STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366430	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OTTERBEIN GAHANNA	402 LIBERTY WAY GAHANNA, OH 43230

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 0573 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review and interview the facility failed to provide medical records as requested. This affected one resident (#35) of one resident reviewed for medical record procurement. Findings include: Review of Resident #35's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review revealed the resident passed away on 07/06/20. Review of an authorization for the release of medical records form, signed 07/09/20 revealed the resident's family requested copies of COVID-19 testing, laboratory and radiology reports, neurological reports, dietary reports, physician orders, a discharge summary, physician progress reports, activity notes, nurse's notes and care plans from 06/21/20 through 07/06/20. On 08/20/20 at 12:05 P.M. interview with Resident #35's family revealed they filled out a form to request a copy of the medical records for Resident #35. However, the family voiced concerns that they had not received all of the records they had requested including any progress notes written by the physician. During the complaint investigation, the facility revealed they had not provided copies of a discharge summary, 06/25/20 nurse practitioner progress note or any physician written progress notes. On 08/21/20 at 6:10 P.M. interview with the Director of Nursing verified the 06/25/20 nurse practitioner progress note was not included in the copies of the medical records provided to Resident #35's family. Assistant Vice President #17 revealed the physician had not been in to visit during that time period and that was why no physician notes were provided. Interview on 08/23/20 at 5:07 P.M. with the DON revealed a discharge summary was not written for the resident. This deficiency substantiates Complaint Number OH 233.
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, policy review and interview the facility failed to ensure timely physician notification of pressure ulcer development and subsequent pressure ulcer infection for Resident #26 and weight gain associated with [MEDICAL CONDITION] for Resident #28. This affected two residents (#26 and #28) of five sampled residents. Findings include: 1. Review of Resident #26's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the initial plan of care (POC) dated [DATE] revealed Resident #26 was at risk for skin breakdown and had no skin impairment at that time. Interventions included a weekly skin assessment, turn and reposition every two hours and as needed and a low air loss mattress to the bed. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed Resident #26 had impaired cognition and was at risk for pressure ulcers or injuries. Further review revealed Resident #26 required extensive assistance from two staff for bed mobility, transfers and bathing. The MDS revealed Resident #26 did not have any pressure ulcers present at the time of the assessment. The facility provided an undated/unsigned typed piece of paper with LPN #21's name written at the top of it. The paper revealed on the night of [DATE], Resident #26's wife had called multiple times in regards to a wound located on the resident's left upper back. The paper noted the resident's wife told the nurse if she was here she would be taking the picture herself. The documentation on the paper revealed the nurse decided that because the wife would be taking the picture anyway if we did not have the visitor restrictions. The typed paper revealed education was provided to the nurse in regards to sending pictures to family members. However, the paper did not include any information as to what the picture was of, did not include a copy of the picture taken or any type of a description of the resident's left upper back at that time. There was no corresponding nursing progress note from LPN #21 dated [DATE]. No evidence the physician was notified of any type of skin impairment on [DATE] and no evidence any type of treatment was initiated at that time. Attempts to contact LPN #21 during the complaint investigation were unsuccessful. Review of the nursing progress note, dated [DATE] at 1:09 P.M. revealed a physician order [REDACTED]. There was no additional information contained in the record as to why this treatment was ordered or any type of wound description noted at that time. Review of an initial wound physician note, dated [DATE] revealed Resident #26 had an unstageable pressure ulcer to the left scapula that measured 2.4 cm in length and 4.4 cm in width with an obscured depth. According to the National Pressure Injury Advisory Panel (NPIAP) an unstageable pressure ulcer has obscured tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. A new treatment order of Santyl ([MEDICATION NAME] ointment) and calcium alginate (to maintain a moist environment to promote healing) was obtained to be applied to the wound. The wound was to be covered with a dry clean dressing and changed daily and as needed. The facility provided a second undated/unsigned typed document with LPN #31's name written at the top. This document revealed a phone conversation was held with LPN #31 on Friday evening [DATE]. During the conversation, the nurse revealed the elder aide (EA) brought to her attention an area on Resident #26's left upper back area. (The document did not include the date the EA brought this to LPN #31's attention). The document revealed the nurse took measurements of the area and applied a dressing to said skin tear. The document also revealed the nurse practitioner was notified towards the end of the nurse's shift, however no treatment was put into the computer because the nurse hadn't heard back from nurse practitioner. The document revealed this nurse notified the resident's wife. Review of the document revealed that although the conversation was held with the nurse on [DATE], it did not include on what date the EA had notified her of the area, did not include the measurements or description of the area and did not include what type of dressing was applied by the nurse. Review of the quarterly MDS 3.0 assessment, dated [DATE] revealed Resident #26 had one unstageable pressure ulcer. Further review of the MDS 3.0 revealed Resident #26 had severely impaired cognition and required extensive assistance from staff with bed mobility, transfers and bathing. Record review revealed ongoing documentation of the presence of the pressure ulcer from [DATE] through [DATE]. Review of a nurse's note, dated [DATE] revealed Resident #26 had a temperature of 100.4 Fahrenheit (F). The note indicated the nurse practitioner (NP) and Assistant Director of Nursing (ADON) were notified of signs of infection to the resident's wound with increased drainage, pain and fever and purulent exudate. However, there was no evidence the NP addressed the change in condition of the pressure ulcer at that time. On [DATE] (two days after the resident was assessed to have new onset fever, increased drainage and purulent exudate) an order was obtained for a wound culture and the resident was ordered an antibiotic, [MEDICATION NAME] 300 milligrams (for a wound infection). Review of the wound progress note, dated [DATE] revealed Resident #26 had a Stage III pressure injury to the left scapula measuring 4.0 cm in length, 3.0 cm in length, and 0.5 cm in depth. The wound bed had 60% granulation and 40% slough with moderate amount of exudate. Debridement was performed to remove 20% slough. Staff reported there was purulent (consisting of pus) drainage and the note revealed culture was taken. Review of a nursing progress note, dated [DATE] revealed the facility was contacted by the laboratory and notified another wound culture specimen for Resident #26 was

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) needed as the specimen tube to collect the wound culture that had been sent to the lab was expired. Record review revealed no evidence the physician was contacted regarding the delay in obtaining the wound culture from [DATE] when ordered until [DATE] when the lab notified them a new specimen would be needed. Review of Resident #26's laboratory testing, revealed on [DATE] at 3:22 P.M. lab results revealed heavy growth of streptococcus pyogenes (group A) (gram positive bacteria), moderate growth [DIAGNOSES REDACTED] pneumoniae (gram negative bacteria), moderate growth lactose fermenter (gram negative bacteria), moderate growth diptheroid bacillus (gram positive bacteria). Record review revealed the wound was susceptible to the antibiotic [MEDICATION NAME] but resistive to the antibiotic [MEDICATION NAME]. However, these tests results were not provided to the physician on [DATE]. Review of the nurse's notes, dated [DATE] at 9:59 P.M. (over 24 hours later) revealed Resident #26's lab results were received and a copy was sent to the NP and DON. No new orders were received as at that time. A nurse's note, dated [DATE] at 6:29 A.M. revealed new orders for Resident #26 were obtained from the NP for the antibiotic, [MEDICATION NAME] ,[DATE] twice daily for ten days. The note indicated the resident would also continue on the [MEDICATION NAME]. On [DATE] at 4:47 P.M. interview with the DON verified the lack of timely physician notification related to the development of the pressure ulcer on [DATE] and related to the pressure ulcer becoming infected on [DATE]. The DON also revealed the treatment order, obtained on [DATE] should have indicated left shoulder and not right shoulder as the resident did not have any type of skin breakdown to the right shoulder. Review of the notification of change of condition policy dated [DATE] revealed the facility would immediately consult the resident's physician for a significant change in the resident health, deterioration in health or clinical complications. 2. Record review revealed Resident #28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].#28 to be weighed daily (related to the [DIAGNOSES REDACTED]. Review of the nursing progress note, dated [DATE] revealed Resident #28 was transferred to the hospital for low oxygen saturation levels and elevated blood pressure of ,[DATE] (normal range is 140 to 160/ 60 to 80). The resident returned to the facility on [DATE]. Review of the hospital records, revealed a record dated [DATE] which indicated Resident #28 was treated at the hospital for exacerbation of [MEDICAL CONDITION]. Review of the discharge summary revealed orders to call the physician of weight gains of two pounds overnight or five pounds in a week. The summary record revealed Resident #28 was to be weighed daily with similar clothes and the weights were to be recorded. Record review revealed no evidence the resident's plan of care or orders were updated to reflect the discharge summary physician notification of a two pound weight gain overnight or five pound weight gain in one week. Review of the [DATE] TAR revealed daily weights were documented on 11 of 31 days ([DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]). The resident's weight on [DATE] was documented to be 186.2 pounds. The resident's weight on [DATE] was documented to be 180 pounds, on [DATE] the resident's weight was 177 pounds and on [DATE] the resident's weight was documented to be 192.3 pounds (a 15 pound weight gain in two days). There was no evidence the physician was notified of this weight gain. Resident #28 was hospitalized from [DATE] to [DATE] as a result of a fall with fracture. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed Resident #28 had severe cognitive impairment and required extensive assistance from two staff for bed mobility, transfers and toileting. Review of the [DATE] TAR (from [DATE] to [DATE]) revealed daily weights were only obtained on [DATE] and [DATE]. The resident's weight on [DATE] was documented to be 193.3 pounds which was noted to be a 13.3 pound weight gain from 30 days prior ([DATE] to [DATE]). Record review revealed on [DATE] Resident #28 was seen by the cardiologist. The progress notes from the visit revealed the resident was being seen in the office on this date. She had been seen in the hospital last week ([DATE]) with evidence of right sided heart failure with anasarca, was given an intravenous dose of the diuretic, [MEDICATION NAME] 40 milligrams and returned to the nursing home facility. At the time of the visit on [DATE], the resident's assistant (personal caregiver) was present. The resident was very drowsy at the time of the appointment. The cardiologist noted the resident was significantly hypervolemic (an abnormally increased volume of blood) with mostly right-sided features which the cardiologist noted he suspected was multifactorial including sodium dietary indiscretion. The assessment/plan revealed the cardiologist discussed the importance of daily weight monitoring with close assessment of her volume status. The note revealed the cardiologist also highly recommended dietary sodium restriction and to resume care with the heart failure clinic. On [DATE] Resident #28 was seen by the nurse practitioner. Review of the nurse practitioner note revealed no mention of the cardiologist findings or recommendations, no evaluation of the resident's weights or weight/fluid status and no coordination of care related to the [DIAGNOSES REDACTED].M. interview with Resident #28's personal caregiver (a family friend who had been handling medical appointments for the resident) revealed she had significant concerns related to Resident #28's increase in weight and disclosed she was at the facility (on this date) to follow the resident to a cardiology appointment she had made for the resident at the heart failure clinic. Review of the nursing progress notes from [DATE] to [DATE] revealed at no time was the physician or the NP made aware weight gain identified for Resident #28. On [DATE] at 1:45 P.M. during an interview with the Director of Nursing (DON) the concern was shared daily weights were not completed as ordered and that nursing staff was not accurately and timely communicating the resident's weight gains to the physician and/or nurse practitioner to implement treatment/interventions for the resident's [MEDICAL CONDITION] resulting in repeated hospitalization s for exacerbation of [MEDICAL CONDITION]. The DON was unable to provide any additional information as to why weights were not being done daily for Resident #28. The DON revealed all of the resident's weights were recorded in point click care (PCC) in the electronic medical record (EMR) as noted above. The DON also verified there was no written evidence to support the resident's physician or nurse practitioner had been notified of any of the actual weights/weight gain that had been identified for Resident #28. Review of a physician note from the heart failure clinic, dated [DATE] at 2:30 P.M. revealed due to the extensive anasarca (general swelling throughout the body), facial droop and wet lung sounds the resident was being sent directly to the hospital via Emergency Medical Services (EMS). Record review revealed the resident was admitted to the hospital for treatment of [REDACTED]. On [DATE] at 8:32 A.M. interview with Registered Nurse (RN) #1 revealed she did not know the current policy regarding what to do if a resident had a significant weight loss or gain. Review of the hospital discharge summary dated [DATE] revealed Resident #28 was admitted to the hospital on [DATE] as a direct admission from the cardiologist for concerns of a 40 pound weight gain. Resident #28 was admitted with a [DIAGNOSES REDACTED]. On [DATE] at 10:49 A.M. interview with the DON verified Residents #28 recent complications of [MEDICAL CONDITION] were directly related to accountability of staff not performing the task of daily weights and communicating with the physician and DON of any negative outcomes including weight gain. Review of the notification of change of condition policy dated [DATE] revealed the facility will immediately consult the resident's physician for a significant change in the resident health, deterioration in health or clinical complications. This deficiency substantiates Complaint Number OH 850.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were accurately completed for Resident #28 and Resident #34 related to falls. This affected two residents (#28 and #34) of three residents reviewed for falls. Findings include: 1. Review of Resident #34's medical record revealed the resident was admitted to the facility 05/20/20 with [DIAGNOSES REDACTED]. Record review revealed a 06/09/20 nurse's note which reflected the resident was found on the floor by his bed on both knees. There was no injury. Review of the 07/13/20 quarterly MDS 3.0 assessment revealed there were no falls coded since the last assessment. On 08/23/20 at 5:07 P.M. interview with the Director of Nursing verified the 07/13/20 MDS 3.0 assessment should of been coded one fall without injury and was coded no falls since last the assessment in error. 2. Record review revealed Resident #28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the 07/22/20 quarterly MDS 3.0 assessment revealed the resident had one fall with no injury and two with minor injuries since the last assessment. The prior assessment was a quarterly assessment completed on 05/05/20. Record review revealed the resident had three falls since admission, falls on 07/08/20, 07/09/20 and 08/02/20. The 07/08/20 fall resulted in no injury. The 07/09/20 fall resulted in a fractured pelvis. On 08/23/20 at 5:07 P.M. interview with the DON verified the 07/22/20 MDS 3.0 assessment was inaccurate related to falls. The MDS should of been coded one fall without injury and one fall with major injury. This deficiency substantiates Complaint Number OH 233.
F 0684 **Level of harm** - 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 record review of two open medical records and two closed medical records [REDACTED]. The facility failed to

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) provide comprehensive and ongoing treatment and monitoring of weight changes for Resident #28 related to a medical [DIAGNOSES REDACTED].#35 and failed to ensure comprehensive and on-going monitoring and care following an acute change in condition for Resident #36. Actual harm occurred on [DATE] when Resident #28 was transferred from an outside clinic appointment (which had been set up by a family personal caregiver) as a direct hospital admission for treatment of [REDACTED]. Hospital documentation noted the resident was assessed to have a 40 pound weight gain, extensive anasarca (general swelling throughout the body), facial droop and wet lung sounds. Prior to this hospitalization , the resident had an order for [REDACTED].#28, #34, #35 and #36) of five residents reviewed for quality of care and treatment. Findings include: 1. Record review revealed Resident #28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].#28 to be weighed daily (related to the [DIAGNOSES REDACTED]. Review of the plan of care for Resident #28 revealed there was no care plan developed related to [MEDICAL CONDITION] or the order for daily weights. Review of the treatment administration record (TAR) revealed daily weights were not documented as being completed as ordered. Review of the [DATE] TAR revealed daily weights were documented on 14 of 30 days during the month. Review of the Dietary Technician (DT) notes, dated [DATE] at 11:53 A.M. revealed Resident #28 had a 30-day weight warning for an 8.7% weight gain of 13 pounds. Review of the nurse practitioner (NP) note, dated [DATE] revealed Resident #28 had mild wheezing and laboratory testing was ordered for exacerbation (acute increase in severity of a problem) of [MEDICAL CONDITION]. Review of the laboratory tests, dated [DATE] revealed a BNP (a blood test used to monitor congested heart failure) level of 1369, normal limit range per this laboratory was ,[DATE]. There was no evidence a comprehensive plan was developed at this time to address the resident's [MEDICAL CONDITION] or abnormal laboratory testing. Review of the nursing progress note, dated [DATE] revealed Resident #28 was transferred to the hospital for low oxygen saturation levels and elevated blood pressure of ,[DATE] (normal range is 140 to 160/ 60 to 80). The resident returned to the facility on [DATE]. Review of the hospital records, revealed a record dated [DATE] which indicated Resident #28 was treated at the hospital for exacerbation of [MEDICAL CONDITION]. Review of the discharge summary revealed orders to call the physician of weight gains of two pounds overnight or five pounds in a week. The summary record revealed Resident #28 was to be weighed daily with similar clothes and the weights were to be recorded. Record review revealed no evidence the resident's plan of care or orders were updated to reflect the discharge summary physician notification of a two pound weight gain overnight or five pound weight gain in one week. Review of the [DATE] TAR revealed daily weights were documented on 11 of 31 days ([DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]). The resident's weight on [DATE] was documented to be 186.2 pounds. The resident's weight on [DATE] was documented to be 180 pounds, on [DATE] the resident's weight was 177 pounds and on [DATE] the resident's weight was documented to be 192.3 pounds (a 15 pound weight gain in two days). There was no evidence the physician was notified of this weight gain. Resident #28 was hospitalized from [DATE] to [DATE] as a result of a fall with fracture. Record review revealed the resident was seen by the nurse practitioner on [DATE] and [DATE]. Neither of the nurse practitioner progress notes acknowledged the resident's weights, weight gain, fluid status or plan related to [MEDICAL CONDITION] and/or [MEDICAL CONDITION] monitoring. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed Resident #28 had severe cognitive impairment and required extensive assistance from two staff for bed mobility, transfers and toileting. Review of the [DATE] TAR (from [DATE] to [DATE]) revealed daily weights were only obtained on [DATE] and [DATE]. The resident's weight on [DATE] was documented to be 193.3 pounds which was noted to be a 13.3 pound weight gain from 30 days prior ([DATE] to [DATE]). Record review revealed on [DATE] Resident #28 was seen by the cardiologist. The progress notes from the visit revealed the resident was being seen in the office on this date. She had been seen in the hospital last week ([DATE]) with evidence of right sided heart failure with anasarca, was given an intravenous dose of the diuretic, [MEDICATION NAME] 40 milligrams and returned to the nursing home facility. At the time of the visit on [DATE], the resident's assistant (personal caregiver) was present. The resident was very drowsy at the time of the appointment. The cardiologist noted the resident was significantly hypervolemic (an abnormally increased volume of blood) with mostly right-sided features which the cardiologist noted he suspected was multifactorial including sodium dietary indiscretion. The assessment/plan revealed the cardiologist discussed the importance of daily weight monitoring with close assessment of her volume status. The note revealed the cardiologist also highly recommended dietary sodium restriction and to resume care with the heart failure clinic. Record review revealed following this cardiology visit, no dietary changes were made and there was no evidence of daily weight monitoring or close assessment of volume status. On [DATE] Resident #28 was seen by the nurse practitioner. Review of the nurse practitioner note revealed no mention of the cardiologist findings or recommendations, no evaluation of the resident's weights or weight/fluid status and no coordination of care related to the [DIAGNOSES REDACTED].M. interview with Resident #28's personal caregiver (a family friend who had been handling medical appointments for the resident) revealed she had significant concerns related to Resident #28's increase in weight and disclosed she was at the facility (on this date) to follow the resident to a cardiology appointment she had made for the resident at the heart failure clinic. Review of the nursing progress notes from [DATE] to [DATE] revealed at no time was the physician or the NP made aware weight gain identified for Resident #28. On [DATE] at 1:45 P.M. during an interview with the Director of Nursing (DON) the concern was shared daily weights were not completed as ordered and that nursing staff was not accurately and timely communicating the resident's weight gains to the physician and/or nurse practitioner to implement treatment/interventions for the resident's [MEDICAL CONDITION] resulting in repeated hospitalization s for exacerbation of [MEDICAL CONDITION]. The DON was unable to provide any additional information as to why weights were not being done daily for Resident #28. The DON revealed all of the resident's weights were recorded in point click care (PCC) in the electronic medical record (EMR) as noted above. The DON also verified there was no written evidence to support the resident's physician or nurse practitioner had been notified of any of the actual weights/weight gain that had been identified for Resident #28. Review of a physician note from the heart failure clinic, dated [DATE] at 2:30 P.M. revealed due to the extensive anasarca (general swelling throughout the body), facial droop and wet lung sounds the resident was being sent directly to the hospital via Emergency Medical Services (EMS). Record review revealed the resident was admitted to the hospital for treatment of [REDACTED]. On [DATE] at 1:00 P.M. interview with Resident #28's personal caregiver verified the resident was sent directly to the hospital form the heart failure clinic appointment on [DATE]. On [DATE] at 8:32 A.M. interview with Registered Nurse (RN) #1 revealed she did not know the current policy regarding what to do if a resident had a significant weight loss or gain. Review of the hospital discharge summary dated [DATE] revealed Resident #28 was admitted to the hospital on [DATE] as a direct admission from the cardiologist for concerns of a 40 pound weight gain. Resident #28 was admitted with a [DIAGNOSES REDACTED]. On [DATE] at 10:49 A.M. interview with the DON verified Residents #28 recent complications of [MEDICAL CONDITION] were directly related to accountability of staff not performing the task of daily weights and communicating with the physician and DON of any negative outcomes including weight gain. Review of the notification of change of condition policy dated [DATE] revealed the facility will immediately consult the resident's physician for a significant change in the resident health, deterioration in health or clinical complications. Review of the weight policy dated [DATE] revealed the physician requesting weekly or daily weights would specify the length of time weekly or daily weights were to be completed and provide instructions for nursing to follow regarding fluctuating weights. 2. Closed medical record review revealed Resident #36 was admitted to the facility [DATE] with [DIAGNOSES REDACTED]. The resident expired on [DATE]. Review of the [DATE] 3:00 A.M. progress note revealed the resident could not urinate, abdomen was distended and pain was noted upon palpation. The resident was straight catheterized for 1450 milliliters of tea colored urine. On [DATE] at 1:59 P.M. a nursing progress note revealed the resident had not urinated and was straight catheterized for 1000 milliliters of urine. On [DATE] at 5:57 A.M. the resident appeared distressed. Pain medication was administered and the resident's urine was assessed to be coffee ground color. The resident was encouraged to drink water. The nurse practitioner visited and the resident's urine was assessed to be red/bright orange. Urinalysis was pending and irrigation ordered. On [DATE] at 12:46 P.M. the family spoke to the nurse with concerns of the resident having an infection and wanted blood work done to check white blood cell levels and additional labs. The family also verbalized concerns with oxygen use at that time. Orders were received for stat laboratory testing including a complete blood count and basic metabolic panel and to wean the resident off oxygen. The note indicated the nurse attempted to take the resident's oxygen off and the oxygen saturation dropped to 85% within ,[DATE] minutes. The resident was placed back on oxygen at two liters per minute. Review of the Medication Administration Record [REDACTED].M. vital signs were not entered and coded #5 which indicated to see progress notes. There were no medications documented as administered from 3:00 P.M. forward. The administration record was marked #6 indicating the resident was in the hospital. The 5:00 P.M. blood sugar was not obtained and coded

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) hospitalized . Record review revealed no nursing progress notes were completed between [DATE] at 12:46 P.M. and 10:52 P.M. The 10:52 P.M. nursing note indicated the resident was sent to the hospital due to [DIAGNOSES REDACTED] (low blood glucose level). The note revealed the resident was unresponsive. Resident #36's urine was bright red and orange. The family member was present when the resident was sent to the hospital. On [DATE] at 12:50 P.M. interview with Resident #36's daughter revealed her and her sister arrived for a window visit on [DATE] at about 5:00 P.M. and a nurse was in the resident's room. The daughter revealed EMS was called and the resident was responding at that time. She indicated EMS told her her mother's blood sugar was 38. She revealed their mother was taken from the facility to the hospital by EMS at 5:30 P.M. and was pronounced dead at 5:49 P.M. She stated she didn't know if the resident made it out of the EMS vehicle alive. The daughter said Resident #36's cause of death was failure to thrive. On [DATE] at 1:14 P.M. interview with the Director of Nursing (DON) verified the lack of nursing progress notes to determine the resident's condition and that the resident was being comprehensively monitored with timely care provided beginning on [DATE] when the resident was noted to have a change in condition until the resident was discharged to the hospital. The DON verified the progress note made it look like the resident went out of the facility at 10:52 P.M. (However, the family reported and the DON confirmed the resident left the faciity on [DATE] at approximately 5:30 P.M. and was pronounced dead at the hospital at 5:49 P.M.). In addition, the DON verified the note indicated the resident left the facility due to [DIAGNOSES REDACTED], but the resident's record did not include what the resident's blood sugar was. The DON also verified the Medication Administration Record [REDACTED]. The DON verified the record was inaccurate and incomplete, the time of transfer was not accurate and there was not documentation of the events leading to the transfer to ensure the resident was being comprehensively monitored, assessed and provided care related to an acute change in condition. 3. Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the pain assessment completed on [DATE] revealed the resident had no pain. Review of a nursing progress note, dated [DATE] at 10:56 P.M. revealed the resident complained of pain to his perineal area. His scrotum and penis were very painful. Green discharge from the tip of his penis was noticed. The note documented the nurse practitioner was notified. On [DATE] at 2:11 P.M. a nursing progress note revealed the nurse was notified the resident had been screaming in pain while urinating. A state tested nursing assistant (STNA) confirmed the resident's penis hurt. The note indicated the nurse practitioner (NP) was notified. On [DATE] at 10:35 P.M. a progress note revealed the NP ordered a urinalysis with culture and sensitivity. However, the note indicated the urine was not collected (at that time) because the lab was only coming to the facility on Monday, Wednesday and Friday, so it would be collected tomorrow. On [DATE] at 1:00 P.M. a nursing progress note revealed the resident refused to get changed and was screaming. The note indicated the oncoming nurse would collect the resident's urine specimen. On [DATE] at 4:45 P.M. the nursing progress note revealed the resident had been screaming and using inappropriate words towards staff stating staff needed to be in his room as soon as he pushed his pendant. On [DATE] at 9:20 P.M. the nursing progress note revealed the nurse tried to get a clean urine catch but there was no success. The note revealed she would try again. On [DATE] at 1:06 P.M. a new order was obtained for [MEDICATION NAME] powder for a rash around the resident's groin area. Review of the Medication Administration Record [REDACTED]. There was no evidence of any follow-up assessments of the green penis drainage after [DATE] or painful penis and scrotum after [DATE]. There was no follow up of the facility not obtaining the urinalysis/culture and sensitivity. The next pain assessment, dated [DATE] revealed the resident exhibited pain levels of five and two on a ,[DATE] scale with 10 being the worse pain. The assessment revealed the resident received the [MEDICATION NAME] Tylenol 325 milligrams two tablets for [MEDICAL CONDITION] with effect. Review of Resident #34's [DATE] quarterly Minimum Data Set (MDS) 3.0 assessment revealed the resident was moderately impaired for daily decision making, had verbal behaviors one to three days, required extensive assistance from two staff for bed mobility and transfers and walking only occurred one to two times during the assessment period. Resident #34 was assessed to be two person staff assist and utilized a wheelchair and walker with lower extremity impairment on one side. The assessment also documented the resident rarely had moderate pain in the last five days. No pain medication was given routinely or as needed during the assessment reference period. On [DATE] at 6:10 P.M. interview with the Director of Nursing (DON) verified there was no follow up assessment or treatment of [REDACTED]. The DON verified the record failed to document the resolution of pain or the green drainage. The DON revealed staff had re-assessed the resident's penis /scrotum on [DATE] (after surveyor intervention) and noted no pain or drainage at that time. On [DATE] at 5:07 P.M. during a follow up interview with the DON, the DON verified the facility had not ever obtained the urinalysis on [DATE]. There was no evidence of the nurse practitioner addressing the urinalysis not being obtained. In addition, the DON verified the facility had not provided any type of pain management on [DATE] at 10:56 P.M. when the resident's scrotum and penis were described as very painful with green discharge from the tip of his penis. The facility did not provide pain management on [DATE] at 2:11 P.M. when the nursing note revealed the nurse was notified the resident had been screaming in pain while urinating and the STNA confirmed his penis hurt. The DON verified there was a failure to provide continued assessments of the pain and drainage. Verification also occurred no medication or pain management was provided for the complaint of painful urination. 4. Review of Resident #35's closed medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident expired away on [DATE]. Review of the nursing progress note revealed a note, dated [DATE] the nurse on duty noticed that both of the residents lower legs and foot were swollen with 2 plus (+) [MEDICAL CONDITION] (the pressure leaves an indentation of ,[DATE] millimeters that rebounds in fewer than 15 seconds). The note revealed the nurse practitioner was notified and ordered [MEDICATION NAME], a diuretic. On [DATE] at 3:00 A.M. a nursing progress note revealed the resident appeared to be restless and short of breath. The note revealed the resident had 4+ [MEDICAL CONDITION] (the pressure leaves an indentation of 8 mm or deeper) to bilateral lower extremities). The note revealed the nurse practitioner was notified at 03:20 A.M. and new orders were obtained for a stat chest x-ray. [MEDICATION NAME] 40 mg was ordered daily for five days for [MEDICAL CONDITION] and an order was also obtained for the antibiotic, [MEDICATION NAME] 500 mg for seven days for shortness of breath. Record review revealed no evidence of an assessment or monitoring of the resident's [MEDICAL CONDITION]/health status between [DATE] and [DATE]. On [DATE] at 6:29 P.M. interview with the DON verified there were no specific assessments for [MEDICAL CONDITION] between [DATE] and [DATE]. The DON included if there was an assessment it would have been entered in the progress notes. This deficiency substantiates Complaint Number OH 233.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review and staff and family interview the facility failed to implement adequate skin risk interventions for Resident #26, who was cognitively impaired, at risk for pressure ulcer development and dependent on staff for turning and repositioning, to prevent the development and subsequent infection of a pressure ulcer to the resident's left shoulder/scapula area. Actual harm occurred on [DATE] when the resident was assessed by a wound specialist to have an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left scapula. However, the pressure ulcer had been first identified by Licensed Practical Nurse (LPN) #21 on [DATE] who failed to comprehensively assess, notify the physician or implement a treatment. The pressure ulcer subsequently declined and was assessed to have an infection present on [DATE]. However, no effective treatment for [REDACTED]. This affected one resident of three residents reviewed for pressure ulcers. Findings include: Review of Resident #26's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the initial plan of care (POC) dated [DATE] revealed Resident #26 was at risk for skin breakdown and had no skin impairment at that time. Interventions included a weekly skin assessment, turn and reposition every two hours and as needed and a low air loss mattress to the bed. Review of the Braden scale (used for predicting pressure ulcer risk), dated [DATE] revealed Resident #26 was at high risk for skin breakdown with a score of 16. Review of the Minimum Data Set (MDS) 3.0 assessment, dated [DATE] revealed Resident #26 had impaired cognition and was at risk for pressure ulcers or injuries. Further review revealed Resident #26 required extensive assistance from two staff for bed mobility, transfers and bathing. The MDS revealed Resident #26 did not have any pressure ulcers present at the time of the assessment. Review of the task section of the electronic medical record, where state tested nursing assistant (STNA) staff document care provided revealed the resident (per family/resident request) was to receive a bath daily. Review of a [DATE] nursing progress note revealed Resident #26 had a skin tear to the left scapula that measured 2.2 centimeters (cm) in length by 3.1 cm width. The note revealed the nurse applied a foam dressing and the nurse practitioner (NP) was notified. Review of the facility provided documentation revealed there was no determination as to how the skin tear occurred at that time or any additional description of the skin tear. Review of the medical record revealed no weekly skin assessment was conducted on [DATE] or [DATE] as care planned. Review of the [DATE] treatment

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	366430	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) administration record (TAR), Medication Administration Record [REDACTED]. In addition, review of the medical record revealed Resident #26 did not received a bath on [DATE], [DATE] and [DATE]. There was also no documented evidence on the TAR from [DATE] to [DATE] the resident was being turned and repositioned by staff every two hours and as needed or that a low air loss mattress was in place to the resident's bed. The facility provided an undated/unsigned typed piece of paper with Licensed Practical Nurse (LPN) #21's name written at the top of it. The paper revealed on the night of [DATE], Resident #26's wife had called multiple times in regards to a wound located on the resident's left upper back. The paper noted the resident's wife told the nurse if she was here she would be taking the picture herself. The documentation on the paper revealed the nurse decided that because the wife would be taking the picture anyway if we did not have the visitor restrictions. The typed paper revealed education was provided to the nurse in regards to sending pictures to family members. However, the paper did not include any information as to what the picture was of, did not include a copy of the picture taken or any type of a description of the resident's left upper back at that time. There was no corresponding nursing progress note from LPN #21 dated [DATE]. No evidence the physician was notified of any type of skin impairment on [DATE] and no evidence any type of treatment was initiated at that time. Attempts to contact LPN #21 during the complaint investigation were unsuccessful. Review of a nursing progress note, dated [DATE] at 1:09 P.M. revealed a physician order [REDACTED]. On [DATE] a physician order [REDACTED].#26. Review of the TAR revealed the low air loss mattress was obtained/initiated on [DATE] even though it had been a care planned intervention since [DATE]. Review of an initial wound physician note, dated [DATE] revealed Resident #26 had an unstageable pressure ulcer to the left scapula that measured 2.4 cm in length and 4.4 cm in width with an obscured depth. According to the National Pressure Injury Advisory Panel (NPIAP) an unstageable pressure ulcer has obscured tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. A new treatment order of Santyl ([MEDICATION NAME] ointment) and calcium alginate (to maintain a moist environment to promote healing) was obtained to be applied to the wound. The wound was to be covered with a dry clean dressing and changed daily and as needed. The facility provided a second undated/unsigned typed document with LPN #31's name written at the top. This document revealed a phone conversation was held with LPN #31 on Friday evening [DATE]. During the conversation, the nurse revealed the elder aide (EA) brought to her attention an area on Resident #26's left upper back area. (The document did not include the date the EA brought this to LPN #31's attention). The document revealed the nurse took measurements of the area and applied a dressing to said skin tear. The document also revealed the nurse practitioner was notified towards the end of the nurse's shift, however no treatment was put into the computer because the nurse hadn't heard back from nurse practitioner. The document revealed this nurse notified the resident's wife. Review of the document revealed that although the conversation was held with the nurse on [DATE], it did not include on what date the EA had notified her of the area, did not include the measurements or description of the area and did not include what type of dressing was applied by the nurse. Review of the wound physician note, dated [DATE] revealed Resident #26 had an unstageable pressure ulcer to the left scapula that measured 2.0 cm in length and 4.2 cm in width. The wound bed tissue was assessed to be 20% granulated and 80% slough. Review of the wound progress note, dated [DATE] revealed Resident #26 had an unstageable pressure ulcer to the left scapula that measured 2.4 cm in length and 4.6 cm in width. The wound bed tissue was 100% slough. The pressure ulcer healing status was described as deteriorated with the peri wound noted to be macerated (cause to grow thinner or waste away) and a moderate amount exudate (fluid that has seeped out). Review of the wound progress note, dated [DATE] revealed Resident #26 had an unstageable pressure ulcer to the left scapula that measured 2.5 cm in length and 4.2 cm in width. The wound bed continued with 100% slough with a moderate amount of exudate. Review of the wound progress note, dated [DATE] revealed Resident #26 had a sharp instrument debridement (removal) of slough of 50% and 50% revealing a Stage III (involves full thickness skin loss potentially extending into the subcutaneous tissue layer) pressure ulcer to the left scapula that measured 2.8 cm in length, 3.7 cm in width, and 0.1 cm in depth. Review of the wound progress note, dated [DATE] revealed Resident #26 had an unstageable pressure injury to the left scapula that measured 3.5 cm in length, 4.5 cm in width, and 0.1 cm in depth. The wound bed appearance had 10% granulation and 90% slough with a moderate amount of exudate. Review of the wound progress note, dated [DATE] revealed Resident #26 had an unstageable pressure injury to the left scapula measuring 3.0 cm in length, 3.5 cm in width, and the depth was unable to determine (UTD). The wound bed continued with 40% granulation and 60% slough with minimal amount of exudate. The healing status was noted to be deteriorated. Review of the wound progress note, dated [DATE] revealed Resident #26 had an unstageable pressure injury to the left scapula measuring 3.5 cm in length, 3.5 cm in width, and UTD depth. The wound bed continued with 10% granulation and 90% slough with moderate amount of exudate. Review of the wound progress note, dated [DATE] revealed Resident #26 had an unstageable pressure injury to the left scapula measuring 4.0 cm in length, 3.5 cm in width, and UTD depth. The wound bed continued with 10% granulation and 90% slough with moderate amount of exudate. The physician discussed Resident #26's wound with staff. Resident #26 was not refusing treatments and the physician would continue to look for reasons for pressure ulcer deterioration. No additional information was provided following this note related to the cause of the deterioration. Review of the quarterly MDS 3.0 assessment, dated [DATE] revealed Resident #26 had one unstageable pressure ulcer. Further review of the MDS 3.0 revealed Resident #26 had severely impaired cognition and required extensive assistance from staff with bed mobility, transfers and bathing. Review of the wound progress note, dated [DATE] revealed Resident #26 had a Stage III pressure ulcer to the left scapula measuring 2.9 cm in length. 4.0 cm in width, and 0.6 cm depth. The wound bed had 50% granulation and 50% percent slough with (new) tunneling (wound that has a channel that tunnels from the wound into the muscle or subcutaneous tissue) 0.5 cm at 9 o'clock with moderate amount of exudate. Record review revealed no evidence the treatment to Resident #26's pressure ulcer was changed between [DATE] and [DATE] even with the noted deterioration and presence of tunneling. In addition, review of the TAR during this time period revealed no evidence the resident was being turned and repositioned every two hours or as needed or that new interventions were implemented to decrease pressure to the left shoulder/scapula area. Review of a nurse's note, dated [DATE] revealed Resident #26 had a temperature of 100.4 Fahrenheit (F). The note indicated the nurse practitioner (NP) and Assistant Director of Nursing (ADON) were notified of signs of infection to the resident's wound with increased drainage, pain and fever and purulent exudate. However, there was no evidence the NP addressed the change in condition of the pressure ulcer at that time. On [DATE] (two days after the resident was assessed to have new onset fever, increased drainage and purulent exudate) an order was obtained for a wound culture and the resident was ordered an antibiotic, [MEDICATION NAME] 300 milligrams (for a wound infection). Review of the wound progress note, dated [DATE] revealed Resident #26 had a Stage III pressure injury to the left scapula measuring 4.0 cm in length, 3.0 cm in length, and 0.5 cm in depth. The wound bed had 60% granulation and 40% slough with moderate amount of exudate. Debridement was performed to remove 20% slough. Staff reported there was purulent (consisting of pus) drainage and the note revealed culture was taken. Review of a nursing progress note, dated [DATE] revealed the facility was contacted by the laboratory and notified another wound culture specimen for Resident #26 was needed as the specimen tube to collect the wound culture that had been sent to the lab was expired. Review of Resident #26's laboratory testing, revealed on [DATE] at 3:22 P.M. lab results revealed heavy growth of streptococcus pyogenes (group A) (gram positive bacteria), moderate growth [DIAGNOSES REDACTED] pneumoniae (gram negative bacteria), moderate growth lactose fermenter (gram negative bacteria), moderate growth diptheroid bacillus (gram positive bacteria). Record review revealed the wound was susceptible to the antibiotic [MEDICATION NAME] but resistive to the antibiotic [MEDICATION NAME]. Review of the nurse's notes, dated [DATE] at 9:59 P.M. (over 24 hours later) revealed Resident #26's lab results were received and a copy was sent to the NP and DON. No new orders were received as at that time. A nurse's note, dated [DATE] at 6:29 A.M. revealed new orders for Resident #26 were obtained from the NP for the antibiotic, [MEDICATION NAME] ,[DATE] twice daily for ten days. The note indicated the resident would also continue on the [MEDICATION NAME]. On [DATE] at 9:27 A.M. LPN #1 was observed completing the dressing change to Resident #26's left shoulder/scapula pressure ulcer. LPN #1 was observed applying gloves without first washing her hands. LPN #1 then placed dressing supplies consisting of Santyl, calcium alginate and package of 4x4 gauze on the bedside stand without a protective barrier in place. The bedside stand was observed to have cracker crumbs and unidentifiable food debris scattered about. LPN #1 then placed a bottle of wound cleanser on Resident #26's bed. LPN #1 proceeded to turn the resident on to his right side and removed the soiled dressing. At the time of the treatment observation, LPN #1 did not obtain measurements of the pressure ulcer. However, the ulcer was noted to have observable depth present. The soiled dressing was placed it in the trash can located near the bed. LPN #1 then reached for the wound cleaner and gauze and proceeded to cleanse the wound. LPN #1 then applied the Santyl ointment with her same gloved finger to the wound bed and covered the wound with the calcium alginate and outside dressing. Interview with LPN #1 verified she did not use a barrier to place dressing supplies on the bedside stand or wash her hands prior to putting her gloves on,

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) after removing the soiled dressing or after the procedure. On [DATE] at 9:37 A.M. interview with Resident #26 revealed he had pain at times when the wound dressing (to the left shoulder/scapula) was being changed. Resident #26 stated he did not get out of bed and did not remember if staff turned him. On [DATE] at 10:00 A.M. interview with STNA #10 revealed Resident #26 was dependent on staff to turn and reposition him. STNA #10 revealed other residents in the facility had turn and reposition tasks documented in their electronic medical record, but Resident #26 did not. On [DATE] at 10:11 A.M. an interview with the Corporate Director of Nursing (DON) revealed the expectation and facility policy for wound dressing changes included to use a barrier at the bedside and to wash hands before, during and after dressing changes. Review of the Hand Hygiene policy and procedure, dated [DATE] revealed to reduce the spread of infection hand hygiene was to be preformed during routine patient care including before and after having contact with patient's intact skin, after contact with blood and bodily fluids or excretions, mucous membranes, non-intact skin or wound dressings. On [DATE] at 4:45 P.M. interview with Resident #26's family revealed she was aware the resident had a pressure ulcer to his shoulder area. During the interview, the family member voiced concerns she did not believe staff were turning and repositioning the resident as frequently as necessary. The family member stated on multiple occasions she had to call the facility and request the resident be turned as he had not been turned or repositioned for a long period of time. On [DATE] at 1:44 P.M. Resident #26 was transferred to the hospital due to an acute change in condition. The resident was found unresponsive by staff. The resident was admitted to the hospital and returned to the facility on [DATE] at 3:50 P.M. Review of hospital record documentation, dated [DATE] revealed Resident #26 had an unstageable pre-hospital acquired wound, to the left upper back. The wound was described as full thickness skin loss measuring 4.8 cm in length by 3.0 cm width by 0.9 cm depth, most likely pressure injury stage 4 over scapula with moderate amount of serosanguinous drainage. The wound bed was noted to have 5% exposed muscle, 45% thickening yellow slough and 50% red tissue. On [DATE] at 4:47 P.M. interview with the DON revealed staff education had been completed on [DATE] because it was identified that weekly skin assessments were not being completed for residents. The DON revealed Resident #26 was not safe to shower or use a bedside commode and there was an order in place for the resident to have a daily bath. The DON verified there was no evidence Resident #26 received a bed bath on [DATE], [DATE] or [DATE]. The DON verified if bathing and weekly assessments had been completed as ordered, it would have been opportunity for the pressure ulcer to have been discovered prior to it being identified as an unstageable pressure ulcer by the wound physician on [DATE]. The DON verified the order for treatment on [DATE] to the right shoulder was written in error and should have been for the left shoulder/scapula area. The DON also verified the plan of care and interventions for Resident #26 to be turned and repositioned every two hours and a low air loss mattress to the bed were not being followed which also contributed to the development of the unstageable pressure ulcer. On [DATE] at 4:18 P.M. interview with the DON verified the pressure ulcer to Resident #26's left shoulder/scapula became infected, per the note on [DATE]. However, a viable specimen was not collected until [DATE] and an order for [REDACTED]. This deficiency substantiates Complaint Number OH 850.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure fall safety interventions were in place as ordered for Resident #34. This affected one resident (#34) of three residents reviewed for falls. Findings include: Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The 05/20/20 admission Fall Risk assessment revealed the resident was at low risk for falls. The assessment noted the resident had change in cognition, was dependent and incontinent, confined to chair and not able to attempt to stand without physical help. Review of the plan of care, dated 05/21/20 revealed Resident #34 was at risk for falls related to history of falling, repeated falls, dementia and idiopathic peripheral autonomic [MEDICAL CONDITION]. Interventions included anticipate needs, be sure call light/pendent was within reach and encourage use for assistance as needed, educate about safety reminders and what to do if a fall occurred, ensure appropriate footwear when ambulating or mobilizing in wheelchair and keep needed items in reach. Record review revealed Resident #34 sustained four falls since admission. A 06/09/20 nursing progress note revealed the resident was found on the floor by his bed on both knees. There was no injury. An intervention was added to the remind resident to keep walker close to bed for transfers. Review of the 07/13/20 quarterly Minimum Data Set (MDS) 3.0 assessment revealed the resident was moderately impaired for daily decision making, had verbal behaviors one to three days, required extensive assist of two staff for bed mobility and transfers and walking only occurred one to two times in assessment period. The resident was assessed to require two person assist and utilized a wheelchair and walker with lower extremity impairment on one side. There were no falls coded since the last assessment. Review of a nursing progress note, dated 07/18/20 (midnight) revealed the resident was found on the floor by a State tested nursing assistant (STNA). When the nurse arrived the resident was lying on his left side. The resident stated he rolled out of bed. The new fall intervention was to ensure the resident's bed was in lowest position at night. On 07/23/20 a nursing progress note revealed the resident was found on the floor. The note indicated the resident fall was as a result of a behavior the resident was having. The intervention listed was for a fall mat at bedside when in bed. On 08/15/20 a nursing progress note revealed the resident was found on the floor in his bed room. The resident was lying by the bathroom door asking for help to get up. He said he was trying to go to the bathroom. The intervention listed was for staff to offer toileting and peri-care upon rising, before and after meals, at bedtime and as needed. On 08/19/20 at 5:55 P.M. observation of Resident #34's room revealed there was not a floor mat in the room. The resident was observed in the kitchen/bar area sitting in his wheelchair. The resident was observed wearing regular white socks. There was no evidence the socks were non-skid/non-slip socks. On 08/19/20 at 6:00 P.M. interview with STNA #15 revealed he arrived to work round 3:00 P.M. and assisted Resident #34 to bed at that time. The STNA revealed he did not put a floor mat on the floor next to the bed at that time. The STNA stated he placed the resident's wheelchair in the bathroom and walker by the dresser. He said the resident usually refused to use the walker. Around 5:20 P.M. he stated he saw the resident in his wheelchair with his gown off. The STNA thought the resident must have walked into the bathroom and got it (the wheelchair). The STNA revealed no other staff reported they had assisted Resident #34 out of bed. At the time of the interview, STNA #15 verified there was no floor mat in the resident's room and indicated he was unaware the resident was supposed to have one. STNA #15 also revealed the resident's bed was not kept in a low position and stated staff usually placed the resident's walker by the dresser so the resident could not get it. During the interview, STNA #15 also verified the resident was wearing plain, regular white socks and no shoes. The STNA was unable to locate non-skid/non-slip socks in the resident's room and stated the resident should have some. Verification occurred the floor mat, non slip footwear and walker placement were not in place as care planned. This deficiency is an incidental finding to Complaint Number OH 233.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure oxygen tubing and respiratory equipment was properly dated and stored. This affected seven residents (#26, #28, #29, #30, #31, #32 and #33) of seven residents receiving oxygen therapy. Findings include: 1. On 08/12/20 at 9:45 A.M. observation of Resident #26's room revealed oxygen was in use via an oxygen concentrator at the foot of the resident's bed. However, the oxygen tubing was not dated or timed as to when it had been first used. In addition, there was no storage bag available to properly store the oxygen tubing when it was not in use. On 08/12/20 at 9:55 A.M. interview with Licensed Practical Nurse (LPN) #2 verified the oxygen tubing in Resident #26's room was not dated/timed and the concentrator at the foot of the bed was without a bag to place the tubing in when not in use. 2. On 08/12/20 at 1:08 P.M. observation revealed Resident #29 and #31 were receiving oxygen therapy. Interview with the social worker in the house at the time of the observation verified there was no date/time on either Resident #29 or Resident #31's oxygen tubing. In addition, observation of the equipment for Resident #29 that was not currently in use revealed the equipment was just hanging in a basket with no storage bag present. 3. On 08/12/20 at 1:30 P.M. observation revealed Resident #26, #28 and #33 were receiving oxygen therapy. On 08/12/20 at the time of the observation, interview with LPN #2 verified none of the resident's oxygen tubing contained a date/time and there were no storage bags available to store the equipment when not in use. 4. On 08/12/20 at 1:40 P.M. observation revealed Resident #30 and #32 were receiving oxygen therapy. Interview with State tested nursing assistant (STNA) #15 at the time of the observation revealed neither resident's oxygen tubing contained a date as to when it was first used. On 08/12/20 at 1:45

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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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) P.M. interview with the Director of Nursing (DON) revealed oxygen tubing and equipment should have a date and initials of the person who last changed the equipment. The DON also revealed there should be an equipment bag placed on each piece of equipment for storage of equipment not in use. Review of the equipment change schedule and disinfection process policy and procedure, dated 10/01/18 revealed all supplies while not in use in a patient room were to be stored in a treatment bag labeled and dated with room number, date changed, initials of staff member completing the change and item. The policy and procedure also indicated nasal cannula tubing was to be changed every seven days. Date and initial tubing and provide set up bag with room number, date and initials. The policy also indicated [MEDICAL CONDITION]/[MEDICAL CONDITION] equipment was to have a set up bag with room number date and initials. This deficiency is an incidental finding to Complaint Number OH 850.
F 0712 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure physician visits were completed as required. This affected two residents (#35 and #37) of three residents reviewed for death. Findings include: 1. Review of Resident #35's closed medical record revealed the resident was admitted to the facility on [DATE] and passed away on 07/06/20. Review of the physician progress notes [REDACTED].#35. The last documented visit by the physician was dated 01/05/20. There was no evidence of a February, March, April, May, June or July 2020 physician visit. The visits were provided by the nurse practitioner. On 08/20/20 at 3:40 P.M. interview with Assistant Vice President #17 verified there were no physician progress notes [REDACTED]. Assistant Vice President #17 revealed the facility Medical Director was the primary care physician for 95% of the residents. The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. 2. Record review revealed Resident #37 was admitted to the facility on [DATE] and passed away on 07/03/20. Review of the physician progress notes [REDACTED].#37. The last visit by the physician was dated 03/13/20. There was no evidence of an April, May, June or July 2020 physician visit. The visits were provided by the nurse practitioner. On 08/23/20 at 5:07 P.M. interview with the DON verified the physician did not visit every 60 days as required when alternating with a nurse practitioner. The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. This deficiency substantiates Complaint Number OH 233.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure Resident #28's medical record contained an accurate fall assessment. This affected one resident (#28) of five residents whose medical records were reviewed for accuracy. Findings include: Record review revealed Resident #28 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An at risk for falls plan of care was initiated on 02/25/20 related to the resident's history of falling, diabetic retinopathy, impaired mobility and dementia. Review of the 05/25/20 Fall Assessment documented the resident had one to two falls in the last 90 days. However, review of the resident's medical record and nursing progress notes, revealed no evidence of falls prior to the 05/25/20 Fall Assessment. On 08/23/20 at 5:07 P.M. interview with the Director of Nursing (DON) verified the 05/25/20 Fall Assessment was inaccurate for falls. This deficiency substantiates Complaint Number OH 233.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review and staff and family interview the facility failed to ensure proper infection control practices were maintained, including screening of staff and visitors and proper use of personal protective equipment (PPE) to prevent the spread of COVID 19 in the facility. This had the potential to affect all 37 residents residing in the facility. Findings include: 1. On [DATE] at 9:03 A.M. the surveyor arrived onsite at the facility to complete observations related to the complaint investigation. Upon entrance to House 403, no staff attempted to screen the surveyor or provide information as to the facility screening process for visitors to the facility. The surveyor had to get the attention of an unidentified staff member on the opposite side of the building and ask to be screened. On [DATE] at 10:17 A.M. the facility coach (the person who oversees the duties of the State tested nursing assistant staff) was observed in the front office of House 400 wearing an N95 face mask below her nose. The coach walked up to the surveyor to answer questions and kept the N95 mask below her nose. Interview with the coach at the time of the observation, verified the N95 mask was not being worn correctly as it was not covering the employee's nose. On [DATE] at 2:48 P.M. State tested nursing assistant (STNA) #16 was observed entering the facility in House 400 without wearing any type of facial covering or mask. Interview with the STNA at the time of the observation verified she was not wearing a mask at the time she entered the facility. On [DATE] at 3:06 P.M. STNA #18 was observed to enter the facility in House 400 without evidence the employee had been screened or was screened at the time of entry for COVID 19. Review of the facility COVID 19 policy and procedure, updated [DATE] revealed every individual regardless of reason entering the facility was to be screened (for COVID 19). The policy also stated visible signage was to be placed at the entrances of each house. The sign revealed all staff or visitors must check in at House 403 to be screened. On [DATE] at 5:06 P.M. interview with the facility coach, Corporate DON, and facility DON revealed staff and any visitors were to first report to House 403 for COVID 19 screening before entering any of the facility other houses (the facility campus was made up of five houses which each had 10 beds for a total facility capacity of 50). However, the staff members verified during interview there was no sign on the front door of the houses that directed all staff and visitors to report to House 403 for screening prior to entering any other house. 2. Review of Resident #35's medical record revealed an admission of [DATE] with [DIAGNOSES REDACTED]. The resident passed away on [DATE] at 3:25 P.M On [DATE] at 12:05 P.M. interview with Resident #35's family revealed when they arrived at the facility approximately 3:50 P.M. after Resident #35 expired (on [DATE]) they were let in through the side door by an STNA. The family revealed no one screened them for COVID. During the interview, the family revealed then on [DATE] at approximately 9:00 A.M. two movers along with the resident's grandson in law came to the facility to obtain the resident's belongings from House 404. The family member revealed the Administrator let them in the building. They signed a log but were not screened for COVID 19. No staff took their temperature, they were not given any personal protective equipment (PPE) to use, but were allowed to enter the building. The family member revealed they removed the resident's possessions out without PPE. Review of the facility COVID 19 policy and procedure, revised [DATE] revealed visitors would be required to wear mask and be instructed on hand hygiene and social distancing. On [DATE] at 6:10 P.M. interview with the Director of Nursing verified there was no evidence of Resident #35's family being screened for COVID 19 on [DATE] or the movers being screened on [DATE]. The DON revealed everyone was to go to House 403 for screening and once screened they would receive a wrist band. The staff should be checking that visitors have a wrist band on when entering the different facility buildings. This deficiency substantiates Complaint Number OH 233.