STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. BUILDING _____ B. WING _____	**07/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINCHESTER CARE & REHABILITATION	**36 LEHMAN DR CANAL WINCHESTER, OH 43110**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy and staff, guardian and family interview the facility failed to ensure Resident #108's legal guardian was notified timely following an acute change in condition and subsequent death and failed to ensure ongoing communication was maintained regarding Resident #1 and Resident #7's status and/or questions from family. This affected three residents (#1, #7 and #108) of five sampled residents reviewed for notification. Findings include: 1. Review of Resident #108's closed medical record revealed the resident was admitted to the facility on [DATE] and passed away on [DATE]. The resident's [DIAGNOSES REDACTED]. Record review revealed the resident had a legal guardian. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed the resident had moderately impaired cognition. Review of the progress notes revealed on [DATE] at 12:03 P.M. the resident's family member was updated regarding a change in the resident's condition including changes in breathing pattern. The resident subsequently passed away at 3:00 P.M. Record review revealed no evidence in the resident's medical record the resident's guardian had been notified of the acute change in condition or resident's death. On [DATE] at 8:55 A.M. a telephone interview with Resident #108's guardian revealed he was not aware Resident #108 had a change in condition. The guardian indicated the resident's death was unexpected and he had not been appropriately updated with health changes the resident had by staff. On [DATE] at 2:28 P.M. a telephone interview with the Director of Nursing (DON) verified there was no evidence in Resident #108's medical record the resident's guardian was notified regarding the condition change and subsequent resident death on [DATE]. Review of the facility policy titled Physician Notification, revised [DATE] revealed the resident's physician and responsible party was notified with any change in condition including life threatening clinical complications. 2. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review revealed the resident had a legal guardian. Record review revealed the resident tested positive for COVID 19 on [DATE] with results received on [DATE] and there was evidence of appropriate notification regarding the positive results. Review of the MDS 3.0 assessment, dated [DATE] revealed the resident had both short and long term memory impairment and severely impaired cognition. Review of Resident #1's progress notes revealed when the guardian was made aware of the positive COVID 19 status on [DATE] he requested updates regarding the resident's COVID 19 signs and symptoms. On [DATE] the guardian was made aware of a seven pound weight loss the past month probably related to the COVID positive status. On [DATE] and [DATE], the notes stated the guardian was called and updated with no other details related to COVID signs or symptoms. On [DATE] at 8:55 A.M. telephone interview with Resident #1's guardian revealed staff were difficult to reach and did not return phone calls and messages. This included requested resident health information and billing/Medicaid information including COVID 19 signs or symptoms. The guardian indicated any time there were questions no person with knowledge would return calls. On [DATE] at 2:34 P.M. a telephone interview with the DON on [DATE] at 2:34 P.M. verified there was no evidence of specific updates for the guardian regarding Resident #1's COVID 19 signs or symptoms as the guardian requested. 3. Review of Resident #7's medical record revealed the resident had [DIAGNOSES REDACTED]. Record review revealed the resident had a grandson as financial power of attorney and wife as health care power of attorney. Review of the MDS 3.0 assessment, dated [DATE] revealed the resident had severely impaired cognition. On [DATE] at 1:30 P.M. a telephone interview with Resident #7's grandson who had financial power of attorney revealed he had difficulty getting the facility staff to answer the phone if he had questions and needed information regarding the resident's finances. No additional information was provided by the facility to review to support ongoing communication was maintained as requested by Resident #7's grandson. This deficiency substantiates Complaint Number OH 212.

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