STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365962	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GENEVA SHORES NURSING AND REHAB	60 WEST ST GENEVA, OH 44041

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** - Few	**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** Based on observation, record review and interview the facility failed to collaboratively conduct a plan of care meeting for Resident #79. This affected one resident (#79) of sixteen residents screened for care planning. Findings include: Record review revealed Resident #79 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was admitted to the facility after a psychiatric hospitalization . The plan of care with a date initiated of 02/26/20 revealed the resident was at risk for elopement and wandering related to a history of exit seeking in a prior facility and she believed she was placed at the current facility as a stepping stone to get home. The interventions included to include the resident in the decision making process. The plan of care also revealed Resident #79 had a legal guardian expiring on 03/12/20 and wanted to go live with her daughter. Record review was conducted of the facility document titled Multidisciplinary Care Conference, dated 02/26/20, revealed Social Service Director/Activity Director (SSD/AD) #500 was the only person to attend the meeting, the resident was receiving physical and occupational therapy and the resident preference was to go home with her daughter. The document indicated the plan was reviewed with the resident and provided a copy. The Minimum Data Set (MDS) 3.0 assessment, dated 03/02/20 revealed the resident had no cognitive impairment, no behaviors and a mood indicator score of three which revealed she felt bad about herself, had trouble with sleep and felt like she had less energy. Review of the progress note, dated 03/10/20, timed 7:54 A.M. and authored by SSD/AD #500. The note revealed SSD/AD #500 spoke with the resident the day before about her discharge plans and the resident wanted to go live with her daughter. SSD/AD #500 explained to the resident she had a legal guardian but the resident kept saying her guardian was her daughter. The resident became angry at the mention of the guardian. SSD/AD #500 told the resident she could probably arrange for her discharge the following week but that it would be up to therapy. Interview and observation were conducted on 03/09/20 at 10:35 A.M. with Resident #79 who informed the surveyor she had not been invited to any plan of care meetings and believed she was to be discharged to live with her daughter but did not know when. The resident appeared very anxious throughout the interview, tapping her feet and rapidly blinking and began to cry stating that she just recently lost her husband and just wanted to be with her daughter. When asked if she had been given a copy of her care plan she stated no but maybe they gave it to her daughter. Interview was conducted on 03/10/20 at 1:59 P.M. with the legal guardian of Resident #79 who revealed the facility had not contacted her about the resident's care, discharge planning or any plan of care meetings for Resident #79. The guardian added when she last spoke to the resident's daughter the daughter wanted her mom to discharge to another care facility closer to the daughter's home in another county. The guardian stated it was fine for the facility and surveyor to speak with the daughter as her guardianship would expire on 03/12/20 and she believed the daughter was going to apply for guardianship. The guardian stated she had not been given a care plan for the resident. Interview was conducted on 03/10/20 at 2:17 P.M. with the daughter of Resident #79 who revealed her mom wanted to live with her but she was not able to accommodate her wishes. The daughter shared she wanted her mom to be discharged to a facility near her home. The daughter stated she had not been invited to any plan of care meetings at the facility nor did she receive a copy of a care plan. Interview was conducted on 03/10/20 at 2:24 P.M. with SSD/AD #500 who verified the daughter, therapy, the guardian nor any other discipline had attended the plan of care meeting as documented on 02/26/20. When asked why the others were not in attendance SSD/AD #500 stated none of them were in the building the day of the meeting. SSD/AD #500 verified she had not documented any attempts to call the guardian or the daughter to come to any meetings regarding the resident since she was admitted to the facility. SSD/AD #500 did not know what the discharge plan was for the resident, as she thought the resident was going to go home with the daughter. Interview was conducted on 03/10/20 at 3:00 P.M. with Administrator in Training (AIT) #600 to notify her of the concern Resident #79 was unaware of the discharge plans expressed by the guardian and daughter and it had not been discussed collaboratively with the interdisciplinary team, guardian, daughter and resident to date. The Administrator verified plan of care meetings were to include the resident, resident representative and members of the care team. Review of the undated Plan of Care Meetings policy revealed participants in the meeting would included but not limited to the resident and/or resident representative, nursing, dietary, social services, activities and therapy.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure bed hold notices were issued for Resident #5 and Resident #16 upon transfer to the hospital as required. This affected two residents (#5 and #16) and had the potential to affect all 27 residents residing in the facility. Findings include: 1. Record review revealed Resident #5 was admitted to the facility on [DATE], discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the Notification of Bed Hold for Resident #5 document revealed the resident had had 29 bed hold days available. However, the notice was issued to the resident on 02/03/20 after she returned from the hospital. Interview on 03/11/20 at 1:43 P.M. with Administrator in Training (AIT) #600 verified the bed hold notice was completed on 02/03/20 and not issued in the timeframe required. 2. Record review revealed Resident #16 was admitted to the facility on [DATE], discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the Notification of Bed Hold document for Resident #16 revealed the resident had 20 bed hold days available. However, the notice was issued to the resident on 12/17/19 after he returned from the hospital. Interview on 03/11/20 at 1:43 P.M. with Administrator in Training (AIT) #600 verified the bed hold notice was completed on 12/17/19 and not issued in the timeframe required.
F 0838 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the facility assessment included an evaluation of the overall number of facility staff needed to provide care and services. This had the potential to affect all 27 residents residing in the facility. Findings include: Review of facility form titled, Facility Assessment with a date of 03/05/20 revealed the assessment did not include an evaluation of the overall number of facility staff needed to ensure there were a sufficient number of qualified staff available to meet each residents need. Interview on 03/12/20 at 10:55 A.M. with Administrator in Training (AIT) #600 verified the facility assessment dated [DATE] did not include an evaluation of the

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

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.

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F 0838 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 1) overall number of facility staff needed to provide care and services at the facility.