

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Vienna Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2510 Vienna Pkwy Dayton, OH 45459	

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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</p> <p>Based on record review, staff and physician interviews and policy review, the facility failed to ensure residents with gastrostomy tubes were administered enteral feedings with a valid physician's order. This affected one (#25) of one residents reviewed for gastrostomy tube care and services. The facility census was 51.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #25 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysarthria, dysphagia, type II diabetes, unspecified anxiety disorder, stage II pressure ulcer, and gastrostomy status.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had severely impaired cognition, had no behaviors, did not wander, and did not reject care.</p> <p>Review of care plan dated 01/09/23 revealed Resident #25 required tube feeding and an oral diet to meet nutrition and hydration needs to support metabolic demands. Interventions included to provide assistance with meals as needed, provide diet/supplements/medications as ordered, and administer tube feeding as ordered.</p> <p>Review of the medical record revealed Resident # 25 had physician orders for a diet of fortified foods, pureed texture, with nectar thickened liquids and one-on-one (1:1) feeding assistance with all meals. Additionally, Resident #25 had orders to flush gastrostomy tube with 400 cubic centimeters (cc) of water every six hours, and 30 cc of water before and after medication pass. Resident #25 had no active orders for supplemental tube feeding.</p> <p>Review of progress note dated 02/02/25 at 1:19 AM revealed an unidentified aide reported to Registered Nurse (RN) #273 that Resident #25 did not receive dinner. RN #273 documented she administered unspecified tube feeding to supplement the missed meal. Resident #25 coughed up some of the tube feed and required the bed linens to be changed.</p> <p>Review of form titled Teachable Moment dated 02/04/25 revealed RN #273 stated to management she had given Jevity 1.5 in a 240 milliliter (ml) bolus to Resident #25 without an order.</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: 366490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Vienna Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2510 Vienna Pkwy Dayton, OH 45459	
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the survey, RN #273 was unable to be reached by telephone for interview on 02/06/25 at 11:42 A.M.</p> <p>During an interview on 02/06/25 at 11:57 A.M. Physician #12 stated Resident #25 took all food by mouth. Physician #12 stated Resident #25 had an order for supplemental tube feeding when less than (<) 50 percent (%) of meals were consumed in the past, but verified Resident #25 did not have a current, active order for supplemental tube feeding on 02/03/25. Physician #12 stated he had not received a request to give orders for Resident #25 to have tube feeding orders.</p> <p>During on interview on 02/06/25 at 12:53 P.M. Regional Nurse # 404 stated the administration error involving RN #273 providing tube feeding to Resident #25 without an order was discovered on 02/04/25. The DON found the progress note referring to the tube feed given on 02/02/25 and called the RN. RN #273 reported to management she had given Resident #25 a 240 ml bolus of Jevity 1.5 Calorie. Regional RN #404 verified Resident #25 had never had an order for Jevity 1.5 and stated the last active order for supplemental feeding was on 08/25/24 for Nepro 1.8 calorie.</p> <p>Review of policy titled Tube Feedings dated 12/20/24 revealed residents who required tube feedings were assessed by a registered dietitian for appropriate tube feeding products to meet estimated calorie, protein and fluid needs. Orders for bolus tube feedings should include the product, amount per bolus, and number of boluses per day.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Vienna Springs Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2510 Vienna Pkwy Dayton, OH 45459	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080</p> <p>Based on observations, staff interview, and facility policy review, the facility failed to provide food safely and labeling and dating all food items. This had the potential to affect all 51 residents residing in the facility. The facility census was 51.</p> <p>Findings include:</p> <p>Observation on [DATE] from 8:36 A.M. through 8:50 A.M. of the facility kitchen with the Executive Director revealed the following areas of concern:</p> <ol style="list-style-type: none"> 1. In freezer the large tub of five gallon chocolate ice cream had the lid off, that exposed ice cream 30 percent (%) in the freezer. 2. In large refrigerator had a large container 12 by 18 by 5 depth of frozen spinach, that had a cufe of six inches in the plastic. The spinach appeared to be freezer burned. 3. In refrigerator located by hand sink, there was a gallon of whole milk that had expired date of [DATE]. The gallon of milk was ,d+[DATE] full of milk. 4. In refrigerator located by hand sink, there was cream cheese in a box opened, ,d+[DATE] full in zip lock bag in box. There was no open date, or labeling on the opened cream cheese. 5. In refrigerator located by prep area, and large sink, that had large bag of 24 frozen burger patties in bottom of refrigerator. No labeling on plastic bag. <p>On [DATE] from 8:35 A.M. through 8:50 A.M., an interview with the Executive Director verified the identified concerns with the kitchen. The facility also confirmed all 51 residents receive their meals from the kitchen.</p> <p>Review of the facility policy titled Food Labeling and Dating Policy dated [DATE] revealed that foods in production need both a production date and use by date. Foods are considered to be in production when they have been taken out of the original container and the seal had been broken. The date code genie can provide both dates on one label. It was the best practice to use the Date Code Genie labels on all food items and food products.</p>