STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365636	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PICKERINGTON CARE AND REHABILITATION	1300 HILL ROAD NORTH PICKERINGTON, OH 43147

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 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, staff interview, and review of facility's care path for dehydration, the facility failed to ensure residents fluid intake was being properly monitored to prevent dehydration. This affected one (Resident #1) of the four residents reviewed for dehydration and also affected Residents #13, #15, and #17. The facility census was 62. Findings include: Review of the medical record for Resident #1 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #1's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 07/24/20 revealed resident with an impaired cognition with an Brief Interview for Mental Status (BIMS) score of 99. Resident #1 experienced long and short term memory problems. Resident #1 required extensive assistance from one staff member for bed mobility, locomotion on and off the unit, dressing, eating, personal hygiene, and toilet use, and extensive assistance from two staff members for transfers. Attempted review of the nutrition risk assessment for Resident #1 was unable to be completed due to the document was not able to be located. On 08/13/20 at 11:00 A.M. during interview, the Administrator revealed the resident had been at the facility for a few years and the facility had been under a few different managements, and they were unable to access one of their past charting systems which is where this assessment would be located. Review of Resident #1's plan of care dated 07/07/20 revealed the resident was at risk for nutritional and/or dehydration related to dysphagia and dementia. Interventions included to change diet to pureed, assess diet tolerance as needed, assist with meals, provide fluids on meal tray and at bedside, and provide supplements as ordered. Review of Resident #1's physician orders revealed a diet order dated for 07/07/20 for Resident #1 to have food with no added salt and a pureed (food blended into a thick liquid or pulp) texture and regular thin consistency liquids. Also noted was an order dated for 06/25/20 for House Supplement (a drink high in nutrients and calories) once a day. Review of Resident #1's Electronic Medication Administration Record [REDACTED]. Review of Resident #1's EMAR for 08/2020 revealed the resident consumed the House Supplement 2 of 4 days at the facility, and refused 2 of 4 days at the facility. Review of nurses progress note dated 08/04/20 at 4:59 P.M. revealed Resident #1 was observed with weakness and unable to swallow medication, food, or drink. Abnormal vital signs were noted. The resident's family notified of change of condition and were educated on changing code status to Do Not Resuscitate comfort care (DNR-cc), but family declined. Family arrived for a visit and decided to send Resident #1 to local hospital for evaluation. Physician Assistant (PA) #1 and Director of Nursing (DON) , and Unit Manager (UM) #24 notified. Review of the nursing progress note dated 08/04/20 at 5:09 P.M. revealed Resident #1's vital signs were 80 beats per minute via apical, blood pressure 70/30 mm Hg. Resident #1 was alert and will respond when asked questions with eye contact. PA #1 contacted earlier this shift and orders given to draw labs in the morning with regards to decreased in meal intake. Family made aware of these orders at family visit. Despite all interventions put in place, family requested Resident #1 be sent to local hospital for evaluation. Review of the dietary progress note for 06/24/20 at 5:29 P.M. revealed the Resident #1 was discussed at the Interdisciplinary/Risk team meeting due to weight change of -7.2 pounds or a -4.9% across the month to a current weight of 140.2 pounds. Meal intakes frequently less than 50%. House supplement being ordered at 120 milliters (ml) every day to regimen for an added 240 calories a day. Current Body Mass Index (BMI) is 27.4. Staff were to monitor the resident. Review of Resident #1's dietary progress note for 08/04/20 at 10:05 P.M. revealed nursing progress notes of this date related to weakness and compromised swallow. Weight loss was noted to 126.8 pounds. Resident transferred to local hospital per family request, monitor course upon return. Review of fluid intake for Resident #1 from 07/14/20 to 08/04/20 revealed an average intake of 451.7 ml a day. The recommended daily intake of fluids or water was to be 1500-2000 ml/day according to information from the USDA. Review of weights revealed on 01/06/20 the Resident #1 weighed 153.6 pounds. On 02/03/20 the Resident #1 weighed 155.0 pounds. On 03/19/20 the Resident #1 weighed 156.2 pounds. On 04/03/20 the Resident #1 weighed 153.4 pounds. On 05/04/20 the resident #1 weighed 147.4 pounds. On 06/23/20 the Resident #1 weighed 140.2 pounds. On 07/09/20 the Resident #1 weighed 139.0 pounds. On 08/04/20 the Resident #1 weighed 126.8 pounds. Observation on 08/12/20 at 2:30 P.M. revealed Resident #13 laying supine in bed, resting quietly with eyes opened. When greeted, no return answer was made. Observation revealed a large cup with a lid and a straw and what appeared to be water sitting on a stand located across the room from where the resident was located. Interview on 08/12/20 at 2:32 P.M. with State tested Nurse Aide #5 revealed the large cup in Resident #13's room was his water pitcher and it was placed on a stand located across the room out of his reach due to him spilling it in his bed all the time and she just changed his sheets. STNA #5 also revealed Resident #13 as unable to obtain a drink with assistance and she offers his drinks through out the day. Observation on 08/12/20 at 2:34 P.M. revealed Resident #15 laying supine in bed resting quietly with eyes closed. Observation revealed beside her bed was a bed side table. No observation of a water pitcher or drinking cups were made. Interview on 08/12/20 at 2:35 P.M. with STNA #5 revealed Resident #15 is on thickened liquids and received Hospice (end of life) services so that's why Resident #15 did not have a water pitcher on her bed side table. Observation on 08/12/20 at 2:38 P.M. revealed Resident #17 laying supine in bed with the head of her bed at a 45 degree angle. Resident #17's bed was placed in the lowest position with a blue fall mat beside it on the floor. No observation of a water pitcher or drinking cup was made. Interview on 08/12/20 at 2:38 P.M. with STNA #5 revealed Resident #17 rolls out of bed a lot so that is why her bed is in lowest position and there is a blue mat next to her bed on the floor. They have tried to place her bed side table next to her before and she has rolled out of bed and caused injuries to herself with the table so it did more harm than good. The bed side table is now placed on the other side of the room up again a wall with Residents #17's water pitcher on it only because there is no other place for the water pitcher to go. STNA #5 revealed she offers Resident #17 drinks through out the day. Interview on 08/12/20 at 2:42 P.M. with the Administrator confirmed Resident #1's fluid intake was not being monitored like it should have been. Review of the facility care path titled, Dehydration, no date, revealed the facility did not monitor Resident #1's fluid intake to ensure adequate intake. The Dehydration care path revealed if there is a decrease in a resident's oral intake over a 48 hour period, swallowing difficulties, and dependent on others for fluids then to obtain a set of vital signs and if abnormal contact the physician right away. Resident #1's intake was not being monitored and was not noticed when Resident #1 was taking in less than 500 ml of fluids a day. Review of the facility policy titled Hydration/Fresh Water and Fluids, revised 11/2018 revealed it is the policy of this facility to offer each resident fluids daily based. Consideration is given to identify risk factors associated with a resident becoming dehydrated such as fluid loss through elevated temperature, diarrhea, uncontrolled diabetes, fluid restrictions, secondary to [MEDICAL TREATMENT], functional impairments that make it difficult to drink, reach and/or communicate fluid needs. Some residents with Dementia will forget to drink, so provide encouragement and assistance as needed. This is an incidental finding to Complaint Number OH 853.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE