STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365259	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVINE REHABILITATION AND NURSING AT CANAL POINTE	145 OLIVE ST AKRON, OH 44310

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of personnel files, policy review, and staff interview the facility failed to complete a thorough investigation of Self-Reported Incident (SRI) # 1 which affected one resident (Resident #4) out of five residents reviewed for an SRI investigation. The facility census was 93. Findings Include: Resident #4 was admitted to this facility on 01/27/20. Her admitting [DIAGNOSES REDACTED]. Review of this resident's Minimum Data Set Assessment ((MDS) dated [DATE] revealed this resident was cognitively intact. Functionally, she needed extensive assistance for most activities of daily living including bed mobility, toilet use and personal hygiene. She was totally dependent on staff for transfers. Her skin assessment showed that she did not have any skin breakdown but was at risk for the development of pressure ulcers. Review of SRI # 1 revealed Resident #4 stated she was hit in the head by the Hoyer lift bar while she was being transferred into bed. She further alleged that the State tested Nursing Assistant who was transferring her was doing so without assistance. She further stated this incident occurred in her room by an aide who she was able to describe. This resident was assessed by the nursing staff and no bruising swelling or lacerations were noted. The resident did refuse a full body assessment. Other staff members were interviewed, and no one had any additional information regarding the allegation. There are no names listed of other staff members that were interviewed besides the two Aides and the Licensed Practical Nurse #282. The STNA #280 was interviewed and stated that Resident #4 asked to have her oxygen refilled and to be changed. He went to the second floor and got another aide to assist him to transfer the resident via Hoyer lift. He stated him and another aide Hoyer lifted the resident to her bed to change her and then lifted her back into her chair. He denied the resident hitting her head on the Hoyer lift. An interview with the second STNA #206 on 02/21/20 revealed she assisted the STNA #280 transfer Resident #4 from the chair to the bed and then back to the chair and nothing unusual happened. Further review of this SR failed to show other residents on that unit were interviewed regarding STNA #280 and or being Hoyer lifted by the STNA. Review of the Facility Policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/21/16 revealed the facility failed to follow their policy in regards to having evidence that an alleged violation was thoroughly investigated. This was an incidental finding during the investigation of Complaint Number OH 570.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and medical record review the facility failed to ensure a safe discharge for one resident (Resident #98) of three residents (Resident #98, #99, and #100) reviewed for discharge. The facility census was 93. Findings Include: Resident #98 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged home on[DATE]. Review of the physician's orders [REDACTED].#98's discharge and an order to send a 14 day supply of medications home with him. The resident was taking [MED] (an anticoagulant) 5 milligrams (mg) by mouth twice a day for blood clot prevention. Review of the Discharge Planning Review Assessment completed by Registered Nurse (RN) #256 on 02/08/20 revealed the discharge was initiated by the resident's insurance carrier due to not requiring continued skilled care. The resident was to be discharged to the community but was not sent home with any medications. The section regarding Learning Needs Related To Conditions was not completed. The section marked other was left blank and did not mention Resident #98 was taking medication to prevent blood clots. Resident #98 was been discharged from the hospital due to a recent blot clot. Review of the nurses' notes revealed no documentation regarding the resident's discharge. Interview with the Director of Social Services (DSS) #305 on 03/06/20 at 2:30 P.M., regarding Resident #98's discharge, revealed Resident #98 did not stay long in the facility. Prior to admission he had been in the hospital with pneumonia and then was admitted to the facility for short term therapy for strengthening. The resident was self sufficient upon admission and did not need much assistance. Resident #98 was mildly intellectually disabled but did not receive services through the Department of Developmental Disabilities. The resident lived on his own, knew how to the take the bus, how to get to his home and to local self-help meetings. Resident #98 had a case manager through a local community mental health agency. DSS #305 said the resident's insurance cut him from services on a Friday and wanted him immediately discharged the same day but DSS #305 said she was unable to do that as it would not be considered a safe discharge. DSS #305 said she spoke with Resident #98 and he was fine with being discharged . She did not know if medications were sent home with the resident. Interview with the Administrator #315 on 03/10/20 at 4:10 P.M. revealed he had been working for the facility for one week and Resident #98 was admitted and discharged prior to his arrival. He stated when insurance cuts a resident from therapy they do not have much they can do other than offer an appeal. It takes awhile to get medications from the pharmacy so they were unable to provide any medications for him prior to his discharge. Most of the residents they admit from the resident's community agency they do not receive payment for so they had to discharge him. This deficiency substantiates Complaint Number OH 560.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two residents were provided appropriate nail care. This affected two residents (Resident #15 and Resident #56) out of four residents reviewed for nail care. The facility census was 93. Findings Include: 1. Resident #15, was admitted to the facility on [DATE]. Her admitting [DIAGNOSES REDACTED]. Review of this resident's Minimum Data Set Assessment ((MDS) dated [DATE] revealed this resident had severe cognitive impairment and was totally dependent on staff for dressing, toileting and personal hygiene. She needed extensive assistance of one for eating. Observation of this resident on 03/09/20 at 2:30 P.M. revealed her nails on both hands had dirt under the nails. They were brownish colored dirt noted around the cuticle area of the nails of both thumbs, and the first and second digit of the right and the left hand. Interview with State tested Nurse Aide (STNA) #218 on 03/09/20 at 2:45 P.M. verified the resident's fingernails did have dirt underneath and there was dirt noted around the cuticles of the thumb, first and second digit of both hands. 2. Resident #56 was admitted to this facility on 08/27/18. Her admitting [DIAGNOSES REDACTED]. Based on her Minimum Data Set Assessment ((MDS) dated [DATE] revealed, Resident #56 was cognitively intact. She needed extensive assistance of one to two people for bed mobility, dressing, toilet use and personal hygiene. Review of this resident's fingernails on 03/09/20 at 3:30 P.M. revealed her nails of her thumb, first, second and third digit on both her right and left hand dirt and debris under her fingernails. Interview with Resident #56 stated that she picks a lot and that was how she got the dirt under her fingernails. Interview with Registered Nurse #256 on 03/09/20 at 4:00 P.M. verified the resident did have noted dirt under her fingernails. Review of the facility policy titled Care of Fingernails/Toenails, dated 07/06, revealed the facility did not implement their policy regarding nail care. Per the policy Nail Care includes Daily Cleaning. This was an incidental finding to Complaint Number OH 570.

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview the facility failed to ensure the glucometer was cleaned appropriately after use. This affected one resident (Resident #43) of 12 residents receiving blood sugar checks on the fourth floor. The facility census was 93. Findings Include: Resident #43 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of the admission comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 was cognitively intact. Interview with the Resident #43 on 03/06/20 at 1:05 P.M. revealed one of her concerns with care was that she was diabetic. She was supposed to have her blood sugars checked before breakfast and before dinner; it was not being done consistently. The resident said she had recently been given a cortisone injection for pain and she was concerned as cortisone can cause her blood sugars to fluctuate. Interview and observation with Licensed Practical Nurse (LPN) #330 on 03/06/20 at 5:25 P.M. revealed she was gathering the medications for Resident #43's evening medication pass and was preparing to enter the resident's room. LPN #330 pulled up Resident #43's Treatment Administration Record (TAR) and located the order to check the resident's blood sugars before breakfast and before dinner. LPN #330 confirmed she had not checked Resident #43's blood sugars that day as she was unaware of the order. LPN #330 then gathered the needed equipment to check the resident's blood sugar and entered the room. LPN #330 administered Resident #43's medications and checked the resident's blood sugar. Upon returning to the medication cart, LPN #330 indicated she was supposed to clean the glucometer with bleach wipes but did not know where they were located. She checked her cart but was unable to locate any bleach wipes. LPN #330 then proceeded to clean the glucometer with an alcohol wipe stating it was better than nothing. This was an incidental finding during the investigation of Complaint #OH 369.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the environment was kept neat and clean. This affected five residents (Resident #6, Resident #2, Resident #15, Resident #97 and Resident #88)out of 93 residents for cleanliness of bathrooms, affected two residents (Resident #24 and Resident #25) out of 93 residents for odors and had the potential to affect all 93 residents regarding the dirt and debris in the elevators. Findings included: 1. Observation of the elevators of this facility on 03/06/20 at 3:00 P.M. to 4:30 P.M. revealed dirt, dust and papers laying in the elevator tracks. Observation of room [ROOM NUMBER]'s bathroom (Resident #15 and Resident #6), on 03/06/20 at 5:00 P.M. revealed black and brown dirt stains in the corners of the baseboard, on the baseboard and on the floor next to the bottom of the toilet. Both findings were verified during an interview with the Housekeeping Director # 295 on 03/06/20 at 5:30 P.M. 2. Walking tour of the facility held with the Housekeeping Director #295 and the Maintenance Director #260 on 03/10/10 from 1:00 P.M. to 1:45 P.M. revealed: There was brown stains on the floor by the toilet, in Resident 97's bathroom. In Resident #85's room, the wall across from the bathroom had scratches, peeling paint and holes in the plaster. In Resident #24 and Resident #25's room, there was an overpowering odor of urine upon entrance into the room and in the hall. Resident #88's baseboard in the bathroom had brown colored stains on it. Interview with the Housekeeping Director #295 and the Maintenance Director #260 on 03/10/20 at 2:00 P.M. verified the above findings. This deficiency substantiates Complaint Number OH 570.