STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365579	A. Building B. Wing	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carroll Healthcare Center Inc	648 Longhorn Street Carrollton, OH 44615

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 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** 46195 Based on observations, staff and resident interviews, medical record review, and facility policy review, the facility failed to ensure Resident #18, who was highly visibly impaired and dependent on staff, was able to locate call light, and Resident #142's call light was within reach. This affected two residents (#18 and #142) of 16 residents screened for call lights. The facility census was 40. Findings include: 1. Review of medical record for Resident #18 revealed an admitted [DATE] and pertinent diagnoses included cerebral infarction (stroke) due to thrombosis (blood clot) of right posterior cerebral (brain) artery, major depressive disorder, restless and agitation, and repeated falls. Review of care plan dated 12/29/22 revealed Resident #18 required limited to extensive assistance, had a potential risk for falls related to poor safety awareness and repeated falls, was blind related to cataracts. Interventions included explaining use of call light and assess ability to use as needed. Review of optometrist exam on 02/27/23 revealed Resident #18 was evaluated for decreased vision in the left and right eye, had decreased vision which affected both near and far vision, and the condition was constant and significant. The exam revealed Resident #18 had changed in retinal vascular appearance and had developed visibly significant age-related cataracts. Review of quarterly Minimum Data Set (MDS) assessment, dated 04/06/23, revealed Resident #18 had highly impaired vision and was dependent on staff for all activities of daily living. Observation and interview on 05/03/23 at 7:50 A.M. revealed Resident #18 sitting in wheelchair with the bed to his right. [NAME] call light cord was observed wrapped around the white positioning bar on the bed. When asked where his call light was, Resident #18 stated I don't know. When asked to show where the call light was located, Resident #18 took his right hand and touched around the top part of bed where the pillow was located and stated, I don't know. (continued on next page)

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/03/23 at 8:18 A.M. revealed State tested Nursing Assistant (STNA) #146 told Resident #18 his call light was located to his right. The call light was observed wrapped around the positioning bar at the top of bed to the right of Resident #18. At the time of observation, along with STNA #146, Resident #18 was asked by the surveyor to locate the call light. Resident #18 touched the pillow and stated it was right there on the pillow. STNA #146 confirmed at the time of observation, Resident #18 could not locate the call light which was wrapped around the positioning bar. Interview on 05/03/23 at 8:26 A.M. with the Director of Nursing (DON) revealed for those with impaired vision, the facility had used colored tape on the call light to help residents better locate the call light. Observation and interview on 05/03/23 at 11:20 A.M. revealed Resident #18 sitting in a wheelchair, and the bed was to his right. The white call light cord was observed laying on top of a red Ohio State blanket in the middle of his bed. When asked where the call light was, Resident #18 stated I don't know. 35765 2. Review of the medical record revealed Resident #142 was admitted to the facility on [DATE]. Diagnoses included intracerebral hemorrhage, hemiplegia, peripheral vascular disease, and chronic pain syndrome. Review of the Five-day Medicare Minimum Data Set assessment dated [DATE] revealed Resident #142 had severely impaired cognition. She required extensive assistance of two staff members for bed mobility, dressing, toilet use and personal hygiene. Observation on 05/01/23 at 9:33 A.M. revealed Resident #142 was in bed and her touch pad call light was hanging up clipped to the call light outlet on the wall. An interview at 9:35 A.M. with Licensed Practical Nurse #178 verified Resident #142's call light was hanging up on the wall outlet and she was unable to reach it while laying in her bed. Review of the undated facility policy titled, Call Light, Use of, revealed the purpose was to respond promptly to resident's call for assistance and to ensure call system was in proper working order. When providing care to a resident, be sure to position the call light conveniently for the resident to use. Tell the resident where the call light was and show them how to use the call light. Be sure all call lights were placed within the reach of each resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46195 Based on observation, interviews and facility policy review, the facility failed to ensure the kitchen was clean and sanitary and items were dated. This had the potential to affect all residents except Resident #33, who was identified as receiving nothing by mouth. The facility census was 40. Findings include: Observation on 05/01/23 from 8:12 A.M. to 8:30 A.M. with Dietary Manager #144 of the kitchen and outside area where the walk-in cooler and freezer were located revealed the following concerns: In the three door reach-in in freezer was observed one gallon storage bag of six breadsticks undated, one half of an opened and resealed factory bag of peas and carrots undated, one half of an opened and resealed factory bag of spinach undated, four individual servings of sauerkraut wrapped in plastic wrap not labeled or dated, one gallon storage (one half full) of mushrooms undated, and one half of a box of hamburger patties open to air. Observation of the walk-in freezer located on the outside of the building revealed an accumulation of black dust blowing from the condenser fans. Observation of the walk-in cooler revealed an offensive odor coming from the unit. The floor of the unit had numerous black corrosion spots. Observed under the shelves of the thawing meat was a pool of black liquid. Sitting on the shelves near the back wall was observed to be one gray standard utility tub which contained one bag of sausage links, one bag of pork chops, and one bag of ground sausage which was undated when pulled; one brown standard utility tub which contained 14 individually sealed Swiss steaks which was not dated when pulled; and one black standard utility tub which contained three bags of chicken which was not dated when pulled. Observed on the shelf on the right-hand side of the walk in cooler was one three fourth, opened and resealed with plastic, log of sliced Swiss cheese undated. Observation of the reach in ice cream freezer located in the kitchen area revealed no thermometer. Observation of the microwave revealed a buildup of multicolored splatter marks on the top inside of unit. Observation of the stand mixer revealed there were white food splatters observed on the metal bowl guard and an accumulation of white and brown food splatters on the base of the unit. At the time of observation, Dietary Manager #144 confirmed the findings. Review of facility policy Food Receiving and Storage, revised July 2014, revealed food service department would always maintain clean food storage areas; all foods stored in the refrigerator or freezer would be covered, labeled and dated; and uncooked and raw animal products and fish would be stored in drip proof containers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy Sanitation, revised October 2008, revealed all kitchens, kitchen areas and dining areas would be kept clean, all equipment would be kept clean.