STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366388	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STONESPRING OF VANDALIA	4000 SINGING HILLS BVLD DAYTON, OH 45414

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 medical record review, observation, family, resident and staff interviews, review of night shift form and review of facility policy, the facility failed to ensure resident care equipment was maintained in a clean and sanitary manner. This affected two Resident's (#8, and #72) of two reviewed for environment. The census was 137. Findings include: 1. Review of the medical record for Resident #8 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed the resident was assessed as being cognitively intact with the need for extensive assistance of one person assist with activity of daily living (ADLs). Interview with Resident #8 on 03/10/20 at 10:03 A.M. revealed she felt staff did not clean her wheelchair very often and she was unable to do it herself. Observations of Resident #8 in her wheelchair on (03/10/20, 03/11/20, 03/12/20) at various times revealed her wheelchair cushion had food noted on it and the rest of the wheelchair was dirty. Interview with Registered Nurse (RN) #777 on 03/12/20 at 12:50 P.M. verified all wheel chairs were cleaned per a schedule on night shift. Review of a night shift form revealed Resident #8's room was supposed to be be cleaned on Tuesday on night shift. This form was verified by RN #777 which revealed Resident #8's wheelchair, along with her room, should have been cleaned on Tuesday night's. The facility refused to give the surveyor a copy of the form. Interview on Thursday, 03/12/20 at 1:00 P.M. with RN #777 verified Resident #8's wheelchair and wheelchair cushion were dirty with food particles noted on the cushion. RN #777 said the wheelchair should have been cleaned Tuesday night. Review of the Wheelchair Policy dated 12/2012 revealed in the area of cleaning; the wheelchairs were cleaned weekly and as needed. 2. Review of the medical record for Resident #72 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the MDS dated [DATE] revealed the resident was unable to be assessed for cognitive status. She was assessed as needing total assistance of two plus persons for ADLs. She had a mechanically altered therapeutic diet and had an abdominal feeding tube with 51% or more intake by tube feed. Review of physician's orders [REDACTED]. Observations on 03/09/20 and 03/10/20 at various times of Resident #72's room revealed the Intravenous (IV) pole and the floor had a large amount of dried tube feed. Interview with a family member of Resident #72 on 03/09/20 at 3:15 P.M. revealed she was upset because the bed side table and the IV pole which had her tube feed on it was dirty with dried tube feed on them. She did not think the resident should have anything dirty around here because she was not able to move. Interview on 03/10/20 at 8:45 A.M. with RN #720 verified the tube feed pole and bedside table had dried tube feed on it. RN #720 also verified a large amount of tube feed on the floor around the IV pole and RN #720 did not know when this occurred. Observation on 03/10/20 at 9:05 A.M. of RN #785 revealed he was taking a new IV pole into the residents room and taking out the other IV pole. RN #785 verified he had to replace the residents IV pole due to dried tube feed on it. Interview with Housekeeper #600 on 03/11/20 at 2:00 P.M. revealed she worked 8:00 A.M. to 4:00 P.M. She revealed all rooms were cleaned daily. She verified there was tube feed on the floor of Resident #72's room. She stated she was not able to mop around it because the nurse was in the room. She stated she had not been previously informed of the tube feed on the floor. She stated she had to get down on the floor and scrap it off because it was so hard. She stated if she had been told prior it would not have been as hard to get it off the floor. Review of facility policy entitled Disinfection of IV Poles dated 03/12/20 revealed the cleaning of IV poles on a routine (weekly basis) was needed and or between resident rental.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interview and review of facility policy, the facility failed to ensure a safe discharge for residents when staff sent home medications not prescribed to the discharging resident. This affected one (Resident #15) out of five residents reviewed for a safe discharge. The current census was 134. Findings include: Review of Resident #15's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged home on[DATE]. [DIAGNOSES REDACTED]. Review the comprehensive admission Minimum Data Set ((MDS) dated [DATE] revealed the resident had intact cognition and was a one person assist with bathing and hygiene. Review of the discharge instructions dated 02/29/20 revealed the nurse discussed the list of prescribed medications with the resident and supplied a two-day supply of medications for the resident along with prescriptions from the physicians. Review of progress notes dated 02/28/20 revealed no documentation was added to the resident's record regarding the wrong medication being sent home with the resident. Interview on 03/11/20 at 11:30 A.M. with Licensed Practical Nurse, (LPN) #710 revealed the nurse discharged Resident #15 to home with her family member. LPN #710 stated she reviewed all the medications with the resident and stated per policy she placed a two-day supply of medications in an envelope and sent it home with Resident #15. LPN #710 stated after the resident arrived home, she called the facility and notified the nurse she had received another resident's medications in the envelope. LPN #710 verified the nurse had accidentally sent home Resident #96's medications with Resident #15. Per LPN #710 the resident did not report if she had taken any of the other resident's medications. Review of Resident #96's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #96 had intact cognition. Review of the medications for Resident #96 dated 02/2020 revealed the resident was to receive [MEDICATION NAME] (for [MEDICAL CONDITION]) 5 milligrams, (mg), [MEDICATION NAME] (diuretic) 40 mg, [MEDICATION NAME] (an [MEDICATION NAME]) 25 mg, [MEDICATION NAME] (an [MEDICATION NAME])10 mg, [MEDICATION NAME] (pain reliever) 5/325 mg, [MEDICATION NAME] (for reflux) 20 mg, Rivaroxaban (blood thinner) 20 mg, [MEDICATION NAME] (a supplement) tablet, [MEDICATION NAME] (diuretic) 20 mg, [MEDICATION NAME] (used for [MEDICAL CONDITION]) aerosol 250-50 micrograms per dose, [MEDICATION NAME]-[MEDICATION NAME] (used for [MEDICAL CONDITION]) solution 0.5 mg per 3 milliliters, (ml), and Potassium (supplement) 20 milliequivalent, (meq). Review of Resident #96's progress notes dated 02/2020 revealed no documentation of the resident's medications being sent home with another resident. Interview on 03/11/20 at 11:45 A.M. with Resident #96 revealed the resident was not informed his medications were sent home with another resident. Resident #96 denied any knowledge of missed medications. Resident #96 state he did not recall if he missed any medications in February. Review of the facility policy titled, Discharge Planning dated 11/2016 revealed the resident will be sent home with a 7-14-day supply of their prescribed medications. This deficiency substantiated Complaint OH 673.
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**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on medical record review, shower schedule review, task worksheet review, observation, interviews, and review of facility policy, the facility failed to provide care to dependent residents to maintain personal hygiene. This affected two Residents (#85 and #102) out of three reviewed for personal hygiene. The current census was 134. Findings include: 1. Review of Resident #102's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set, ((MDS) dated [DATE] revealed the resident had impaired cognition, and required one person assist with personal hygiene and a two person assist with bathing. Review of Resident #102's care plans dated 06/20/18 revealed a focus for self-care deficit related to impaired mobility, activity intolerance, [MEDICAL CONDITION] and muscle weakness. Interventions included extensive assist with dressing, bathing, toilet use, transfers, and personal care. Review of Resident #102's shower schedule revealed the resident was scheduled to receive showers on Mondays and Thursday evenings. Review of Resident #102's task worksheet dated 02/2020 revealed the resident was documented as refusing baths on 02/03/20, 02/17/20, 02/20/20, and Not Applicable on 02/10/20, no documentation of missed baths was noted on 02/13/20 or 02/27/20. Review of progress notes dated 02/03/20 to 02/27/20 revealed no documentation of the resident being offered another shower after refusals or any documentation regarding the missing showers. Review or Resident #102's task worksheet dated 03/2020 revealed the resident was documented as refusing a bath on 03/06/20. No other personal hygiene tasks were listed on the worksheet. Review of progress notes dated 03/06/20 revealed the resident refused shower, no notation of the resident being offered another shower was documented. Observation on 03/09/20 at 9:45 A.M. of Resident #102's room revealed the resident's bed was bare of linens, sheets, pillows and blankets. Resident #102's husband/roommate, Resident #85, was in the room being assisted by two staff. A strong odor of urine was noted in the residents' room. Observation on 03/09/20 at 11:40 A.M. of Resident #102 revealed the resident was being wheeled by a staff member into the resident's room. A strong odor of urine was noted. Interview on 03/09/20 at 2:15 P.M. with Resident #102 and Resident #85, the resident's husband, revealed Resident #102 stated she preferred to be bathed in the whirlpool tub. Resident #102 stated she had not received a shower in a few days and stated even when staff do bathe her, she was not washed properly, and she felt she still had an odor afterwards. Resident #102 stated she was upset due to her personal hygiene needs not being met at the facility. Resident #85 stated he was blind but could still smell the odor from Resident #102 when she was not bathed properly. Observation and interview on 03/10/20 at 10:30 A.M. revealed Resident #102 lying in bed, a strong odor of urine was noted in and around the resident. Resident #85 stated the resident requested to be showered but did not receive a shower. Resident #102 stated she wanted to be washed properly. Interview on 03/10/20 at 10:55 A.M. with Registered Nurse, (RN) #720 revealed Resident #102 was scheduled to have a shower on Monday nights per the shower schedule. RN #720 verified the strong smell of odor on Resident #102. RN #720 stated the resident has refused showers and bed baths in the past because the resident had issues with breathing while lying flat. RN #720 stated the resident was on continuous oxygen and was unable to be washed fully in a bed bath because she could not lie flat. RN #720 stated the resident preferred to use the whirlpool, but it was difficult to give the resident a whirlpool bath, so it was often not offered. RN #720 stated the policy was to offer another bath on another shift if a shower was missed. Interview on 03/10/20 at 4:30 P.M. with RN #777 revealed Resident #102 had refused showers and baths in the past. RN #777 stated the resident had incontinence issues so she would often have an odor. RN #777 stated the resident's care plan was updated on 03/10/20, during the survey, to include the refusals of showers and baths. RN #777 verified when a resident refused a shower they were to be offered another shower or bath and it was to be documented in the record. Interview on 03/12/20 at 11:15 A.M. with family friend #1 revealed she visited the residents in the facility frequently and each time had noted the strong pervasive odor of urine in both Resident #102's room and on the resident's person. She stated the staff were notified of the smell but they had not taken actions to clean the resident properly or per the resident's choice. 2. Review of Resident #85's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had impaired cognition and was a one person assist with bathing and hygiene. Review of Resident #85's task worksheets dated 02/2020 revealed the resident refused showers on 02/04/20, 02/11/20, 02/18/20, and 02/25/20. No documentation of personal hygiene was noted on the worksheet. Interview on 03/10/20 at 2:10 P.M. with Resident #85 revealed the resident stated he could not remember the last time he was given a shower. Per Resident #85 he had never refused a shower or bath when they were offered. Resident #85 stated he preferred his face to be shaved daily but understood if it could only be done a couple of times a week. Resident #85 stated he had not been shaved in over a week. Observation at the time of the interview revealed Resident #85 had noticeable facial hair. Interview on 03/11/20 at 8:50 A.M. with RN #777 revealed Resident #85 did refuse showers at times. Per RN #777 the resident had received showers on the scheduled days without the documentation. Per RN #777 the procedure for when a resident missed a shower due to refusal was to chart the refusal and offer the resident another shower on the next shift. Review of the facility policy titled, Bathing and General Hygiene' dated 05/2015 revealed all residents were to receive showers or bath per their choice. Men were to be shaved daily or as needed. This deficiency substantiated Complaint Numbers OH 635, OH 673 and OH 81.