STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365588	A. BUILDING _____ B. WING _____	07/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCADIA VALLEY SKILLED NURSING AND REHABILITATION	25675 EAST MAIN STREET COOLVILLE, OH 45723

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, policy review, and staff interview, the facility failed to ensure the physician was notified when a resident had a significant change in condition. This affected one of six sampled residents (Resident #45). The facility census was 44. Findings include: Review of the closed medical record for Resident #45 revealed an admission date of [DATE]. The resident was admitted from the hospital after back surgery. Other [DIAGNOSES REDACTED]. On admission the resident had physician's orders for insulin at bedtime and an oral medication to lower blood sugar daily ([MEDICATION NAME]). On 06/22/20 the resident had an order to check his blood sugar twice daily with no coverage of insulin. The resident was on a consistent carbohydrate diet. A Minimum Data Set Assessment completed 06/28/20 stated the resident had long and short term memory problems, required extensive assistance from staff with bed mobility, transfers, dressing, toileting, hygiene, and bathing, and required limited assistance from staff with eating. Review of blood sugar records revealed that between 06/22/20 and 06/30/20 only one of 17 blood sugars was above 300. The rest were in the range of 142-279. However, review of blood sugar records for 07/01/20 to 07/07/20 revealed 11 of 13 blood sugars were above 300 as follows: 07/01/20 376; 07/02/20 376 and 389; 07/03/20 372; 07/04/20 398 and 325; 07/05/20 360 and 349; 07/06/20 378 and 349; 07/07/20 322. There was no evidence the physician was notified of the blood sugars above 300. Review of a nutritional assessment completed 06/25/20 revealed Resident #45's average intake was 25-50%. However, review of meal intake records revealed between 07/03/20 and 07/06/20 the resident had 10 of 12 meals with intake of 0-25%. There was no evidence the physician was notified of the decreased oral intake. Review of medication administration records for June 2020 revealed on 06/29/20 and 06/30/20 Resident #45 refused his morning oral medications, including his [MEDICATION NAME] (used to lower blood sugar). The resident did take his insulin. On 07/03/20 he refused eight of his morning oral medications. There was no evidence the physician was notified of the resident's refusal of medications. Review of physical therapy notes on 06/30/20 at 1:11 P.M. revealed Physical Therapy Assistant (PTA) #52 documented Resident #45 was difficult to arouse. On 07/01/20 at 11:29 A.M. PTA #52 documented the resident was unable to arouse and nursing was notified. However, review of nurses progress notes on 06/30/20 and 07/01/20 revealed no evidence the physician was notified of his decreased alertness. Interview with PTA #52 on 07/16/20 at 1:10 P.M. revealed she had worked with Resident #45. She confirmed he was more lethargic on 06/30/20-07/02/20. She stated she had reported this to nursing. Review of nurse progress notes on 07/06/20 at 10:22 A.M. by Assistant Director of Nursing #50 revealed a message was left with the neurosurgeon and the nurse practitioner who managed the resident's [MEDICAL CONDITION] regarding his general decline in condition. However, there was no evidence staff ever spoke to either practitioner. There was also no evidence Resident #45's attending physician was notified of the decline in condition noted. Review of a nurse progress note on 07/07/20 at 7:31 A.M. revealed Licensed Practical Nurse #51 documented that a nursing assistant reported to her that Resident #45's oxygen saturation level was 80% on room air. The head of the bed was elevated. Oxygen was started at 2 liters per nasal cannula with the oxygen saturation level coming up to 93%. The resident was less responsive than the norm. The resident's blood pressure was 99/55, respirations 22, pulse 78, temperature 96.4. Lungs sounds with wheezes and rhonci. The resident's blood sugar was noted as 322 on the morning of 07/07/20. The physician was notified and the resident was sent to the hospital for evaluation. Interview with Licensed Practical Nurse #51 on 07/16/20 at 1:25 P.M. revealed she was concerned if a resident had a blood sugar higher than 300. Review of hospital records revealed on 07/07/20 the resident was treated at the emergency room at the hospital. Resident #45 had a temperature of 100.3 and a blood sugar of 442 (normal listed as 70-100). Blood tests done which can indicate dehydration were sodium level: 156 (normal 136-145); chloride 120 (normal 98-107); BUN (blood, urea, nitrogen) 92.6 (normal 8-23); and creatinine 3.77 (normal 0.67-1.17). The resident was treated with insulin to lower the blood sugar, breathing treatments, intravenous fluids to rehydrate, and antibiotics for aspiration pneumonia. Differential [DIAGNOSES REDACTED]. The resident was transferred to a different hospital on [DATE]. Review of those hospital records revealed a progress note on 07/12/20 which stated the resident had aspiration pneumonia, labs stable for acute kidney injury, and blood sugar had been lowered. A tube feeding was surgically inserted for nutrition. The resident remained hospitalized as of 07/12/20. Interview with Assistant Director of Nursing #50 on 07/16/20 at 1:45 P.M. confirmed the nurse progress note that she had left a message with Resident #45's surgeon and nurse practitioner who manages [MEDICAL CONDITION] on 07/06/20 regarding a decline in condition. She described the decline in condition as not opening his eyes or talking anymore, decreased appetite, decreased fluid intake. She confirmed there was no evidence that anyone spoke to any physician regarding the resident's decline in condition. She stated the physician was to be notified if a resident's blood sugar was above 301. Interview with the Director of Nursing on 07/20/20 at 8:20 A.M. revealed the facility did not have a policy to indicate when a physician was to be notified of elevated blood sugars. She stated the policy stated to notify the physician if blood sugar above or below normal limits or as ordered. She confirmed Resident #45 did not have an order of when to notify the physician of blood sugars. She further confirmed Resident #45's blood sugars were elevated the week of 07/01/20 to 07/07/20 in comparison to the previous week. She confirmed the resident's consistent decreased intake from 07/03/20 to 07/06/20. She stated she was aware he had been refusing his medications. She confirmed there was no evidence the physician was notified of the decline in condition. Review of the facility policy titled Blood Glucose Testing dated 12/03/13 revealed staff are to notify the physician if the blood sugar is above or below normal limits or as ordered. Review of the facility policy titled Change in Condition Notifications dated 07/16 revealed the facility will immediately or at least within 24 hours inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative when there is a significant change in the resident's physical, mental, or psychosocial status (i.e.: a deterioration in health); A need to alter treatment (discontinue or start new form of treatment). This deficiency substantiates Complaint Number OH 104.
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 medical record review, policy review, and staff interview, the facility failed to provide treatment and care for one resident (Resident #45) who presented with with elevated blood sugars, decreased meal intake, and refusal of medications (including oral medication to lower blood sugar) from 06/29/20 to 07/07/20. This resulted in actual harm to Resident #45 who required hospitalization for treatment of [REDACTED]. The resident received intravenous fluids, insulin, antibiotics, and had a feeding tube surgically inserted at the hospital. In addition, the facility failed to maintain

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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ARCADIA VALLEY SKILLED NURSING AND REHABILITATION	25675 EAST MAIN STREET COOLVILLE, OH 45723

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) ongoing monitoring/measurements of non pressure skin issues. This affected one of six sampled residents (Resident #45). The facility census was 44. Findings include: 1. Review of the closed medical record for Resident #45 revealed an admission date of [DATE]. The resident was admitted from the hospital after back surgery. Other [DIAGNOSES REDACTED]. On admission the resident had physician's orders for insulin at bedtime and an oral medication to lower blood sugar daily ([MEDICATION NAME]). On 06/22/20 the resident had an order to check his blood sugar twice daily with no coverage of insulin. The resident was on a consistent carbohydrate diet. Review of the Minimum Data Set Assessment 2.0 (MDS) completed 06/28/20 indicated the resident had long and short term memory problems, required extensive assistance from staff with bed mobility, transfers, dressing, toileting, hygiene, and bathing, and required limited assistance from staff with eating. Review of blood sugar records revealed that between 06/22/20 and 06/30/20 only one of 17 blood sugars was above 300. The remainder were in the range of 142-279. However, review of blood sugar records for 07/01/20 to 07/07/20 revealed 11 of 13 blood sugars were above 300 mg/dL as follows: 07/01/20 376; 07/02/20 376 and 389; 07/03/20 372; 07/04/20 398 and 325; 07/05/20 360 and 349; 07/06/20 378 and 349; 07/07/20 322. There was no evidence of any type of treatment to lower the blood sugars above 300. There was no documented evidence the physician was notified. Review of a nutritional assessment completed 06/25/20 revealed Resident #45's average intake was 25-50%. However, review of meal intake records revealed between 07/03/20 and 07/06/20 the resident had 10 of 12 meals with intake of 0-25%. There was no evidence of any interventions related to the decreased intake except a nutritional supplement was started once daily on 07/03/20 based on an assessment completed by the dietician on 06/25/20 indicating weight loss on admission. Review of medication administration records for June 2020 revealed on 06/29/20 and 06/30/20 Resident #45 refused his morning oral medications, including his [MEDICATION NAME] (used to lower blood sugar). The resident did take his insulin. On 07/03/20 he refused eight of his morning oral medications. There was no evidence of any action by the facility due to the resident's refusal of medications. There was no documented evidence the physician was notified. Review of physical therapy notes on 06/30/20 at 1:11 P.M. revealed Physical Therapy Assistant (PTA) #52 documented Resident #45 was difficult to arouse. On 07/01/20 at 11:29 A.M. PTA #52 documented the resident was unable to arouse and nursing was notified. However, review of nurses progress notes on 06/30/20 and 07/01/20 revealed no action taken regarding the resident's condition. There was no documented evidence the physician was notified. Interview with PTA #52 on 07/16/20 at 1:10 P.M. revealed she had worked with Resident #45. She confirmed he was more lethargic on 06/30/20-07/02/20. She stated she had reported this to nursing. Review of nurse progress notes on 07/06/20 at 10:22 A.M. by Assistant Director of Nursing #50 revealed a message was left with the neurosurgeon and the nurse practitioner who managed the resident's [MEDICAL CONDITION] regarding his general decline in condition. However, there was no evidence staff ever spoke to either practitioner. There was also no evidence Resident #45's attending physician was notified of the decline in condition noted. Review of a nurse progress note on 07/07/20 at 7:31 A.M. revealed Licensed Practical Nurse (LPN) #51 documented that a nursing assistant reported to her that Resident #45's oxygen saturation level was 80% on room air. The head of the bed was elevated. Oxygen was started at 2 liters per nasal cannula with the oxygen saturation level coming up to 93%. The resident was less responsive than the norm. The resident's blood pressure was 99/55, respirations 22, pulse 78, temperature 96.4. Lungs sounds with wheezes and rhonci. The resident's blood sugar was noted as 322 on the morning of 07/07/20. The physician was notified and the resident was sent to the hospital for evaluation. Review of hospital records revealed on 07/07/20 the resident was treated at the emergency room at the hospital. Resident #45 had a temperature of 100.3 and a blood sugar of 442 (normal listed as 70-100). Blood tests done which can indicate dehydration were sodium level: 156 (normal 136-145); chloride 120 (normal 98-107); BUN (blood, urea, nitrogen) 92.6 (normal 8-23); and creatinine 3.77 (normal 0.67-1.17). The resident was treated with insulin to lower the blood sugar, breathing treatments, intravenous fluids to rehydrate, and antibiotics for aspiration pneumonia. Differential [DIAGNOSES REDACTED]. The resident was transferred to a different hospital on [DATE]. Review of those hospital records revealed a progress note on 07/12/20 which stated the resident had aspiration pneumonia, labs stable for acute kidney injury, and blood sugar had been lowered. A tube feeding was surgically inserted for nutrition. The resident remained hospitalized as of 07/12/20. Interview with LPN #51 on 07/16/20 at 1:25 P.M. revealed she was concerned if a resident had a blood sugar higher than 300. Interview with Assistant Director of Nursing #50 on 07/16/20 at 1:45 P.M. confirmed the nurse progress note that she had left a message with Resident #45's surgeon and nurse practitioner who manages [MEDICAL CONDITION] on 07/06/20 regarding a decline in condition. She described the decline in condition as not opening his eyes or talking anymore, decreased appetite, decreased fluid intake. She confirmed there was no evidence that anyone spoke to any physician regarding the resident's decline in condition. She stated the physician was to be notified if a resident's blood sugar was above 301. Review of the facility policy titled Blood Glucose Testing dated 12/03/13 revealed staff are to notify the physician if the blood sugar is above or below normal limits or as ordered. Interview with the Director of Nursing on 07/20/20 at 8:20 A.M. revealed the facility did not have a policy to indicate when a physician was to be notified of elevated blood sugars. She stated the policy stated to notify the physician if blood sugar above or below normal limits or as ordered. She confirmed Resident #45 did not have an order of when to notify the physician of blood sugars. She further confirmed Resident #45's blood sugars were elevated the week of 07/01/20 to 07/07/20 in comparison to the previous week. She confirmed the resident's consistent decreased intake from 07/03/20 to 07/06/20. She stated she was aware he had been refusing his medications. She confirmed there was no evidence of any action taken until 07/07/20 (sent to the hospital) regarding his decline in condition beginning around 06/30/20. Review of the facility policy titled Change in Condition Notifications dated 07/16 revealed the facility will immediately or at least within 24 hours inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative when there is a significant change in the resident's physical, mental, or psychosocial status (i.e.: a deterioration in health); A need to alter treatment (discontinue or start new form of treatment). 2. Record review revealed Resident #45 had a fall on 06/26/20 at 10:19 A.M. The resident was noted with abrasions on his left and right toes. He was also noted with a skin tear on the right elbow. However, there was no evidence of any assessment, measuring, or monitoring of the areas on the toes or elbow. A treatment was not obtained for the toes until 06/29/20. The order said to cleanse second digit on right and left second toe with wound cleanser, apply antibiotic ointment, and dry dressing every day. A nurses note on 06/27/20 at 10:14 A.M. stated a dressing to the right elbow was intact. However, there was no evidence of a physician's order for a dressing to the right elbow. On 06/28/20 at 11:49 A.M. the resident fell and was noted with a red area on the right outer ankle. A physician's order on 06/28/20 stated to monitor red area to right outer ankle every shift. However, there was no evidence of any measurements or description of the area after 06/28/20. A policy on measuring/monitoring non pressure skin areas was requested but not provided. Interview with the Director of Nursing on 07/20/20 at 8:20 AM. revealed staff are to do a weekly skin grid to include measurements and description of non pressure skin areas. She confirmed weekly skin assessments were not completed for Resident #45 for areas on the toes, right ankle, and right elbow. She confirmed there was no physician's order for a dressing to the right elbow even though a dressing was documented in the nurses notes. She confirmed the treatment to the toes started on 06/29/20 when the injury occurred on 06/26/20. This deficiency substantiates Complaint Number OH 104.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review, and staff interview, the facility failed to ensure a resident maintained acceptable parameters of nutritional status, such as body weight. This affected one of six sampled residents (Resident #45). The facility census was 44. Findings include: Review of the closed medical record for Resident #45 revealed an admission date of [DATE]. The resident was admitted from the hospital after having surgery on his back. Other [DIAGNOSES REDACTED]. The resident was 72 inches tall and weighed 186.3 pounds on admission. A nutritional evaluation completed on 06/25/20 stated the resident was on a consistent carbohydrate diet with no supplement orders. The evaluation stated the resident's intake varied from 0-100% with an average intake of 25-50 percent. An ideal body weight of 178 pounds was included in the evaluation. The evaluation included that the resident weighed 200 pounds in the hospital (06/16/20) and had experienced a 6.9 percent, 13.7 pound significant weight loss from 6/16/20 until 06/21/20 admission weight. The evaluation stated significant weight loss was likely due to fluids received at hospital stay for surgery. The evaluation stated the resident had increased protein needs related to surgical incision healing as evidenced by poor oral intakes. The evaluation stated weight trends would be monitored from established facility baseline weight. A house supplement (237 milliliters) everyday to promote wound healing and weight maintenance was recommended on 06/25/20 by the dietician. There was no evidence the house supplement was ordered by the physician until 07/02/20. Review of nutrition recommendations by the dietician dated 07/02/20 revealed it stated: continue to recommend house supplement every day to assist in meeting needs and for healing. Review of the Medication Administration Record [REDACTED]. Review of the plan of care dated 06/25/20

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) revealed the resident had potential for alteration in nutrition and hydration related to decreased oral intake, increased estimated needs related to surgical incision, malnutrition risk, significant weight loss of 6.9 percent in one week. Interventions on 06/25/20 included supplements as ordered and weights as ordered. Review of meal intake records revealed Resident #45 ate 0-25 percent of 10 of 12 meals between 07/03/20 and 07/06/20. There was no evidence Resident #45 was weighed again (after 06/21/20) until 07/07/20 (16 days later). On 07/07/20 the resident weighed 163.3 pounds. This represents a 23 pound, 12 percent, severe weight loss in 16 days. There was no documentation in the medical record of any refusals to be weighed. Resident #45 was transferred to the hospital on [DATE]. There was no evidence of any other nutritional interventions between 07/02/20 and 07/07/20. Interview with the Director of Nursing on 07/16/20 at 2:15 P.M. confirmed residents are to be weighed weekly for four weeks after admission. She stated Resident #45 had refused to be weighed the week after admission when he was due for his weekly weight. She confirmed this was not documented in the medical record. She confirmed the recommendation from the dietician on 06/25/20 for daily supplements was not ordered until 07/02/20 and was not started until 07/03/20. She stated the paper she received from the dietician for recommendations on 06/25/20 was blank. Therefore, she was unaware of the recommendation for supplements for Resident #45 until 07/02/20. She confirmed the resident had poor intake, especially from 07/03/20 to 07/06/20. She confirmed there were no additional nutritional interventions for the resident. Review of the facility weight policy dated August 2017 revealed weight is an important factor in accurately assessing the nutritional status of every resident. Each resident's weight will be monitored consistently by the interdisciplinary team. All residents with unplanned insidious or significant weight change will be assessed by the facility dietetic professional as indicated. Interventions to address nutritional issues will be initiated and incorporated into the resident's care plan and re-evaluated periodically. Appropriate measures will be taken to ensure that a resident maintains acceptable parameters of nutritional status unless the resident's clinical condition and documentation demonstrates that is not possible. All weights obtained shall be documented in the electronic medical record. All newly admitted residents shall be weighed weekly for four weeks to establish a baseline weight. If possible, weights should be done on the same day of each week. This deficiency is cited as an incidental finding to Complaint Number OH 104.