STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365289	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE LANE NURSING AND REHABILITATION	5425 HIGH MILL AVENUE NW MASSILLON, OH 44646

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, resident interview, and facility policy the facility failed to ensure a resident was treated with dignity and respect. This affected one resident (Resident #43) of three residents reviewed for dignity and respect. Findings include. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #43 had intact cognition and did not have any verbal behaviors director toward others. Review of the progress notes dated 05/28/20 at 2:15 P.M. revealed Resident #43 was offered a private room and declined. The resident's son was updated and also declined the room change at this time. Review of the census dated 05/29/20 revealed Resident #43 was moved to room [ROOM NUMBER], a private room. Review of the progress notes from 04/01/20 to 05/30/20 revealed no documentation of Resident #43 having any behaviors towards her roommate. Interview on 09/23/20 at 1:30 P.M. Resident #43 indicated she had been on the 100 hall for five years and one day the Administrator, the director of nursing, and the hall manager all came into her room. The first thing the Administrator said to her was she was a bully. She asked him what he had just said to her and his reply to her was, do you know what a bully is, it is you! She indicated he told her every time she got a new room mate, she would complain about them. She stated he told her they did not want to hear a word from her, and she was just to listen and he would do the talking. She indicated he told her she had two options; to go to a private room or he would give her a 30-day discharge notice and she could find somewhere else to live. She indicated she is scared to say anything to anyone. She indicated she quit going to resident council because the administrator told her if she complained one more time he was giving her a 30-day discharge notice and she did not want to be accused of complaining. She stated she is [AGE] years old and she does not want to move again, all her friends are here. Interview on 09/28/20 at 11:04 A.M. Licensed Practical Nurse (LPN) #25 indicated she had went in with the Administrator to speak to Resident #43 about the room change. She indicated the Administrator told the resident she was being accused of being a bully by the other residents and they wanted to make sure that was not true. She indicated Resident #43 stated to the Administrator she was not a bully and she got along fine with her roommate. LPN #25 indicated the Administrator told Resident #43 they could not have residents bullying other residents. The Administrator said he had a private room he wanted her to move in to and Resident #43 did not want to move. Review of the undated facility policy, Dignity and Respect, revealed the facility was fully committed to fostering an inclusive and supportive working and living environment, where difference were celebrated and seen as a strength and where all members, residents and employees of the facility, volunteers , visitors and third parties had mutual respect for each other. This deficiency substantiates Complaint Numbers OH 831 and OH 105.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to ensure the call light was within reach for Resident #110. This affected one resident (Resident #110) of three residents reviewed for call lights. Findings include: Review of medical record revealed Resident #110 was admitted [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly MDS 3.0 assessment date 07/01/20 revealed Resident #110 had severely impaired cognition and required extensive assistance with personal hygiene. Observation on 09/27/20 11:55 A.M. revealed Resident #110 was up in a tilt-in-space wheel chair on the right side of the bed, her touch pad call light was hanging up on the wall mount on the left side of the bed out of reach. Interview on 09/27/20 at 12:00 P.M. Nursing Assistant # 56 verified Resident #110 was able to use the call light, however it was not within reach of the resident. This deficiency substantiates Complaint Number OH 105.
F 0563 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, family interview, and staff interview the facility failed to allow end of life visits for the family of Resident #149. This affected one resident (Resident #149) of three residents reviewed for end of life visitation. Findings Include: Review of the medical record revealed Resident #149 was admitted to the facility on [DATE] and expired [DATE] in the facility. [DIAGNOSES REDACTED]. Review of the Social Service Note dated [DATE] at 12:17 P.M. revealed the social service director contacted the resident's son to notify him of the resident's decline and offer hospice services. The son declined hospice services. Review of the physician's progress note dated [DATE] at 5:01 P.M. revealed Resident #149 was slowly declining. Review of the nurse's note dated [DATE] at 7:55 P.M. revealed the family was notified of physician's visit, declining condition and the order for a hospice consult. The family declined hospice consult at this time. Review of the Nurse Practitioner's (NP) progress note dated [DATE] at 5:37 P.M. revealed Resident #149 was visually hallucinating. The resident had a significant decline in health as well as mental health and would benefit from hospice services. The family refused hospice services. Nursing had stated the resident has had minimal food intake but continues to drink some fluids. The resident has had a 24 pound weight loss since admission in February 2020. Review of the NP progress notes dated [DATE] at 2:30 P.M. revealed the physician had offered the family hospice services and they had declined. The social service director had offered hospice on two different occasions and the family had declined. It is suspected the resident was at the end of life and the son was called to offer hospice again. The NP indicated in her note she explained to the son due to the State of Ohio limiting visitation in long term care facilities during the COVID-19 pandemic to outside only, unless the resident was under hospice care and at end of life. Family agreed to hospice consult and requested to come into the facility to see their father. The NP explained to them the consult would be ordered and she would attempt to expedite the process, however, it may take up to 24 hours to get done. Review of the progress notes dated [DATE] at 10:30 P.M. Resident #149 was absent of all vital signs. Interview on [DATE] at 3:27 P.M. Family Member #200 indicated she had asked on Tuesday [DATE] if they could see their father because the facility had been calling, indicating he was declining and needed hospice but they wanted to see for themselves how bad he really was doing. She was told by the staff they would not be able to visit until [DATE]th or 20th and he needed to be on hospice first. She indicated on [DATE] her brother in law had received a call from the facility (they were on a three-way call) stating Resident #149 was at the end of life and needed to be placed on hospice now. She asked if they could come in and see him, the nurse practitioner told them no. She indicated she called hospice to see if they could see him and they said they could see what they could do. She indicated her father passed away later that night and they never got to see him. He died alone. Interview on [DATE] at 10:37 A.M., the Director of Nursing indicated the facility allows for end of life visits. She indicated she got a call in

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 0563 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the middle of the night from the staff concerning Resident #149, they wanted to know if the family could come in and visit the residents and she told them yes, they could. She was not aware if the family had come in to visit. Interview on [DATE] at 11:15 A.M., the Administrator indicated the corporate nurse and the medical director make the decision to allow families end of life visits. He indicated they would allow the family in two at a time and for 30 minutes a visit unless the resident was actively dying and they would be allowed to stay. Interview on [DATE] At 9:32 A.M., Licensed Social Worker #19 indicated the facility allows for considerate visits with the families. He indicated the resident does not have to be on hospice, however, they have to be actively dying but every situation was different. He verified the nurse practitioner had called the family and told the family Resident #149 was actively dying, however, she did not think he would die that quick, so they had not allowed the family to come in to visit yet. Review of the facility policy, COVID-19 Visitation, dated ,[DATE] revealed the policy was to ensure each facility met the state and federal requirement as it related to resident visitation during the COVID-19 pandemic. The facility would ensure there would be no visitors allowed other than in end of life situations. For End of Life visits, the family members would be notified when a substantial change in condition takes place and provide as much notification as possible prior to the resident actively dying to the family members. This deficiency substantiates Complaint Number OH 725.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview the facility failed to ensure dependent residents fingernails were cleaned and trimmed. This affected two (Resident #41 and Resident #110) of three residents reviewed for activities of daily living. Finding include: 1. Review of the medical record revealed Resident #41 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #41 had severely impaired cognition and required total assist of one for personal hygiene. Observation on 09/27/20 at 10:20 A.M. revealed Resident #41 had long jagged, dirty fingernails, both his hand were contracted into fists and his nails were digging into the palm of his hand, however, the skin was not broken open. Interview on 09/27/20 at 10:22 A.M.,. Licensed Practical Nurse (LPN) #111 verified Resident #41's fingernails were long and jagged and curled into the palm of the resident's hand. He was unaware of how often resident nails were to be trimmed. 2. Review of the medical record revealed Resident #110 was admitted [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly MDS 3.0 assessment date 07/01/20 revealed Resident #110 had severely impaired cognition and required extensive assistance with personal hygiene. Observation on 09/27/20 11:55 A.M. revealed Resident #110 had long, dirty fingernails. Interview on 09/27/20 at 12:00 P.M. Nursing Assistant #56 verified Resident #110's fingernails were long and dirty. She also indicated she did not know when resident fingernails were to be trimmed. Interview on 09/28/20 at 10:37 A.M., the Director of Nursing indicated resident fingernails would be trimmed on shower days, during weekly skin checks and as needed. Review of the facility policy, Nail Care, dated 11/13 revealed the policy was to ensure residents nails were trimmed and hygiene maintained. The State tested Nursing Assistance would provide nail care to non-diabetic residents. Nail care was to be provided to the residents as part of the residents shower procedure. Nail care included cleansing under their nails and clipping the nails of both hands and feet. The nurse will trim the nails of the diabetic residents. This deficiency substantiates Complaint Numbers OH 173, OH 588.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to properly change and store respiratory equipment for residents receiving oxygen therapy. This affected two residents (Resident #27 and Resident #62) of three residents reviewed for respiratory therapy. Findings include: 1. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #62 had intact cognition and did not require oxygen. Review of the physician's orders [REDACTED].#62 had an order for [REDACTED].M. revealed Resident #62 oxygen nasal cannula was lying on her bedside stand not in a protective barrier and was not dated as to when it was last changed. Interview with the resident at this time revealed she had not placed it on the table, the staff did. Interview on 09/23/20 at 9:27 A.M. Licensed Practical Nurse (LPN) # 115 indicated all respiratory equipment was to be dated as to when it was changed last and was to be stored in a plastic bag when it was not being used. She verified the oxygen nasal cannula was lying on the bedside stand not in a protective barrier and was not dated as to when it was last changed. 2. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #27 had moderately impaired cognition and required oxygen. Review of physician orders [REDACTED].#27 had an order for [REDACTED].M. revealed Resident #27's oxygen tubing was not dated as to when it was changed last. Interview on 09/23/20 at 1:37 P.M. LPN #104 verified Resident #27's oxygen was not dated as to when it was changed last. She indicated the facility had a respiratory company come in and change them weekly. Interview on 09/28/20 at 10:37 A.M., the Director of Nursing indicated oxygen tubing was to be changed once a week. She indicated the facility has a company come in and change out the respiratory supplies weekly, however, due to pandemic precaution they have been just dropping them off at the front desk and the facility staff was to change them out. She indicated the respiratory equipment was to be dated as to when it was changed and should be stored in a plastic bag when not in use. This deficiency substantiates Complaint Numbers OH 105.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review, staff interview, and family interview the facility failed to ensure a resident received timely pain management. This affected one resident (Resident #148) of three residents reviewed for pain management. Findings include: Review of the closed medical record revealed Resident #148 was admitted to the facility on [DATE] and expired on [DATE] in the facility. [DIAGNOSES REDACTED]. Review of the Pharmacy delivery slips revealed on [DATE] Resident #148 received carvedilol, duloxetine, [MEDICATION NAME], potassium chloride, vitamin D2 and latanoprost. On [DATE] she received, pantoprazole, [MEDICATION NAME], and potassium chloride liquid. On [DATE] the resident received [MEDICATION NAME] and [MEDICATION NAME]. Review of the February 2020 physician's orders [REDACTED]. Review of the chest X-ray dated [DATE] revealed Resident #148 had left lower lobe consolidated pneumonia. Review of the physician's progress notes dated [DATE] at 7:47 A.M. revealed Resident #148 was seen and was complaining of severe back pain on ambulation, she refuses to wear her back brace. Review of the nurse's notes dated [DATE] at 10:52 A.M. the Nurse Practitioner order a STAT x-ray due to Resident #148's complains of pain in the chest and back. Review of the February 2020 medication administration records (MAR) revealed Resident #148 was given the first dose of [MEDICATION NAME] 50 milligrams on [DATE] at 7:49 A.M. Interview on [DATE] at 3:27 P.M. Family Member #200 indicated her mother had asked for pain medication on [DATE] and was told she did not have medication for pain ordered and they would need to get a prescription from hospice. They received the prescription, however, her mother was still not given any pain medication until [DATE]. She indicated her mother had called her to tell her she still had not had any pain medication and she had to call into the facility before they gave her anything. Interview on [DATE] at 11:45 A.M. the DON indicated she was unable to find out any information as to why Resident #148 did not receive her pain medication until [DATE]. She verified the Nurse Practitioner had ordered a chest x-ray on [DATE] due to the resident was complaining of so much pain. Review of the facility, Pain Assessment and Management Protocol, dated ,[DATE] revealed the procedure was to assess each residents' individual pain through direct observation and use of the nursing assessment process with the goal to identify pain and develop a management protocol in order to maximize each resident's functional capabilities and quality of life. This deficiency substantiates Complaint Number OH 725 and OH 173.