STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365448	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REST HAVEN NURSING HOME INC	1096 NORTH OHIO STREET GREENVILLE, OH 45331

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 medical record review, staff interview, review of facility policy, the facility failed to notify a resident's family/representatives for significant changes in condition. This affected one (#44) of three residents residents reviewed for notification of change. Facility census was 42. Findings include: Review of Resident #44's closed medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Resident #44 was assessed as being moderately cognitively impaired on a comprehensive Minimum Data Set ((MDS) dated [DATE]. Resident #44 was discharged from the facility on 08/03/20. Review of a health status note dated 07/21/20 at 10:16 A.M. revealed Resident #44 was noted with confusion and a decline in activities of daily living (ADL's). Review of a physician note dated 07/23/20 at 5:17 P.M. revealed Resident #44 was seen per nursing request due to increased confusion. Nursing reported Resident #44 was not herself and seemed less active. Review of physician orders [REDACTED]. Apply a heart-shaped bordered foam patch upside down. Use skin-prep (preventive skin treatment) to area around open area to secure foam patch. Treatment is to be completed every evening shift, every three days for open area on buttock. Another order dated 07/24/20 was to check border foam patch for placement every shift. Further review of Resident #44's closed medical record revealed no documentation of family/representative notification of increased confusion first noted on 07/21/20 and assessed for by physician on 07/23/20 or for the open area to buttock discovered on 07/24/20. Interview with the Director of Nursing (DON) on 09/22/20 at 1:00 P.M. confirmed there was no documentation of Resident #44's family/representative being notified of increased confusion on 07/21/20 and assessed for by physician on 07/23/20 or for the open area to buttock discovered on 07/24/20. Review of the facility's undated policy titled Change in a Resident's Status of Condition revealed unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status. This deficiency substantiates Complaint Number OH 100.
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** Based on medical record review, staff interview, and review of facility policy, the facility failed to appropriately document and assess a resident's wound. This affected one (#44) of three residents sampled during the survey for skin breakdown. Facility census was 42. Findings include: Review of Resident #44's closed medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Resident #44 was assessed as being moderately cognitively impaired on a comprehensive Minimum Data Set ((MDS) dated [DATE]. Resident #44 was discharged from the facility on 08/03/20. Review of physician orders [REDACTED]. Apply a heart-shaped bordered foam patch upside down. Use skin-prep (preventive skin treatment) to area around open area to secure foam patch. Treatment is to be completed every evening shift, every three days for open area on buttock. Another order dated 07/24/20 was to check border foam patch for placement every shift. Review of treatment administration records (TAR's) form 07/24/20 through 08/03/20 revealed wound treatments were completed as ordered. Further review of Resident #44's closed record revealed there were no documentation of assessment of the buttock wound. No documentation of the buttock wound's size or condition was found. There was no etiology documented for Resident #44's wound. Review of weekly skin assessments dated 07/17/20 and 07/31/20 revealed there were no documentation of an open area to the buttock. Interview with the Director of Nursing (DON) on 09/22/20 at 1:00 P.M. confirmed there were no assessments of Resident #44's buttock wound in the medical record. The DON confirmed wounds should be assessed for size and condition on a regular basis, and that this should be documented in a resident's medical records. The DON confirmed that Resident #44's wound etiology was not documented in the medical record. Review of the facility's undated policy titled Pressure Ulcer Prevention and Managing Skin Integrity revealed skin Integrity and/or conditions affecting the resident's skin must be documented according to established procedures. The presence of skin breakdown/abnormal skin appearance, i.e. abrasion, blister, bruising - due to pressure, burn, denuded, [DIAGNOSES REDACTED], hematoma, laceration, rash, skin tear and wound, will be documented upon admission and regularly. Upon identification of a wound, a full wound assessment, including its location, and description of the tissue involved, will be completed. Interventions and progress toward outcome focused goals need regular documentation according to established procedures. This deficiency substantiates Complaint Number OH 100 and Complaint Number OH 712.
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** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure a resident was free from unnecessary medication by not having justification for the administration of an anti-anxiety medication. This affected one (#50) of three residents reviewed for unnecessary medications. Facility census was 42. Findings include: Review of Resident #50's closed medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Resident #50 was assessed as having severe cognitive impairment in a comprehensive Minimum Data Set ((MDS) dated [DATE]. Resident #50 was discharged on [DATE]. Review of physician orders [REDACTED]. Review of progress notes dated 07/10/20 at 11:51 A.M. and 6:06 P.M. revealed Resident #50 has had increased anxiety and was started on [MEDICATION NAME] 5.0 mg twice a day. Further review of progress notes dated 06/07/20 through 07/09/20 revealed no documented instances of Resident #50 displaying anxiety or increased anxiety. Review of behavior assessments dated 07/02/20 through 07/17/20 revealed no documented anxiety for Resident #50. All assessments reviewed noted that no behaviors, including anxiety, were present on those days. Review of medication administration records (MAR's) dated 07/10/20 through 08/14/20 revealed [MEDICATION NAME] 5.0 mg was administered twice a day 07/11/20 through 08/13/20 at 8:00 A.M. and 8:00 P.M. [MEDICATION NAME] 5.0 mg was administered on 07/10/20 at 8:00 P.M. and on 08/14/20 at 8:00 P.M. Resident #50 was administered [MEDICATION NAME] 5.0 mg a total of 70 times. Interview with the Director of Nursing (DON) on 09/22/20 at 1:00 P.M. revealed there was no documentation of

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #50 displaying anxiety or increased anxiety prior to 07/10/20. The DON confirmed there was no documented justification for Resident #50 being started on [MEDICATION NAME] on 07/10/20. Review of the facility's undated policy titled Medication Management and Monitoring revealed when a resident receives a new medication, the medication order is evaluated for a written diagnosis, an indication, and/or documented objective findings that support the use of the medication. This deficiency substantiates Complaint Number OH 665.