident #9 regained his balance and began to ambulate through the dining room. STNA #412 did not attempt to assist Resident #9 with bringing the four wheeled walker to within his reach, regaining his balance or attempting to readjust the right sock that was dragging on the floor. Review of Resident #9's medical record revealed admitted [DATE] with diagnoses including Huntington's Disease, chronic obstructive pulmonary disease (COPD), depression, anxiety, and history of falls. Resident #9 required assistance from staff to complete activities of daily living (ADL) and had severely impaired cognition. Resident #9 used a four wheeled walker for assistance with independent ambulation, and severely impaired balance and gait due to the diagnosis of Huntington's Disease. Review of Resident #9's recent fall investigations dated 09/04/23, 10/16/23, 12/23/23, 12/25/24, 01/11/24, and 06/06/24 revealed the falls occurred in the dining room during mealtime and involved Resident #9 attempting to sit in a chair or standing up from the table following the completion of the meal. Safety measures implemented for these falls include the following: 09/04/23 - Resident #9 encouraged to ask staff for help during transfers and sitting. 10/16/23 - Resident #9 educated to use walker when out of bed. 12/23/23 - Resident #9 to notify staff if stuck behind chair and needing assistance 12/25/23 - Staff educated to assist Resident #9 to the chair when coming into the dining room for meals. 01/11/24 - Staff educated to continue with current fall prevention interventions. 06/06/24 - Resident #9 educated to ask for help when transferring or sitting. (continued on next page)

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	366412	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Als Mount Vernon Inc	1135 Gambier Road Mount Vernon, OH 43050

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's at risk for falls care plan dated 06/13/21 revealed other safety measures including providing staff assistance as needed, to wear non-skid footwear when ambulating, and implement fall prevention devices as ordered by the physician. Interview on 06/24/24 at 8:58 A.M. with STNA #438 confirmed Resident #9's right sock was folded under his foot and was dragging on the floor. STNA #438 stated Resident #9 should have shoes on instead of the non-skid socks. Interview on 06/24/24 at 9:20 A.M. with the Director of Nursing (DON) confirmed Resident #9's fall interventions were repetitive and ineffective safety measures due to Resident #9's impaired cognition. The DON stated it has been challenging to implement safety measures for Resident #9 due to diagnosis and impaired cognition. 47990 2. Review of Resident #6's medical record revealed an admitted [DATE]. Medical diagnoses included dementia without behavioral disturbances, anemia in chronic kidney disease, and diabetes. Review of Resident #6's MDS 3.0 quarterly assessment, dated 05/28/24, revealed Resident #6 was recorded to have a Brief Interview for Mental Status score of 00, indicating severely impaired cognition. The resident was recorded as requiring set-up assistance for eating and was dependent on staff for all other ADL and mobility tasks. Review of Resident #6's fall risk assessment, dated 06/01/24, revealed the resident scored a 9, indicating she was at risk for falls. Review of Resident #6's interdisciplinary progress notes revealed a note dated 06/01/24 which indicated Resident #6 fell out of bed. The resident was assessed for injury and transferred to the local hospital for evaluation in the emergency department. Resident #6 returned to the facility later that date after all x-rays and scans returned negative for injury. Resident #6's listed interventions included implementation of a perimeter mattress and a padded mat to the floor to the open side of the bed. Review of Resident #6's care plan, revised 06/02/24, revealed the resident was at risk for falls and potential injury related to weakness and dementia. Listed interventions included a bed with a perimeter mattress, a floor mat to the exit side of bed, and keeping commonly used articles within easy reach. An observation on 06/24/24 at 8:09 A.M. revealed Resident #6 in bed with the head of bed elevated. Her breakfast tray was in front of her. The padded mat was in a folded position leaning against the wall, approximately six feet from the resident's bed. An observation and interview on 06/24/24 at 8:14 A.M. with STNA #438 revealed Resident #6 remained in bed, awake and alert, feeding herself a sausage link. STNA #438 verified Resident #6's padded fall mat was not in place and should have been. STNA #438 replaced the fall mat during the interview. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Managing Falls and Fall Risk, reviewed 08/2023, revealed based on previous evaluations and current data, staff will identify interventions related to the resident's risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician/ nurse practitioner (NP) as needed, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident. Staff will monitor residents' response to interventions intended to reduce falling.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, record review, interview, and review of the facility policy the facility failed to obtain a physician's order for the administration of oxygen therapy. This deficient practice affected one resident (#11) out of one resident reviewed for respiratory care. The facility census was 19. Findings include: Observation on 06/17/24 at 8:23 A.M. revealed Resident #11 sitting in a recliner chair receiving continuous two liters of oxygen therapy from an oxygen concentrator via a nasal canula tubing. Review of Resident #11's medical record revealed an admitted [DATE] with diagnoses including pneumonia, high blood pressure, heart failure, and rib fractures. Resident #11 required assistance from staff to complete activities of daily living (ADL) tasks and had moderately impaired cognition with a score of seven out of fifteen on Brief Interview of Mental Status (BIMS) score. Review of Resident #11's at risk for altered respiratory status care plan dated 05/14/24 revealed intervention for the use of oxygen as ordered. Review of Resident #11's hospice progress notes dated 05/09/24 revealed a physician order for oxygen two to five liters continuous via nasal cannula tubing. Review of Resident #11's physician orders dated 06/01/24 revealed no order transcribed for oxygen two to five liters continuous via nasal cannula tubing. Interview on 06/17/24 at 4:17 P.M. with Licensed Practical Nurse (LPN) #475 confirmed Resident #11 did not have physician's order for oxygen two to five liters continuous via nasal cannula tubing. LPN #475 stated Resident #11 has always been using oxygen since admission. Review of the facility's policy titled, Oxygen Administration dated 04/01/23 revealed, Oxygen is administered under orders of a physician.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47059 Based on record review and staff interview, the facility failed to ensure there was a registered nurse (RN) on duty for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 19 residents currently residing in the facility. Findings include: Review of the staff schedule for June 2024 revealed there was no RN scheduled in the building on 06/01/24 (Saturday), 06/02/24 (Sunday), 06/05/24, 06/06/24, 06/07/24, 06/10/24, 06/11/24, 06/14/24, 06/15/24 (Saturday), 06/16/24 (Sunday), 06/17/24, 06/19/24, 06/20/24, 06/21/24, 06/24/24, 06/25/24, 06/28/24, 06/29/24 (Saturday) and 06/30/24 (Sunday). Interview on 06/19/24 2:45 P.M. with Licensed Practical Nurse (LPN) #402 confirmed the schedule does not have an RN listed for at least eight hours a day, seven days a week. LPN #402 stated The director of nursing (DON) is here the days the RN is not. I can fix the schedule to reflect that. When asked about the weekend RN coverage no explanation was given, and no evidence was provided there was an RN in the facility every Saturday and Sunday. Interview on 06/20/24 10:43 A.M. with RN #600 confirmed there is no RN on the schedule for eight hours a day, seven days a week.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on staff interview, record review, and facility policy review, the facility failed to ensure physician-ordered medication parameters were followed for Residents #4 and #5. This affected two (#4 and #5) of six residents reviewed for unnecessary medications. The facility census was 19. Findings include: 1. Review of Resident #4's medical record revealed an admitted [DATE]. Medical diagnoses included cerebrovascular accident (stroke), atrial fibrillation, coronary artery disease, and hypertension. Review of Resident #4's Minimum Data Set (MDS) 3.0 quarterly assessment, dated 06/03/24, revealed the resident had a Brief Interview for Mental Status score of six, indicating severely impaired cognition. Review of Resident #4's physician's orders revealed an order dated 05/13/24 for Carvedilol (an antihypertensive medication to lower blood pressure and/or heart rate) 3.125 milligram (mg) one tablet twice daily, with instructions to hold the medication for a systolic blood pressure less than 90 or for a resting heart rate less than 60. Resident #4 also had an order dated 05/13/24 for lisinopril (an antihypertensive medication to lower blood pressure) 5 mg once daily with instructions to hold the medication if the systolic blood pressure is less than 110. Review of Resident #4's May 2024 Medication Administration Record (MAR) revealed the resident was administered the dose of Carvedilol when his heart rate was recorded as being less than 60 beats per minute. These administrations occurred on 05/01/24, 05/02/24, 05/06/24, 05/11/24, 05/12/24, 05/16/24, 05/25/24, 05/28/24, 05/29/24, and 05/30/24. Additionally, Resident #4 was administered the dose of lisinopril when his systolic blood pressure was less than 110 on 05/01/24 and 05/30/24. Review of Resident #4's June 2024 MAR revealed the resident was administered the dose of Carvedilol when his heart rate was less than 60 beats per minute on 06/04/24, 06/08/24, 06/09/24, and 06/18/24. Resident #4 was administered his ordered dose of lisinopril on 05/13/24 when his systolic blood pressure was recorded as less than 110. 2. Review of Resident #5's medical record revealed an admitted [DATE]. Medical diagnoses included diabetes mellitus, a history of a myocardial infarction, and dementia with unspecified severity. Review of Resident #05's MDS 3.0 quarterly assessment, dated 04/17/24, revealed a BIMS score of nine, indicating moderately impaired cognition. Review of Resident #5's physician's orders revealed an order dated 11/02/23 for Midodrine (a medication used to raise blood pressure) 5 mg once daily, with instructions to hold the medication if the systolic blood pressure was greater than 120. Review of Resident #5's May 2024 and June 2024 MAR revealed no correlating blood pressure documented prior to medication administration. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 06/17/24 at 8:23 A.M. with Resident #5 revealed he had a recent fall and reported sometimes he felt dizzy. An interview conducted on 06/20/24 at 10:42 A.M. with Assistant Director of Nursing (ADON) #402 verified Resident #4's medications had been administered outside of parameters when the medication should have been held. ADON #402 additionally verified Resident #5 should have had correlating blood pressure documented prior to medication administration but did not. Review of the policy titled Medication Administration - General Guidelines, dated 07/01/21, revealed medications are administered as prescribed in accordance with good nursing principles and practices. Medications are administered in accordance with written orders of the prescriber.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on record review, interview, and facility policy review the facility failed to complete routine assessments for monitoring of psychotropic medication side effects. This deficient practice affected one resident (#9) out of five residents reviewed for unnecessary medications. The facility census was 19. Findings include: Review of Resident #9's medical record revealed admitted [DATE] with diagnoses including Huntington's Disease, chronic obstructive pulmonary disease (COPD), depression, anxiety, and history of falls. Resident #9 required assistance from staff to complete activities of daily living (ADL) and had severely impaired cognition. Resident #9 used a four wheeled walker for assistance with independent ambulation and had severely impaired balance and gait due to the diagnosis of Huntington's Disease. Review of Resident #9's physician orders revealed an order with revised date of 06/12/24 for antipsychotic medication Olanzapine oral tablet 7.5 milligrams (mg) give one tablet by mouth one time a day related to Huntington's Disease. Review of Resident #9's completed routine assessments revealed a completed Abnormal Involuntary Movement Scale (AIMS) dated 10/04/21 with the results of minimal/normal severity of abnormal movements at a score of ten out of 28. The next completed AIMS for Resident #9 was dated 01/24/24 with the results of moderate severity of abnormal movements for Resident #9 with a score of 18 out of 28. Interview on 06/24/24 at 9:16 A.M. with the Director of Nursing (DON) confirmed Resident #9 was receiving the anti-psychotic medication Olanzapine for some time and there were not any AIMS assessments completed prior to 01/24/24, and there had not been an AIMS completed since 01/24/24. The DON stated the AIMS assessments should be completed when an anti-psychotic medication is initiated and at least quarterly for routine monitoring of side effects with the use of anti-psychotic medications. Review of the facility's policy titled, Medication Monitoring and Management, dated 07/14/21, revealed, In order to optimize the therapeutic benefits of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff and resident interview, and record review, the facility failed to recognize Resident #5's bottom dentures were missing and failed to timely refer him to a dental provider. This affected one resident (#5) of one resident reviewed for dental services. The facility census was 19. Findings include: Review of Resident #5's medical record revealed an admitted [DATE]. Medical diagnoses included diabetes mellitus, a history of a myocardial infarction, and dementia with unspecified severity. The record contained no evidence Resident #5 had seen a dental provider since admission on 02/03/23. Review of Resident #5's Minimum Data Set (MDS) 3.0 quarterly assessment, dated 04/17/24, revealed a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The assessment indicated the resident required set-up assistance for eating and did not have any broken or loosely fitting dental appliance. The assessment additionally revealed the resident had no reported difficulty with chewing. Review of Resident #5's physician's orders revealed an order dated 02/03/23 for the resident to see podiatrist, dentist, and optometrist as needed. Review of Resident #5's care plan, revised 12/11/23, revealed Resident #5 had the potential for alteration in nutrition and hydration related to multiple medical diagnoses and the presence of upper and lower dentures with no chewing or swallowing disorders. Review of Resident #5's interdisciplinary progress notes revealed a note dated 04/24/24 indicating the resident was edentulous (missing all natural teeth), had upper and lower dentures, and tolerated his recommended diet without chewing or swallowing difficulty or pain. Previous progress notes dated 01/31/24 and 11/03/23 also reflected Resident #5 as being edentulous and using both upper and lower dentures. An observation and interview on 06/17/24 at 8:26 A.M. with Resident #5 revealed he was finishing breakfast. Resident #5 was alert, feeding himself, and answered questions appropriately. Resident #5 stated he had been missing his bottom dentures for approximately four months and had not seen a dentist. Resident #5 stated he had told about everyone awhile back about his missing bottom dentures but no one ever found his dentures. Resident #5 smiled and revealed a full set of top dentures and no natural teeth or presence of a dental appliance present on the bottom. Interviews conducted on 06/18/24 between 10:24 A.M. and 10:30 A.M. with State tested Nurse Aide (STNA) #421 and STNA #438 revealed they were unaware what type of dentures Resident #5 utilized. An interview conducted on 06/18/24 at 1:22 P.M. with Registered Nurse (RN) #413 revealed he was unsure if Resident #5 had both upper and lower dentures, or only upper dentures. RN #413 indicated he had never received information that Resident #5 had been missing dentures. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/18/24 at 2:12 P.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #402 revealed Resident #5 should have both his top and bottom dentures and stated they were unaware the dentures were missing. The DON stated she coordinated ancillary services and would be sure Resident #5 saw the dentist upon the dentist's next visit to the facility. An interview on 06/24/24 at 11:24 A.M. with Regional Nurse #600 revealed a list of all residents scheduled to see the dentist on the next visit, scheduled for 07/02/24. Resident #5 was present on the list to see the dentist, which listed the resident's primary insurance and stated Dental New Patient Exam. Dental full mouth x-ray. Regional Nurse #600 verified the list contained no mention of Resident #5's missing dentures and the reason or cause for the dental examination. The surveyor discussed concern of the dentures previously being reported missing to facility staff on 06/18/24, and Resident #5's medical record still contained no mention of the missing dentures, or what the facility had done to ensure the resident was able to eat or drink appropriately. Regional Nurse #600 stated she would have the speech therapist evaluate Resident #5 upon their next visit to the facility.