STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365748	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITE OAK MANOR	1926 RIDGE AVENUE WARREN, OH 44484

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 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on record review and interview the facility failed to provide sufficient space to allow all residents to participate in the monthly resident council meetings. This affected six residents (#3, #9, #23, #20, #33 and #19) and had the potential to affect all 46 residents residing in the facility. Findings include: On 03/02/20 at 2:26 P.M. during a resident group meeting, Resident #37, Resident #6 and Resident #40 revealed they regularly attended the facility monthly resident council meetings. However, the residents reported they needed more space to hold the resident council meetings because the activities room where the meetings were held did not accommodate (space wise) all the residents who wanted to attend. Resident #37 stated she suggested the resident council meeting be moved to a room with more space, such as the facility conference room but that no changes had been made Interview on 03/05/20 at 11:01 A.M. with the Administrator revealed she was aware of a concern raised by residents during the resident council meeting held on 02/12/20, that there was not adequate space for all residents who wished to attend. She was aware of the complaint but indicated there were very few spaces that could be closed off to hold the meeting in the facility, because of the facility size. Therefore, the concern was not addressed. Review of the resident council meeting minutes from the meetings held from September 2019 through February 2020 revealed the minutes lacked any documented evidence of concerns discussed related to their not being enough space for the residents present in the facility to attend the meeting. Interview on 03/05/20 from 1:33 P.M. to 3:35 P.M. with six alert and interviewable residents, Resident #3, Resident #9, Resident #23, Resident #20, Resident #33 and Resident #19 revealed each resident indicated they might attend resident council more if there was additional room.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep residents' personal and medical records private and confidential.** Based on observation and interview the facility failed to maintain resident privacy/confidentiality related to nutritional/dietary needs. This affected 13 residents (#6, #8, #13, #19, #26, #29, #33, #36, #38, #193, #194, #195 and #196) of 13 residents who received thickened liquids or nutritional supplements. The facility census was 46. Findings include: On 02/27/20 at 12:36 P.M. and 2:55 P.M. observation of the main dining service area from the kitchenette revealed a Resident List taped at the opening of the service window facing into the main dining room area. The list indicated Resident #13, #29, #36, #193, #195 and #196 received thickener in liquids, and Resident #6, #8, #19, #26, #33, #38, #194 and #196 received nutritional supplements. Staff, residents and visitors were observed in the main dining room area and the sign was visible to all. Interview on 02/27/20 at 2:55 P.M. with State tested Nursing Assistant (STNA) #24 verified the Resident List was posted at the kitchenette service window and faced into the main dining room area. STNA #24 indicated the main dining room area was also used as an activity area and common visiting area. STNA #24 confirmed the Resident List was visible to anyone in the room, and indicated it was always there for staff to reference when meals were served. Interview on 02/27/20 at 3:00 P.M. with STNA #42 verified the Resident List was posted at the kitchenette service window and faced into the main dining room area. STNA #42 confirmed the Resident List was visible to anyone in the room, and indicated it was there for staff to reference. Observation on 03/02/20 at 11:57 A.M. revealed the Resident List was not observed at the kitchenette service window at this time. Interview on 03/05/20 at 1:15 P.M. with the Director of Nursing revealed the Resident List previously observed at the main dining room kitchenette service window had been removed for resident privacy and indicated the Resident List was now hanging inside the kitchenette area. This deficiency substantiates Complaint Number OH 449.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to maintain a safe, clean, comfortable environment for all residents in the facility. This had the potential to affect all 46 residents residing in the facility which included Residents #32, #34, #4, #194, #195, #36, #9, #33, #8, #93, #21, #25, #2, #10, #31, #20, #16, #13, #5, #38, #30, #5, #27, #12, #35, #193, #19, #40 and #26 who were interviewed and/or resided in the rooms observed. Findings include: An environmental tour was conducted on 03/03/20 from 9:22 A.M. to 10:33 A.M with Director of Maintenance (DM) #100 of the general facility environment and each resident room. The following concerns were observed and verified at the time of the observations: 1. In the hallways and common rooms throughout the facility the floors were heavily covered with black scuff marks and presented as dull and dirty. Dried spilled liquid stains and cracked floor tiles were observed in multiple areas in the hallways. 2. The walls had multiple areas of chipped paint and some patched areas that were not sanded and painted and had various scuff marks. 3. In the dayroom on the 100 unit, the baseboard heater was heavily coated in dirt. The walls were stained, the chair rail was spotted with paint, the doors were scuffed and had chipped paint and most of the light covers had multiple dead bugs and dirt in them. 4. The wall in the 200/300 unit common room area had patched white areas that were not sanded or painted, and the countertop was missing pieces of Formica, making the surface jagged and sharp. There were dead bugs and dirt in most of the ceiling lights in all common areas. 5. On the wall nearest the vending machine area by the smoking porch was an approximately three-foot area missing drywall that appeared to have been patched and primed but remained unfinished. Observations of the resident rooms revealed the following findings: 1. In room [ROOM NUMBER] the wall had gauges and scuff marks, a broken electrical outlet cover and widow still. The bathroom light fixture had dead bugs in it and holes in the wall 2. In room [ROOM NUMBER] there was a missing door threshold, the light switch cover was cracked and the nightstand had multiple scratches. 3. In room [ROOM NUMBER] the door threshold was missing, the windowsill was severely scuffed/loose, the door frame marred and chipped and the handrail right outside the door missing in hall missing the end cap. 4. In room [ROOM NUMBER] the door threshold was missing, the chair rail was missing, the windowsill was damaged, the door frame was marred and chipped, the water faucet was cracked in the bathroom and an electrical outlet in the room was cracked. 5. In room [ROOM NUMBER] an outlet cover was cracked. 6. In room [ROOM NUMBER] the windowsill was loose, cracked and missing laminate and the nightstand chipped and scarred. 7. In room [ROOM NUMBER] the nightstands were scuffed up, there was cracked flooring linoleum tiles, no threshold between the hallway and room with a wide strip of dirty floor stretching between the doorway where the threshold strip had been. 8. In room [ROOM NUMBER] a missing threshold between the hallway and room with a wide strip of dirty floor stretching between the doorway where the threshold strip had been, a scratched chair rail behind the bed and the bathroom light was dirty. 9. In room [ROOM NUMBER] there were cracked floor tiles. 10. In room [ROOM NUMBER] there was chipped paint on the walls and doorframes, dirty

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) baseboards, dead bugs, the privacy curtain was torn from some anchors, patched walls in bathroom and water damage behind the sink. 11. In room [ROOM NUMBER] there were cracked floor tiles, a missing electrical outlet cover on the wall toward the hallway, a rusted drain in the bathtub, and missing caulking around bathtub. In addition there was a missing toilet paper holder, no cover to the tub drain and rusty hopper and spicket. 12. In room [ROOM NUMBER] there was chipped paint on the door frames, missing base boards, no headboard to the bed and the resident's nightstand was heavily scratched. 13. In room [ROOM NUMBER] there were scuffed unrepaired walls and the nightstand was heavily scratched. 14. In room [ROOM NUMBER] there were cracked, stained floor tiles, missing caulking around tub, dirty lights, the baseboard in bathroom broken and the bathroom sink was loose. 15. In room [ROOM NUMBER] there was a rusted drain on bathroom tub and no drain cover, caulking around the bathtub was missing, bugs and dirt were in the bathroom lights and the nightstand and chair had chips and scratches on it. 16. In room [ROOM NUMBER] the walls had been patched but not sanded and were unpainted. 17. In room [ROOM NUMBER] the bathroom sink was dripping, caulking was missing around the bathtub, there was chipped paint on the door frame and the room smelled strongly of urine. 18. In room [ROOM NUMBER] there was a rusty base board heater in the bathroom, bugs and dirt in the lights, and the bathtub drain was rusty. The floor molding was dirty and loose. There was floor water damage by the toilet and a bedroom cabinet was deeply scarred. 19. In room [ROOM NUMBER] the nightstands were in poor repair and the bathroom door threshold was missing with a wide strip of dirty floor stretching between the doorway where the threshold strip had been 20. In room [ROOM NUMBER] there were patched holes in the walls not sanded and left unpainted, the threshold was missing with a wide strip of dirty floor stretching between the doorway where the threshold strip had been and the light switch plate was cracked. 21. In room [ROOM NUMBER] the room very cluttered and dirty, with an extremely strong odor. The floor was dirty with visible ants on the floor. The wall outside of 306 was missing an end cap on the handrail. 22. In room [ROOM NUMBER] the baseboard was coming apart from the wall. The bathroom had a loose sink and the bathroom floor was stained and discolored 23. In room [ROOM NUMBER] the walls were scuffed and the wall was cracked by bathroom. An outlet cover in the room was cracked. 24. In room [ROOM NUMBER] the threshold was missing from between the hallway and the room with a wide strip of dirty floor stretching between the doorway where the threshold strip had been, the electrical outlet wall plate was cracked and walls by the bathroom has several cracks. 25. In room [ROOM NUMBER] the floor was very dirty, the light covers had dead bugs, the nightstand was heavily scratched, loose sink in the bathroom. On 02/27/20 from 10:05 A.M. to 2:45 P.M. interviews with Resident #32, Resident #10, Resident #2, Resident #10, Resident #20, Resident #27 and Resident #31 revealed environmental concerns with their rooms. 1. On 02/27/20 at 10:30 A.M. Resident #32 revealed her room was always dirty and the walls had holes. The resident stated the room needed painting and repair and the floor was dull and stained. 2. On 02/27/20 at 10:32 A.M. Resident #5 revealed there was a gradual slow flow of hot water from the bathroom sink and there was a toilet paper roll sitting on back of toilet. Interview with Resident #5 indicated it had been that way for a long time, plumber here yesterday repaired much of the problem and all that is left is the slow flow of water. 3. On 02/27/20 at 02:20 P.M. interview with Resident #2 revealed the toilet paper was sitting on the side of the bathtub and there was no rod to hold the paper. 4. Interview on 02/27/20 at 02:57 P.M. with Resident #20 revealed the wall was peeling along the base board of room by the bathroom, the wall along the bed had chair rail missing and peeling dry wall, and the bathroom toilet paper holder was broken. 5. Interview on 02/27/20 at 2:33 P.M. with Resident #10 revealed there was toilet paper on the side of the bath tub and no rod to hang the toilet paper on. 6. Interview on 02/27/20 at 02:43 P.M. with Resident #27 revealed the toilet paper roll was sitting on the back of toilet because there was no holder in bathroom. 6. Interview on 02/27/20 at 2:45 P.M. with Resident #31 revealed hot water running continuously in the sink. On 02/27/20 between 4:05 P.M. and 4:30 P.M. all observations during resident interviews were confirmed/verified by Dietary Aide #17. An interview with Maintenance Director (MD) on 03/03/20 at 10:35 A.M. revealed he had been hired recently and realized the facility had many environmental issues when he got to the facility. He stated he had been working hard to repair them but there was only himself and a part time maintenance person to address all of it, especially for a structurally older facility. The MD said the facility hired a third person to do interior painting who started the previous week. An interview with Housekeeper #16 on 03/03/20 at 2:15 P.M. revealed there were two housekeepers scheduled for the day shift and a floor technician was supposed to strip the floors and apply wax three days a week. Housekeeper #16 indicated the floors were mopped daily but didn't look any cleaner due to many linoleum tiles were cracked and deeply dirty and most of the floors needed replaced. Housekeeper #16 agreed the floors looked dull, dirty and stained. An interview on 03/05/20 at 11:19 A.M. with the Administrator revealed she realized there were multiple environmental issues that needed to be addressed, and the facility and the MD and his assistant had been working to address them all, and progress had been made, but there was still a lot of environmental issues left to be corrected. Review of the Housekeeping/maintenance staffing schedule for February 1, 2020 to 03/05/20 revealed the facility had had two housekeepers, five days a week for eight hours, a floor tech three days a week for eight hours, and a part time maintenance person to assist the Maintenance Director. Review of the resident Council Minutes since the last annual survey revealed multiple environmental concerns voiced in the monthly meetings, including the following requests: 1. On 07/02/19 residents present at the meeting complained the air condition /heating vents in rooms were dirty and need to be cleaned. 2. On 11/20/19 residents present at the meeting complained the facility was not stocking enough toilet paper or filling all the soap dispensers and not cleaning the rooms daily. 3. On 12/18/19 residents present at the meeting revealed complaints the facility was not stocking enough toilet paper or paper towels, or filling all the soap dispensers when needed, not mopping the floors daily, and not cleaning on the weekends. 4. On 01/08/20 residents present at the meeting revealed heater/air-conditioning vents needed to be cleaned in the resident's rooms. room [ROOM NUMBER] needed a new doorknob, room [ROOM NUMBER]'s bathroom sink was clogged and room [ROOM NUMBER] had dead bugs in the windows that needed to be cleaned. 5. On 02/12/20 the residents present at the meeting requested again the heater/ air-conditioning vents in the resident's room needed to be cleaned. The review of the facility Concern/Grievance Logs revealed on several environment concerns including: 1. On 08/20/19 air conditioning heating units in rooms needed clean, a doorknob needed replaced, and paper towel were needed in the resident's rooms. 2. On 12/18/19 several resident rooms lights needed to be fixed, soap dispensers lacked soap, and more toilet paper was needed in residents' rooms. 3. On 01/08/20 room [ROOM NUMBER] doorknob needed replaced and had a clogged sink in the bathroom, lights covers needed to be cleaned of dead bugs. Review of the work orders revealed the facility had ordered a few items to address some of the facilities environmental concerns such as new facets for resident rooms, new steam table, and new call lights, but many additional areas needed to be addressed. Facility work orders revealed the facility had contact with a professional exterminator company for monthly and as needed pest control spraying. This deficiency substantiates Complaint Number OH 453 and Complaint OH 449.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure care plans were reviewed and revised for Resident #5 related to fall interventions and for Resident #29 related to infection treatment and prevention interventions. This affected two residents (#5 and #29) of seven residents reviewed for care plans. Findings include: 1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the plan of care, dated 11/20/19 revealed Resident #5 was at high risk for falls and injury related to debilitation, weakness, dementia, unsteady gait, poor decision making skills, and a history of falls leading to his admission to the facility; was frequently incontinent of bladder, occasionally incontinent of bowel, and non-compliant with proper toileting hygiene; and was at risk for activities of daily living (ADL) functional decline related to alteration in ADL performance. Interventions for this care plan included to provide a commode or urinal at the bedside, have commonly used articles within reach, maintain a clear pathway, referral to urologist, offer and assist with toileting every two hours, provide incontinence care as needed and staff to anticipate needs and assist as needed. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had no cognitive impairment. Review of the Fall Risk Assessment, dated 11/20/19, revealed Resident #5 was at moderate risk for falls. Review of the progress notes dated 01/16/20 at 7:45 A.M. revealed Resident #5 was observed on the floor between his bed and nightstand. Review of the progress notes dated 01/16/20 at 12:38 P.M. revealed Resident #5 returned from the hospital emergency room with sutures in the left eyebrow. Review of the facility fall investigation, dated 01/16/20 at 7:45 A.M. revealed Resident #5's bedroom floor was clean and dry, he had a laceration near the left eyebrow, and non-skid socks were applied as an intervention. Interview on 03/04/20 at 12:33 P.M.

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) with Director of Nursing (DON) verified Resident #5 fell on [DATE], sustained a laceration above the left eye, and the facility instituted non-skid socks as a fall intervention measure. Further interview with DON confirmed Resident #5's care plan was not updated to reflect the fall on 01/16/20 or the non-skid socks as a fall intervention. Review of facility policy titled Falls Policy, revised 10/2018 revealed relevant information would be documented regarding the fall, assessment, notifications and interventions. 2. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed the resident had severe cognitive impairment. Functionally, the resident required extensive one staff assistance for bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. The assessment indicated Resident #29 was frequently incontinent of urine and bowel. Review of the progress note, dated 01/29/20 at 5:46 P.M. revealed Resident #29 was ordered [MEDICATION NAME] ophthalmic (antibiotic eye drops) drops, one drop to both eyes four times daily for five days. Review of the progress note, dated 02/05/20 at 4:15 P.M. revealed Resident #29's bilateral eyes were red and irritated with a moderate amount of yellowish green drainage, and the last dose of antibiotic eye drops were administered the previous day. Review of the progress note, dated 02/05/20 at 8:05 P.M. revealed Resident #29 returned from the hospital with a new order for Rimexolone 1% ophthalmic suspension (steroid eye drops), one drop into both eyes four times daily for seven days. Review of the progress note, dated 02/11/20 at 10:35 A.M. revealed staff reminded the resident not to touch or rub eyes which was not very effective. Review of the progress note, dated 0[DATE] at 1:18 P.M. revealed Resident #29 returned from an eye specialist appointment with new orders to decrease [MEDICATION NAME] (antibiotic) eye drops to one drop in both eye three times daily with no stop date, and to return for a follow-up appointment. Review of the physician's orders [REDACTED].#29 received [MEDICATION NAME] 3 milligrams per milliliter (antibiotic) eye drops, one drop into both eyes three times daily. Review of the plan of care, dated 03/02/20 revealed Resident #29 care plan revealed eye infection treatment and prevention interventions were not included in the care plan. Interview on 03/03/20 at 3:03 P.M. with the DON verified Resident #29 received treatment for [REDACTED]. The DON confirmed Resident #29's care plan did not include eye infection treatment or infection prevention interventions. Review of facility policy titled, Care Plan Policy and Procedure, dated 12/01/18 revealed the comprehensive care plan must be updated quarterly and as necessary to ensure accuracy.
F 0680 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure the activities program is directed by a qualified professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure the activities program was directed by a qualified professional. This had the potential to affect all 46 residents residing in the facility. Findings include: Review of the personnel record for Activities #25 revealed a job description titled Activity Director, signed by Activities #25 on 07/24/19. Further review of Activities #25's job description revealed she reported to the Administrator. Review of the personnel record for Activities #25 revealed a written job offer signed by the Administrator, dated 11/12/19, for Activities #25 to commence the position of Activities Director with an increase in rate of pay effective 10/06/19, and an agreement for facility compensation for Activity Director certification with additional pay increase upon completion. Review of the personnel record for Activities #25 revealed no documentation to verify Activities #25 had the appropriate training and/or education to hold the position of Activity Director. There was no evidence Activities #25 was licensed or registered, if applicable, by the State in which [MEDICATION NAME], was eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990, has two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program, was a qualified occupational therapist or occupational therapy assistant or had completed a training course approved by the State. Review of Quality Assurance meeting attendance sheets revealed Activities #25 signed the attendance forms as the Activity Director on 08/21/19, 09/05/19, 01/15/20 and 02/12/20. Interview on 03/03/20 at 10:50 A.M. with Activities #25 revealed she ran the department because she was at the facility full-time, but indicated there was an Activities Director at a sister facility, Activities #100, she called daily and who came to the facility approximately five hours per week. Activities #25 revealed she conducted activities, created the department schedule, created the activity schedule, attended Quality Assurance meetings, attended Resident Council meetings, addressed resident concerns and grievances, completed resident assessments, completed resident quarterly assessment notes, created and evaluated resident care plans and tracked department spending as the Activity Director for the facility. Interview on 03/04/20 at 2:50 P.M. with Activities #25 verified she signed the Activities Director job description on 07/24/19 and confirmed she received the Activities Director job offer from the Administrator, dated 11/12/19. Activities #25 indicated she was not really the Activity Director because she did not have an Activity Director certification, although she verified she accepted the Activity Director position. Interview on 03/04/20 at 3:05 P.M. with Administrator verified Activities #25 signed the Activity Director job description on 07/24/19, and indicated Activities #25 was initially hired as an Activity Assistant on 07/24/19 and she believed Activities #25 was given the wrong job description. Administrator confirmed on 10/06/19, Activities #25 was offered the Activity Director role with the agreement she would get her certification (to function as the Activity Director). The Administrator verified Activities #25 was listed as the facility Activity Director and attended Quality Assurance meetings in which she signed as the Activities Director. The Administrator revealed Activities #100 worked full-time as the Activity Director at a sister facility and provided oversight for the facility activity program in the Activity Director role. Yet, the Administrator confirmed Activities #100 was not listed as an employee of the facility and was not able to provide any additional information to support Activities #100 was the facility Activity Director. Interview on 03/05/20 at 11:46 A.M. with Activities #100 revealed she was the full-time Activity Director at a sister facility and also the Activity Director at this facility. Activities #100 revealed she worked at the facility one day per week but was available by telephone if she couldn't make it in. Activities #100 revealed she worked approximately five hours per week training Activities #25. Activities #100 confirmed she did not attend facility Quality Assurance meetings and the last resident council meeting she attended was in October 2019. Activities #100 verified she was not included on the Activity Department schedule and indicated she did not have set hours to be at the facility because the staff just called when they needed her. Activities #100 indicated she held meetings with the Activity Department but confirmed she did not keep minutes and was unable to provide evidence of communication between her and the Activity Department staff. Activities #100 verified Activities #25 completed the quarterly assessments, created and revised the care plans, collected data for the Minimum Data Set (MDS) assessments, Section F, and addressed concerns. Activities #100 indicated she visited residents from time to time if there was a problem or concern, looked at care plans if there was an issue, or addressed problems if she received a phone call. Observation during the onsite survey on 02/27/20 from 8:00 A.M. to 5:18 P.M., 03/02/20 from 7:55 A.M. to 4:53 P.M., 03/03/20 from 8:12 A.M. to 5:07 P.M. and 03/04/20 from 8:10 A.M. to 5:12 P.M. revealed Activities #100 was not observed in the facility. Review of the facility Employee List revealed Activities #100 was not listed as an employee of the facility, and the Activity Director was listed as Activities #25.
F 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review the facility failed to ensure Resident #29's food was pureed to the proper consistency. This affected one resident (#29) of one resident who received a pureed diet. Findings include: Record review revealed Resident #29 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #29's plan of care, revised on 01/07/20 revealed an increased nutrition /hydration risk related to infection and variable meal intakes, dysphagia requiring an altered diet and thickened liquids. Interventions on the plan of care included to provide a divided plate for meals and to provide diet as ordered. A review of Resident #29's Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #29 was edentulous (had no teeth or dentures), received a mechanically altered diet and needed supervision for eating her meals. An observation of Cook #29 preparing Resident #29's pureed diet on 03/02/20 at 11:15 A.M. revealed the preparation was not prepared to a pureed consistency. Cook #29 indicated Resident #29 was the only resident to receive a pureed diet in the facility. During the observation, Cook #29 placed one serving of beef stew in the food processor and blended the beef stew. After blending the beef stew in the food processor, Cook #29 indicated the beef stew was ready to serve. Upon inspection, the beef stew was lumpy and not smooth. The beef stew was tested for consistency which revealed there were small chunks of meat present and was not the proper consistency. The Kitchen Manager walked over and verified Resident #29's beef stew was not prepared to the pureed consistency. Cook #29 left

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F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) the kitchen visibly upset and returned at 11:35 A.M. to puree Resident #29's lima beans. Cook #29 placed the one serving of lima beans in the food processor. Cook #29 indicated the lima beans were ready to serve to Resident #29. Upon inspection, the lima beans had visible lumps, and a test for consistency revealed the lima beans were not smooth and there were small pieces of the lima beans throughout the serving. The Kitchen Manager directed Cook #29 to place the lima beans back in the food processor and continue to blend until the lima beans reached the proper consistency. Cook #29 indicated a second time the lima beans were ready to serve to Resident #29. An inspection of the lima beans indicated there were still visible chunks, and the consistency was not pureed. Cook #29 indicated I don't know what you want me to do! and left the kitchen. A review of the facility undated policy titled Tray Line Checklist revealed food for all diets should be available and correct. Food should be tasted and prepared at the correct consistency. The Kitchen Manager verified the above findings on 02/02/20 at 11:50 A.M.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and review of facility policy and procedure the facility failed to serve food at the proper food temperature out of the danger zone and failed to ensure a sanitary kitchen was maintained to prepare meals and to ensure the dishwasher was monitored for proper sanitizer level to ensure dishes were sanitized appropriately for reuse. This had the potential to affect all 46 residents residing in the facility. Findings include: During the initial tour of the kitchen accompanied by the Kitchen Manager on 02/27/20 at 9:45 A.M., the kitchen floor and shelves used to store food items and equipment were not clean. The Kitchen Manager verified the floor had dirt and grease build-up around all of the food preparation tables, storage racks and the side of the oven. Surfaces of the metal shelf storage for pans, trays and other cookware were dirty with grease build-up. The Kitchen Manger used a dishcloth and was able to wipe the grease off the metal shelf and indicated the shelf had not been cleaned properly. The floor in the kitchen had black grease/dirt build-up around the perimeter of the kitchen and under all of the moveable metal shelves and food preparation table. An observation of the kitchen on 03/02/20 at 11:10 A.M. with the Kitchen Manager indicated the dishwasher chlorine sanitizing solution was checked while the dishwasher was running three times a day at mealtime. The Kitchen Manager indicated a log was maintained and staff were to document the results of a litmus test when they checked the dishwasher sanitizer solution. The Kitchen Manager performed the litmus test, and the result indicated the chlorine was zero parts per million (ppm). The Kitchen Manager indicated the sanitizer solution should maintain chlorine at 100 ppm on the litmus paper. The Kitchen Manager observed the bucket under the sink which contained the sanitizing agent and discovered the sanitizing solution was empty. A review of the sanitization test log flow sheet indicated the staff had failed to check the sanitization level of the dishwasher prior to washing the breakfast dishes and preparation/serving equipment on 03/02/20. The sanitization test log dated 02/01/20 to 03/02/20 indicated the last time the litmus test was performed was prior to the dinner meal on 03/01/20. The Kitchen Manager verified the above finding at the time of the observation. An observation of the kitchen with the Kitchen Manager on 03/02/20 at 12:50 P.M. verified the build-up of grease on the floor, the side of oven and shelving surfaces of the kitchen. The kitchen floor tiles were cracked in front of the dishwashing area. The plastic cart and metal cart used for transporting food items and/or condiments utensils, beverages in the kitchen had food and grease dried on each shelf of the carts. Moveable metal storage shelving, preparation table and carts in the kitchen had grease and food adhered the wheels and rust present on the castors. The metal shelving unit had rust present on the legs supporting the shelves. An observation of the meal service on 03/02/20 at 11:50 A.M. indicated the food items were prepared in the kitchen and trays of food were transported to the steam table located in the servery kitchen on the ground floor of the facility. At 12:11 P.M., Cook #29 loaded the trays of food onto a cart in the kitchen and transported the food to the ground floor servery and placed them in the steam table. Cook #29 used a thermometer to check the temperature of beef stew, mashed potatoes and carrots prior to plating the food for the residents. The temperature of the carrots was 106 degrees Fahrenheit (F), beef stew was 120 degrees F and the mashed potatoes measured 107 degrees F. While checking the temperature, Cook #29 used a dry dish towel to wipe the thermometer between foods. There was no sanitizing solution applied to the dish towel, and the food from one item was potentially transferred to another food item during the process. The plated food was placed in an insulated cart. At 12:37 P.M. the last plate was filled and the cart was delivered to the nursing unit. At 12:48 P.M. the last resident meal was served and a test tray was observed and tasted for palatability. The temperature of the food was measured, and the beef stew measured 110 degrees F and the carrots measured 102 degrees F. The food was lukewarm and not maintained at an adequate temperature for palatability and to prevent possible food borne illness. State tested Nursing Assistant (STNA) #5 verified the food temperatures and palatability on 03/02/20 at 12:48 P.M. A review of the facility policy and procedure titled Dietary: Sanitation (undated) indicated the food service area shall be maintained in a clean and sanitary manner. The procedure indicated all kitchen areas should be kept clean. All utensils, counters, shelves and equipment should be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas. The facility policy titled Cooking Temperatures (undated) indicated the definition of the danger zone (Food temperature held between 41 degrees F to 135 degrees F.) The policy indicated minimum internal temperatures should be maintained by measuring the food temperature with a thermometer. Prior to serving, all food temperatures should measure 135 degrees or hotter. The facility undated policy titled Tray Line Check List revealed food should be placed in the steam table no more than 30 minutes prior to serving. The food temperature should be 135 degrees F or hotter at the start of the meal service. This deficiency substantiates Complaint Number OH 449.
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 interview the facility failed to maintain Residnet #13's medical record in a complete manner as monthly weights were not obtained in January and February 2020 as ordered by the physician. This affected one resident (#13) of two residents reviewed for nutrition. Findings include: Review of Resident #13's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 was severely cognitively impaired. Review of Resident #13's physician's orders [REDACTED]. Review of the medical record revealed there were no weights obtained between 12/24/19 (141.9 pounds) and 03/02/2020 (157.4 pounds.) The medical record was silent on weights for January 2020 and February 2020. Interview with Licensed Practical Nurse (LPN) #11 on 03/05/2020 at 9:39 A.M. confirmed that the record had not recorded any resident weights taken for January 2020 and February 2020.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, record review, interview and policy review, the facility failed to maintain acceptable infection control practices during the administration of [MED] for Resident #32 to prevent the spread of infection. This affected one Resident (#32) of one resident observed receiving [MED]. Findings include: On 03/02/20 at 11:27 A.M. Licensed Practical Nurse (LPN) #6 was observed administering medication, including [MED] to Resident #32. During the observation, LPN #6 was observed to prepare two units of [MED] 100 units [MED], entered Resident #32's room without wearing gloves, administered the [MED] into Resident #32's left upper abdomen without wearing gloves and then used hand sanitizer following the administration. Interview on 03/02/20 at 11:52 A.M. with LPN #6 confirmed she did not wear gloves when administering [MED] to Resident #32. Review of facility policy titled Specific Medication Administration Procedures, IIB14: Injectable Medication Administration revised 01/17 revealed the policy directed staff to put on gloves (during the administration of the medication).
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365748	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITE OAK MANOR	**1926 RIDGE AVENUE WARREN, OH 44484**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Based on observation and interview the facility failed to ensure the resident call system was functional and available for use for all residents. This affected five Residents (#2, #3, #23, #32 and #196) of 46 residents residing in the facility. Findings include: On 03/05/20 from 9:20 A.M. to 10:15 A.M. observation of the resident call system in all resident rooms in the facility, shower rooms and resident bathrooms with the Director of Maintenance revealed the following: 1. Resident #32's call light was not functioning as the call light was not plugged all the way into the wall. 2. Resident #196's call light was not functioning. The call light cord/button was broken and needed replaced. 3. Resident #3's call light was not within reach for the resident to use. The resident was able to use the call light after it was positioned within reach. During an interview on 02/27/20 at 10:07 A.M. with Resident #3, the resident indicated his call light was not within reach, and he was often unable to find the call light. 4. Resident #2's call light was not functioning. The call light cord/button was broken and needed replaced. 5. Resident #23's call light was not within reach for the resident to use. The resident was able to use the call light after it was positioned within reach. On 03/05/20 at 9:21 A.M., the Maintenance Director verified all non-functioning call lights and immediately replaced them and placed the call lights within reach for the residents for whom they were out of reach. This deficiency substantiates Complaint Number OH 449.
F 0921 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation and interview the facility failed to ensure the laundry area was maintained in a safe and clean manner. This had the potential to affect all 46 residents residing in the facility. Findings include: On 03/05/20 at 3:05 P.M. observation of the laundry room revealed the following: 1. The washing machines were coated with several dried white and black chemical drips. 2. Water and waste pipes in the laundry room coated with dust and lint. 3. The cement floor was dirty with dried detergent by the washing machines. 4. The walls by the washing machine were peeling with multiple white paint chips. On 03/05/20 at 3:11 P.M. interview with Laundry Aide/Housekeeper #39 verified the above findings. This deficiency substantiates Complaint Number OH 449 and Complaint Number OH 453.