STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366271	A. BUILDING _____ B. WING _____	09/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACKSON RIDGE REHABILITATION AND CARE CENTER	7055 HIGH MILL AVENUE NW CANAL FULTON, OH 44614

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review and interview the facility failed to ensure Resident #45's responsible party and physician were notified timely following a decline in meal intake. This affected one resident (#45) of four residents reviewed for notification of change. Findings include: Review of Resident #45's closed medical record revealed Resident #45 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's medical record identified a daughter was listed as power of attorney (POA) for health care. Resident #45 was discharged to the hospital on [DATE]. Review of the weight record revealed on 03/09/20 the resident's weight was 152 pounds. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/15/20 revealed the resident was cognitively intact and needed set up assistance and supervision at meals. The MDS revealed the resident's weight was 152 pounds which reflected no weight loss. Review of the progress note, dated 04/07/20 revealed Resident #45 had a temperature of 100 degrees Fahrenheit and a cough. The note indicated she had had the cough for a couple days. The daughter was informed, the resident was in isolation, and a COVID-19 swab test was done. Review of the laboratory test report, dated 04/09/20 revealed Resident #45 was positive for COVID-19. Review of the State tested nursing assistant documentation in Resident #45's electronic medical record from 03/26/20 through 04/25/20 revealed a lack of documentation for many of the meal intakes. What meals were documented revealed Resident #45 had a decline in meal intakes beginning around 04/12/20. Previously, the resident's meal intakes were documented 51 to 100 percent, usually 76 to 100 percent. Beginning around 04/12/20, Resident #45's meal intakes varied between 0 and 50 percent, usually 0 to 25 percent. There was no indication the resident's physician and/or nurse practitioner and the POA were notified of the decreased appetite until 04/23/20 and 04/24/20 respectively. Review of a progress note by the nurse practitioner, dated 04/23/20 indicated per staff, resident has been medically declining, decreased appetite, and needing more hands on care for activities of daily living. A progress note dated 04/24/20 by Social Service (SS) #105 revealed she updated the POA. During an interview on 09/21/20 at 9:16 A.M., Licensed Practical Nurse (LPN) #100 indicated when Resident #45 was first admitted her appetite was okay. When she had COVID-19, her appetite was poor. During an interview on 09/21/20 at 12:57 P.M., the Director of Nursing (DON) indicated he could find no documentation indicating the physician, nurse practitioner, or POA were notified in a timely manner of the decline in Resident #45's appetite. The DON stated when you have COVID-19, you do not have an appetite. This deficiency substantiates Complaint Number OH 134.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on record review and interview the facility failed to ensure staff timely reported potential allegations of employee to resident abuse and failed to ensure all allegations of abuse were reported to the State agency as required. This had the potential to affect 19 residents (#6, #11, #12, #16, #17, #20, #21, #22, #24, #25, #27, #30, #31, #33, #35, #37, #38, #41 and #43) of 40 residents residing in the facility. Findings include: On 09/15/20 at 5:59 A.M. interview with State tested Nursing Assistant (STNA) #130 revealed she had witnessed staff to resident abuse. Upon further interview, the STNA revealed she had observed STNA #155 being abusive to the residents on the unit where this STNA worked. STNA #130 indicated in the past month or two, STNA #155 had been rude and stated petty, hateful things to residents on the unit. The STNA indicated she thought the issue had been taken care of as STNA #155 no longer worked in the facility. Review of a facility resident roster revealed 19 residents, Resident #6, #11, #12, #16, #17, #20, #21, #22, #24, #25, #27, #30, #31, #33, #35, #37, #38, #41 and #43 resided on the unit STNA #155 worked. On 09/15/20 at 7:30 A.M., an interview with Registered Nurse (RN) #140 who worked the 6:30 P.M. to 7:00 A.M. shift on the unit where STNA #155 worked, revealed she had observed STNA #155 being rude to residents. RN #140 revealed she had reported this behavior to administrative staff. Review of the facility self reported incidents (SRI's) related to abuse revealed there had been no reported incidents to the State agency during the past month or two with STNA #155 identified as the alleged perpetrator. On 09/15/20 at 8:04 A.M. interview with the Administrator revealed she was not aware of any complaints of STNA #155 being rude or verbally abusive towards residents. The Administrator verified no SRI's had been completed or submitted to the State agency within the past two months involving STNA #155. At the time of this investigation, STNA #155 was noted to be currently suspended related to another matter. On 09/21/20 at 1:20 P.M. interview with the Director of Nursing (DON) revealed the DON denied knowledge of STNA #155 being rude or verbally abusive to residents. Review of the facility Mistreatment, Abuse, Neglect, and Misappropriation of Resident Property policy, dated September 2016 revealed verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Review of the facility Reporting Abuse to Facility Management, revised November 2016 indicated any staff member or person affiliated with this facility who had witnessed or who believed a resident had been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report or cause a report to be made of, the mistreatment or offense. This deficiency is an incidental finding to Complaint Number OH 937.
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review and interview the facility failed to ensure laboratory test results for Resident #45 were reported timely to the physician and/or nurse practitioner. This affected one resident (#45) of four residents reviewed for notification of change. Findings include: Review of Resident #45's closed medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged to the hospital on [DATE]. Review of the progress note dated 04/07/20 indicated Resident #45 had a temperature of 100 degrees Fahrenheit and a cough. The note indicated the resident had the cough for a couple days. The daughter was informed, the resident was in isolation, and a COVID-19 swab test was done. Review of the laboratory tested reported 04/09/20 revealed Resident #45 was positive for COVID-19. The physician was notified and ordered Hydrochloroquine, [MEDICATION NAME], and laboratory testing. Review of laboratory results revealed laboratory tests were completed on 04/14/20, 04/17/20, 04/20/20 and 04/24/20. The test dated 04/17/20 indicated the resident's blood urea nitrogen (BUN) level was above the normal range and had gone up 19 milligrams

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 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) (mg)/decaliters (dL) over the previous laboratory test on 04/14/20 in which it was in the normal range. The BUN/creatinine ratio had also gone from within the normal range to above the normal range, going from 22 on 04/14/20 to 35 on 04/17/20. This could indicate conditions including dehydration or [MEDICAL CONDITION]. The test dated 04/20/20 indicated the BUN had again gone up 4 more mg/dL and the BUN/creatinine ratio 4 more points. Review of the record revealed no evidence laboratory tests, including a comprehensive metabolic panel and complete blood count completed 04/17/20 and 04/20/20 were reported to the physician in a timely manner. A progress note dated 04/23/20 by the nurse practitioner indicated she reviewed the laboratory test results. There is no evidence prior to 04/23/20, the physician or nurse practitioner were notified of the resident's laboratory testing including the abnormal lab results. During an interview on 09/21/20 at 1:08 P.M., the Director of Nursing (DON) revealed he could not find evidence the physician or nurse practitioner were notified of Resident #45's 04/17/20 or 04/20/20 laboratory results. He stated he or another nurse usually take a picture with their phone and send the results to the physician. He could not find evidence anyone did that. The DON indicated he was off work during that time period due to illness. This deficiency substantiates Complaint Number OH 134.
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 closed record review and interview the facility failed to ensure daily meal intakes were documented for Resident #45. This affected one resident (#45) of three residents reviewed for nutrition. Findings include: Review of Resident #45's closed medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #45 was discharged to the hospital on [DATE]. Review of the State tested nursing assistant documentation in Resident #45's electronic medical record from 03/26/20 through 04/25/20 revealed a lack of documentation for many of the meal intakes. There was no documentation of meal intakes on 03/28/20, 03/29/20, 03/30/20, 04/01/20, 04/07/20, 04/09/20, 04/10/20, 04/11/20, 04/13/20, 04/15/20, 04/16/20 and and 04/17/20. In addition, only one or two meals had documented meal intakes on 03/26/20, 03/27/20, 03/31/20, 04/02/20, 04/03/20, 04/04/20, 04/05/20, 04/06/20, 04/08/20, 04/14/20, 04/18/20, 04/19/20, 04/20/20, 04/21/20, 04/22/20, 04/23/20 and 04/24/20. On 09/21/20 at 12:57 P.M. interview with the Director of Nursing (DON) verified many meals were not documented to reflect Resident #45's meal intake as noted above. This deficiency is an incidental finding to Complaint Number OH 134.
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, policy review and interview the facility failed to maintain acceptable infection control practices to prevent the spread of infection during incontinence care for Resident #38. This affected one resident (#38) of two residents observed during incontinence care. Findings include: On 09/14/20 at 11:40 A.M., Resident #38's room was noted to have an odor of feces. An attempt to interview the resident was unsuccessful due to the resident being hard of hearing and the surveyor wearing a mask. At the time of the observation, Licensed Practical Nurse (LPN) #110 reported the odor to State tested Nursing Assistant (STNA) #115. On 09/14/20 at 11:46 A.M. STNA #115 was observed providing incontinence care to Resident #38. The STNA first obtained supplies, washed her hands, applied gloves and then proceeded to provide incontinence care. Resident #38 was incontinent of a large amount of liquid stool. During the observation, STNA #115 placed the soiled washcloths, towels, and bed pad with incontinence brief directly on the floor next to the resident's bed. The STNA also had to leave the room during the process to obtain additional supplies. She removed her gloves, cleansed her hands and left room. Upon returning to room, the STNA applied new gloves and continued to provide incontinence care cleaning the resident's front peri area, again placing soiled item on the floor. STNA #115 then changed the bottom sheet, placed the top sheet and blanket back on the bed, folded the sheet at top and tucked it under the resident's arms. She then used the bed control device to adjust the resident's bed. STNA #115 did all this wearing the same gloves she used to clean the front peri area of resident. The STNA then placed the soiled linen inside two separate bags, removed her gloves and carried the bags to soiled linen room where she washed her hands. On 09/14/20 at 12:05 P.M. STNA #115 verified she placed the soiled washcloths, towels and bed linen directly on the floor next to Resident #38's bed. She indicated she usually places soiled linen inside a plastic bag not on the floor. The STNA confirmed she did not wash or cleanse her hands after providing peri care or before touching the clean bed sheets, resident, and bed controls. Review of the facility Soiled Laundry and Bedding policy, revised July 2009 revealed soiled laundry and bedding contaminated with blood or other potentially infectious materials must be handled as little as possible and with a minimum of agitation. Place contaminated laundry in a bag or container at the location where it is used. Transport contaminated laundry in bags. Review of the facility Handwashing/Hand Hygiene policy, revised August 2015 revealed all personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infection. The policy indicated to use an alcohol-based hand rub containing at least 62% alcohol or alternatively soap and water for situations including before moving from a contaminated body site to a clean body site and after contact with blood or bodily fluids. This deficiency is an incidental finding to Complaint Number OH 134.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to timely notify Resident #37's responsible party of a positive coronavirus (COVID-19) test result. This affected one resident (#37) of three residents reviewed for COVID-19. Findings include: Review of Resident #37's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review revealed the resident's son was listed as her emergency contact. Review of quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/05/20 revealed the resident was cognitively intact. Review of a progress note, dated 04/10/20 revealed the social service designee spoke with Resident #37's son to inform him of the presence of COVID-19 in the facility. She also informed him the resident had shown at least one symptom of [MEDICAL CONDITION] and was being tested for COVID-19. The social service designee indicated as soon as the facility received results, he would be notified. Review of the laboratory test to detect COVID-19 indicated a specimen was obtained on 04/10/20. The results, reported to the facility on [DATE] were positive for COVID-19. Review of the medical record revealed on 04/21/20 Social Service Designee (SSD) #105 attempted to reach Resident #37's son. The voice mailbox was full so no message was left. There was no other indication the facility attempted to notify the son of the resident's positive COVID-19 results. On 09/21/20 at 9:16 A.M. interview with Licensed Practice Nurse (LPN) #100 revealed administrative staff were completing the notification of families for residents with positive COVID-19 tests. On 09/21/20 at 12:45 P.M. interview with the Director of Nursing (DON) confirmed there was no evidence the facility attempted to notify Resident #37's son of the positive COVID-19 test until 04/21/20 (six days after the positive test results were provided) with no success. This deficiency substantiates Complaint Number OH 134 and Complaint Number OH 937.