STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365583	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA CAMILLUS THE	10515 E RIVER RD COLUMBIA STATION, OH 44028

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 0569 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure funds were conveyed timely upon death for one Resident (#212); and failed to notify two (#56 and #211) residents when their personal funds account balance was within two hundred dollars of the state allowed limit. This affected three (#212, #56, and #211) of four residents reviewed for funds conveyance and notices. The facility census was 59. Findings Include: 1. Record review revealed Resident #212 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #212 expired in the facility on [DATE]. Review of the resident account list revealed Resident #212 had forty dollars in her personal funds account. Interview on [DATE] at 6:45 P.M. the Administrator verified Resident #212 had current funds in her account and the funds should have been conveyed within 30 days. 2. Record review revealed Resident #56 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the resident account list revealed a balance of $2,981.65. Review of the business office file revealed no evidence a spend down letter was issued to Resident #56 or their representative as required. 3. Record review revealed Resident #212 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the resident account list revealed a balance of $2,646.65. Review of the business office file revealed no evidence a spend down letter was issued to Resident #212 or their representative as required. Interview on [DATE] at 6:47 P.M. the Administrator verified no spend down letter had been issued to Resident #56 and #212 as required.
F 0570 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Assure the security of all personal funds of residents deposited with the facility.** Based on review of the surety bond, trial balance funds sheet and staff interview the facility failed to provide a surety bond large enough to cover the total amount of money in all resident personal funds accounts. This had the potential to affect 59 of 59 residents who currently resided in the facility. The facility identified 46 residents currently had a resident funds account with the facility. The facility census was 59 Findings include: Review of this facility's surety bond revealed it was in the amount of $30,000.00. Review of the resident trial balance funds documented the total money in the resident funds account totaled $32,476.70. Interview on 03/11/20 at 6:45 P.M. the Administrator verified the amount of monies in the resident funds account exceeded the amount of the surety bond.
F 0577 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on record review and staff interview the facility failed to ensure the most recent state survey results were readily accessible to residents, staff and the general public. This had the potential to affect 59 of 59 residents who currently resided in the facility. The facility census was 59 Findings Include: Review of the facilities survey results binder located in the front of the facilities publicly accessible survey book revealed the last result in the book were from an annual survey completed on 02/13/19. The state agency completed complaint surveys at the facility on 07/31/19, 10/19/19, 12/10/19 and 0[DATE]. No results from these surveys were located in the binder. Interview on 0[DATE] at 9:15 A.M. the Administrator verified the binder was not up to date with the most current surveys.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review the facility failed to ensure advanced directives were present in the electronic chart and failed to ensure physicians orders were in place for resident advanced directives. This affected 11 (#3, #9, #22, #26,#32, #33,#38,#43, #45, #47 and #57) of 24 Residents reviewed for advanced directives. The facility census was 59. Findings include: 1. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. The paper medical record identified a code status of Do Not Resuscitate (DNR). Review of the electronic medical record identified no evidence of the residents advanced directives request and no physician orders to identify the request. 2. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE]. The paper medical record identified a code status of DNR-arrest. Review of the electronic medical record identified no evidence of the residents advanced directives request and no physician orders to identify the request. 3. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE]. The paper medical record identified she wanted to be a Do Not Resuscitate-Comfort Care (DNR-CC). Review of the electronic medical record identified no evidence of the residents advanced directives request and no physician orders to identify the request. 4. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. The paper medical record identified he wanted to be a full code. Review of the electronic medical record identified no evidence of the residents advanced directives request and no physician orders to identify the request. 5. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE]. The paper medical record identified she wanted to be a DNR-arrest. Review of the electronic medical record identified no evidence of the residents advanced directives request and no physician orders to identify the request. 6. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE]. The paper medical record identified she wanted to be a DNR-arrest. Review of the electronic medical record identified no evidence of the residents advanced directives request and no physician orders to identify the request. 7. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE]. The paper medical record identified she wanted to be a DNR-arrest. Review of the electronic medical record identified no evidence of the residents advanced directives request and no physician orders to identify the request. 8. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. The paper medical record identified the resident requested to be a full code. Review of the electronic medical record identified no evidence of the residents advanced directive request and no physician order to identify the request. 9. Review of the medical record revealed Resident #33 was admitted to the

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) facility on [DATE]. The paper medical record identified Resident #33 requested to be a DNR-CC. Review of the electronic record identified no evidence of a physician order or information that identified the residents wishes. 10. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. The paper medical record identified Resident #45 requested to be a Full Code. Review of the electronic record identified no physician orders to identify the residents wishes. 11. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE]. The paper medical record identified their advanced directive wishes for DNR. Review of the electronic record identified no physician order for [REDACTED].M. with the Director of Nursing (DON) confirmed the advanced directive wishes of each resident should be in both medical records (paper and electronic), and match. The DON confirmed the electronic chart should have included a physician order, which identified each residents wishes so nursing staff can quickly access the information in the event of an emergency. Review of the facility policy titled Advance Directives, dated 10/16 revealed upon each resident admission each resident would be provided written information to formulate their wishes regarding end of life care. The policy identified documentation must be recorded in the medical record of such directive and a copy of the directive must be included in the residents medical record. The DON would notify the attending physician of the advance directive so that appropriate orders can be documented in the residents medical record and plan of care.
F 0582 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure required Notices of Medicare Non-Coverage (NOMNCs) were given to residents upon the discontinuation of skilled services had correct information. This affected three (#209, #210 and #211) of three residents reviewed for beneficiary notice. Findings Include: 1. Review of the medical record revealed Resident #209 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #209 was discharged to her personal residence on 01/13/20. Review of the required NOMNC given to resident #209 on 01/08/20 revealed incorrect contact information was present on the notice for appeals information. The notice listed Ohio Kepro as the quality improvement organization (QIO) to contact to initiate an appeal for discharge from skilled services. Review of https://qioprogram.org/locate-your-qi (Medicare's official website for locating quality improvement organizations) revealed Livanta is the current contracted agency to survey as the states QIO and to handle skilled services discharge appeals. 2. Review of the medical record revealed Resident #210 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #210 was discharged to her personal residence on 12/2[DATE]9. Review of the undated required NOMNC given to resident #210 revealed incorrect contact information was present on the notice for appeals information. The notice listed Ohio Kepro as the quality improvement organization (QIO) to contact to initiate an appeal for discharge from skilled services. Review of https://qioprogram.org/locate-your-qi (Medicare's official website for locating quality improvement organizations) revealed Livanta is the current contracted agency to survey as the states QIO and to handle skilled services discharge appeals. 3. Review of the medical record revealed Resident #211 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #211 was discharged to her personal residence on [DATE]. Review of the required NOMNC given to resident #211 on 12/17/19 revealed incorrect contact information was present on the notice for appeals information. The notice listed Ohio Kepro as the quality improvement organization (QIO) to contact to initiate an appeal for discharge from skilled services. Review of https://qioprogram.org/locate-your-qi (Medicare's official website for locating quality improvement organizations) revealed Livanta is the current contracted agency to survey as the states QIO and to handle skilled services discharge appeals. On 0[DATE] at 3:16 P.M., the Administrator verified the incorrect contact information in an all of the above letters.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, the facility failed to ensure a resident/or resident representative was provided written notification of a resident hospitalization . The facility also failed to notify the ombudsman of the resident's hospitalization . This affected three (#34, #47 and #59) of three residents reviewed for hospitalization . The facility census was 59. Findings include: 1. Review of Resident #47's medical record identified admission to the facility occurred on 12/20/11, with medical [DIAGNOSES REDACTED]. The record identified Resident #47 required hospitalized from [DATE] through [DATE] for surgical repair of a [MEDICAL CONDITION]. The record identified no written evidence was provided to the resident/representative or ombudsman regarding the reason for transfer to the hospital. The record did identify Resident #47 was readmitted to the facility following the hospitalization . 2. Review of the medical record of Resident #34 revealed an admssion date of [DATE] with Diagnoses: [REDACTED]. Further review of the medical record revealed Resident #34 was discharged to a local hospital on [DATE]. Review of both the electronic and hard charts revealed no evidence the long-term care ombudsman was notified of Resident #34's discharge to the hospital. The facilities Administrator verified the long-term ombudsman was not notified of Resident #34's discharge to the hospital in an interview on 0[DATE] at 10:40 A.M. The Administrator also noted that due to staff turnover no staff person was currently assigned to or making sure the long-term care ombudsman was notified of any resident's discharge to the hospital. 3. Medical record review for Resident #59 revealed admitted [DATE] discharge date [DATE]. [DIAGNOSES REDACTED]. Review of the progress note dated 12/20/19 Resident discharged to home. All discharge instructions and medication instructions reviewed with the resident and resident stated understanding and had no other further questions. All medications and personal belongings sent home with resident. Resident accompanied by wife to personal vehicle to transport home. Interview with the Administrator on 0[DATE] at 10:40 A.M., verified (#34, #47 and #59) residents were provided with written notice and the ombudsman was not notified of the discharge from the facility.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility bed hold policy and staff interviews, the facility failed to ensure two (#34 and #47) of three residents reviewed for hospitalization were provided bed hold notification. The facility census was 59. Findings include: 1. Review of Resident #47's medical record identified admission to the facility occurred on 12/20/11, with medical [DIAGNOSES REDACTED]. The record identified Resident #47 required hospitalized from [DATE] through [DATE] for surgical repair of a [MEDICAL CONDITION]. The record identified no written evidence was provided to the resident/representative regarding the facility's bed hold policy. 2. Review of Resident #34's medical record was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Further review of the medical record revealed Resident #34 was discharged to a local hospital on [DATE]. Review of both the electronic and hard charts revealed no evidence Resident #34 or her family/representative were given information regarding bed hold days remaining and other related procedures for her return to the facility. Interview with the Administrator, occurred on 0[DATE] at 10:40 A.M., verified the lack of bed hold notice given to Resident #34 and Resident #47, or their family/representative. The Administrator also noted that due to staff turnover no staff person was currently assigned to or making sure that residents were receiving required bed hold notices upon discharge to the hospital.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** Based on medical record review and staff interviews, the facility failed to ensure all Minimum Data Sets (MDS) were completed every 3 months as required. This affected one (#203) on 18 sampled residents. The facility census was 59.

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F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Findings include: Review of Resident #203's medical record identified admission to the facility occurred on 0[DATE]9/18 and discharge occurred on [DATE], to another facility. The record identified the most recent MDS assessment was dated 11/01/19. The record identified no evidence of a submitted MDS since that time. Interview with Licensed Practical Nurse #24 on 03/12/20 at 9:40 A.M., confirmed she is new to the facility but confirmed there is no evidence Resident #203 had a quarterly MDS submitted as required.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, the facility failed to ensure all minimum data set (MDS) assessments were completed accurately. This affected one (#45) of two residents reviewed for enteral feedings. The facility census is 59. Findings include: Review of Resident #45's medical record identified admission to the facility occurred on 0[DATE]9/17, with medical [DIAGNOSES REDACTED]. Review of the dietary notes dated 10/23/19 identified Resident #45 had a new enteral tube feeding placed. The record identified Resident #45 was receiving all nutritional needs through the feeding tube. The record identified Resident #45 was noted with significant weight lose. Review of the facility MDS assessments dated 11/19/19 and 01/28/20, in section K (nutrition) does not evidence Resident #45 has the enteral tube feeding and that all nutrition is being provided through this tube. Interview with the facility Director of Nursing on 3/11/20 at 1:21 P.M., confirmed the MDS assessments dated 11/19/19 and 01/28/20 are not accurate. The interview confirmed Resident #45 is receiving all nutrition through a tube feeding. Interview with the Dietician (RD) #70 on 03/11/20 at 1:35 P.M., confirmed she completed section K on the MDS assessments. The interview confirmed she did not complete Resident #45's assessments from 11/19/19 and 01/28/20, correctly. The interview confirmed Resident #45 has been receiving all nutrition and hydration via tube feeding since 10/2019.
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, resident and staff interviews, the facility failed to ensure residents and/or their representatives were invited to and involved in care plan meetings. This affected one (#57) of one resident reviewed for care planning. The facility census was 59. Findings include: Review of Resident #57's medical record revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was cognitively intact. Interview with Resident #57 on 03/09/20 at 9:15 A.M. revealed that Resident #57 was unaware of his last care conference or being invited. Review of the hard chart revealed the last documented care conference was from 05/22/19 with the resident not in attendance. Further review of the electronic and hard charts revealed no other documented care conferences in the medical record. Interview with the Administrator on 0[DATE] at 5:01 P.M., verified the lack of care conferences and invitations.
F 0680 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Ensure the activities program is directed by a qualified professional.** Based on personnel record review and staff interview, the facility failed to ensure a qualified staff person was employed to serve as its activity's director. This had the potential to affect 59 of 59 residents. The facility census was 59. Findings include: Review of the staff personnel list on 03/10/20 revealed no staff person was currently employed at the facility as the activity's director. Interview with the Administrator on 03/10/20 at 1:55 P.M. revealed the facility had been without an activity's director since 02/21/20 and that the facility was just begining the interview process. Interview with Activities Assistant (AA) #35 on 03/10/20 at 1:58 P.M. revealed she had been covering as best she could for the activities program. AA #35 also revealed she is not certified as an activities director or has necessary experience to qualify as an activity's director per federal and state regulation.
F 0684 **Level of harm** - Minimal harm or potential for 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 observations, medical record review and staff interviews, the facility failed to ensure interventions for [MEDICAL CONDITION] were completed for one (#22) of one resident reviewed for [MEDICAL CONDITION]. The facility census was 59. Findings include: Review of Resident #22's medical record revealed admission to the facility occurred on 12/19/12, with medical [DIAGNOSES REDACTED]. Review of Resident #22's physician orders [REDACTED]. Observations of Resident #22 occurred on 03/09/20 at 11:01 A.M., 0[DATE] at 8:25 A.M. and 0[DATE] at 8:25 A.M. The observations identified Resident #22 was up in her wheelchair and did not have the ordered TED hose on. Observation of 03/12/20 at 8:18 A.M., identified Resident #22 was up in her wheelchair in the main dinning room. The Director of Nursing stopped to check if Resident #22's TED hose were on and confirmed again they were not. Interview with State tested Nursing Assistant (STNA) #68 was completed on 03/11/20 at 8:40 A.M. The interview identified Resident #22 is gotten up by the night shift staff, which was an agency staff last night. The interview confirmed the agency staff have not been putting Resident #22's TED hose on before they get her up. The interview confirmed Resident #22 does not currently have her hose on as ordered. STNA #68 was asked to go to the computer to identify if this was listed on the STNA's tasks and she confirmed it is listed on the tasks to be completed for Resident #22.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review and staff interviews, the facility failed to ensure pressure ulcers for one (#55) of two residents were assessed on a weekly basis. The facility census was 59. Findings include: Review of Resident #55's medical record identified admission to the facility occurred on 09/24/19, with [DIAGNOSES REDACTED]. Review of the progress notes dated 01/03/20 at 12:24 A.M., identified Resident #55 had an open area to right buttock. Area cleaned with normal saline, allevyn applied. The record lacked any measurements of the open area. Review of the physician orders [REDACTED]. The record lacked any on-going assessments or measurements of the wound. Review of Resident #55's quarterly assessment dated [DATE], under section M, identified a unhealed pressure ulcer. The assessment identified the ulcer was listed as a stage II (Partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer). Observation of Resident #55's buttock occurred on 03/10/20 at 1:06 P.M. The observation identified the wound was healed. Interview with the Director of Nursing on 03/10/20 at 1:13 P.M., confirmed the facility has has a current pressure ulcer treatment for [REDACTED]. The interview confirmed all pressure ulcers should be assessed and measured weekly. The interview further identified physician orders [REDACTED].
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 and staff interviews, the facility failed to ensure one (#45) of two residents identified with weight loss had weights obtained to monitor for further issues. The facility census was 59. Findings include: Review of Resident #45's medical record identified admission to the facility occurred on 04/19/17, with medical [DIAGNOSES REDACTED]. Review of the dietary notes dated 10/23/19 identified Resident #45 had a new enteral tube feeding placed. The record identified Resident #45 was receiving all nutritional needs through the feeding tube. The record identified Resident #45 was noted with significant weight loss. Review of a care plan that was initiated on 01/29/20 revealed Resident #45 receives tube feeding for all nutrition. The plan identified weekly weights for 4 weeks and then monthly, if stable would be completed. The plan identified to notify the registered Dietician for significant weight changes. Review of Resident #45's weights, listed in the computer was completed on 03/09/20. The last weight that was obtained was 01/03/20. The chart identified no weekly weights or monthly weights were completed. The weight listed on 01/03/20 was 105.6 pounds and evidenced a -8.73 % Loss. The record identified on 08/02/19, Resident #45 weight was 115.7 pounds. Interview with Licensed Practical Nurse (LPN) #3 on 03/11/20 at 10:49 A.M., confirmed the facility used to have one State tested Nurse Assistant (STNA) that completed all the weights and placed them in the computer. The interview confirmed there are no weights noted for Resident #45, since 01/03/20. Interview with the Director of Nursing on 03/11/20 at 1:21 P.M., confirmed the facility staff should be placing all resident weights in the computer. The interview confirmed there are no weights listed for

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Resident #45 since 01/03/20. The interview confirmed the plan of care dated 01/29/20 identified she should have had weekly weights completed to monitor for possible further weight loss.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and review of the facility's policy, the facility failed to administer tube feeding per physicians order. This affected one (#9) of one resident reviewed for the care of tube feeding. The facility identified two residents receiving tube feed. The facility census was 59. Findings include: Review of Resident #9's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the physician orders, dated 01/08/20, revealed an order to administer enteral feed continuous every shift at 20 (ml) milliliters and hour and advance as tolerated 10 ml every twenty-four hours to goal of 40 ml every shift. Review of the care plan dated 12/17/19, revealed the resident required tube feeding for nutrition and hydration support. Observation on 03/11/20 at 9:58 A.M., and again at 10:40 A.M., the resident's tube feed was not being administered as ordered to run continuously for on three shifts. Interview with Licensed Practical Nurse (LPN) #34 on 03/11/20 at 10:40 A.M., confirmed the tube feeding for Resident #9 is a continuous feed and was not being administered as ordered. Review of the facility's policy titled Enteral Nutrition, undated, revealed adequate nutritional support through enteral feeding will be provided to residents as ordered and enteral nutrition will be ordered by the physician based on recommendations of the dietician.
F 0776 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.** Based on medical record reviews and staff interviews, the facility failed to ensure a STAT (immediate) X-ray was obtained timely. This affected one (#47) of two residents reviewed for accidents. The facility census was 59. Findings include: Review of Resident #47's medical record identified admission to the facility occurred on 12/20/11. The record revealed Resident #47 had severe pain in the hip area occurring on 03/05/20. The progress notes identified notification to the physician whom ordered a STAT X-ray to be completed. The order was placed into the electronic chart on 03/05/20 at 4:36 P.M. Review of the X-ray report identified the X-ray was not obtained until 03/06/20. The report identified Resident #47 did have a fracture in the hip area and was immediate sent to the hospital following the facility receiving the results on 03/06/20. Interview with the Director of Nursing (DON) on 03/12/20 at 11:10 A.M., verified the facility was unable to locate any procedures for ordering a STAT laboratory or X-ray test. The interview identified she looked into the issue and the staff working on 03/05/20 believed when they entered the X-ray order into the computer it automatically notifies the X-ray company of the need for the X-ray. The interview confirmed, because the order was written for STAT, the staff needed to call the X-ray company to ensure the order was received and completed immediately.
F 0838 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on record review and staff interview, the facility failed to ensure a comprehensive annual facility assessment to determine the resources necessary to assure the level and competencey of the staff to meet the needs of the resident. This had the potential to affect the 59 of 59 residents residing in the facility. The facility of census 59. Findings include: Review of the annual binder and additional annual information during the survey on 03/10/20 revealed no facility assessment. Interview with the Administrator on 03/10/20 at 1:36 P.M., revealed they do not have a facility assessment and is not aware of what the facility assessment consist of. In addition, does not have a policy regarding the facility assessment.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observations, review of quality assurance plans and staff interviews, the facility failed to implement action plan to ensure the facility environment was proper maintained for all residents. This affect 59 of 59 residents residing in the facility. The facility census was 59. Findings include: Review of the facility quality assurance program was conducted with the facility Administrator on 03/12/20. The sign in sheets identified a meeting was held on 08/20/19, which identified the shower rooms located in the facility were in need of repair. The program identified a performance improvement plan was going to be developed on 08/20/19 for the facility's shower room repairs. The facility was unable to locate any actual plan developed to correct the shower room repairs that were needed. Observations of the facility three showers rooms was conducted throughout the annual inspections from 03/09/20 through 03/12/20. The shower rooms were all in need of repair to the shower stalls, many of which were not functional, missing most of the flooring and or did not have functioning hot water. Interview with the facility Administrator on 03/12/20 at 9:58 A.M. confirmed she recently started at the facility and was not here at that time. The interview confirmed the facility has three shower room locations in the building and all three are in disrepair and or not working. The interview confirmed she was unable to locate any actual performance plan only the tracking that identified a plan was going to be implemented on 08/20/19. Interviews with multiple staff (whom wishes to remain anonymous) was conducted throughout the inspection completed from 03/09/20 through 03/12/20. The staff identified the facility has three shower room all which have been in disrepair for a long time. The interviews confirmed the shower rooms have multiple stalls which have broken water lines, missing flooring, ripped flooring, holes in the flooring, lack of hot water, missing tiles, walls and whirlpool tubs that do not work. The staff identified they can not get anyone to fix these issues. Staff confirmed all three shower rooms are affected and therefore all residents. The staff identified the shower rooms repair has been brought up at every quality improvement meeting since at least 08/20/19 and they just have not been able to get approved for the funding to repair/remodel these rooms.
F 0921 **Level of harm** - Minimal harm or potential for actual 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 staff interview, the facility failed to maintain its environment (shower rooms and boiler rooms) in a clean and sanitary manner. This had the potential to affect 59 of 59 residents. The facility census was 59. Findings include: 1. Observation of the boiler room on 03/11/20 at 4:40 P.M. revealed a leaking pipe and a bath basin in place to catch the water dripping from the leaking pipe Interview on 03/11/20 at 4:45 P.M., with Maintenance Director #58 verified the leaking pipe. 2. Observation of the three shower rooms in the facility on 03/12/20 between 7:30 A.M. and 7:45 A.M. noted the following concerns: -The Oakwood unit shower rooms floor was noted to be crumbling exposing the concrete floor which initiated a noticeable uneven surface that would present a tripping hazard to staff and residents. -The Juniper shower room contained noticeable peeling linoleum exposing the concrete floor and creating an uneven surface that would present a tripping hazard to staff and residents. - The Evergreen shower room contained noticeable peeling linoleum exposing the concrete floor and creating an uneven surface that would present a tripping hazard to staff and residents. Interview on 03/12/20 at 8:15 A.M. with Maintenance Director #58 verified the condition of the shower rooms. This deficiency substantiates complaint number OH 734