STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365634	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McCrea Manor Nsng and Rehab Ctr LLC	2040 McCrea Street Alliance, OH 44601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 39333 Based on observations, interview and record review, the facility failed to ensure residents were provided activities on the memory care unit. This affected 15 (#8, #11, #16, #24, #26, #27, #35, #42, #44, #47, #49, #52, #53, #55, and #57) of 16 residents residing on the memory care unit. Resident #31 was identified as a resident taken off the memory care unit for activities. The facility census was 68. Findings include: Observation on 08/26/24 at 3:02 P.M. of the memory care dining room revealed the television was on the music channel, few residents were sitting at the tables, and agency State tested Nursing Assistant (STNA) #500 was sitting at a table eating potato chips, drinking pop, and looking at her phone. STNA #500 stated she was on a small break and not there to do activities. Observation and interview on 08/26/24 at 3:30 P.M. revealed STNA #236 was coming out of a male resident's room and standing near the doorway. STNA #236 stated that she was trying to redirect a female resident out of the male resident's room. STNA #236 stated that she was standing at the doorway to keep an eye on the female resident and would reapproach in a few minutes. STNA #236 verified that there were no activities going on, but she was taking care of residents. Interview on 08/26/24 at 3:45 P.M. with the Director of Nursing (DON) revealed that one STNA was supposed to do activities at 3:00 P.M. because the residents got antsy before dinner, while the other STNA took care of the residents that were not in activities. Agency staff should find out their responsibilities from the facility staff. Interview on 08/27/24 at 10:59 A.M. with Activity Assistant (AA) #212 revealed she organized and completed the activities for the skilled residents and tracked the activities for all residents. AA #212 stated that there was not a specific time for movies to be shown in the memory care unit, but she assumed that the staff put a movie on the television which was their activity. AA #212 verified that music was played in the memory care unit from 10:00 A.M. through 3:30 P.M. and although she documented the residents participated in a movie activity no movie was provided for the residents to watch. AA #212 also documented all residents participated in reading and reality orientation because she delivered daily chronicles to the memory care unit and the STNAs were supposed to go over it with the residents and she assumed they did. The daily chronicles were documented as reading and reality orientation because they included the day and date on them. (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/27/24 at 11:40 A.M. with the DON revealed that the activity department documented activities as completed, not the STNAs but the DON did not know how the STNAs communicated with the activity department regarding what activities were completed and when. The DON also indicated morning care could hinder activities from being completed. Review of the staff in-service dated 02/27/24 revealed STNAs were to complete activities with the residents at 9:30 A.M. and 3:00 P.M. Interview with the Director of Nursing on 08/26/24 at 3:45 P.M. verified that the in-service was provided to STNAs. Review of the memory care unit activity calendar revealed that there were only two activities scheduled daily at 9:30 A.M. and 3:00 P.M. There were no evening activities on the memory care unit. Review of the current resident census revealed Residents #8, #11, #16, #24, #26, #27, #31 #35, #42, #44, #47, #49, #52, #53, #55, and #57 resided on the memory care unit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, medical record review, interview, and review of facility policy, the facility failed to ensure Resident #9's wound related treatments were implemented as ordered; Resident #18's skin was assessed and treatments were applied as ordered; Resident #34's thrombo-embolic deterrent (TED) hose and geriatric sleeves were implemented as ordered; and Resident #45's percutaneous endoscopic gastrostomy (PEG) tube dressing was implemented as ordered. This affected three (Residents #9, #18 and #34) of three residents reviewed for general skin conditions; and one (Resident #45) of one resident reviewed for PEG tube care. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus with other circulatory complications, diabetic neuropathy, intervertebral disc degeneration of the lumbar region, fibromyalgia, depressive disorder, and stage three kidney disease. Review of the active diagnoses further revealed an additional diagnosis added on 07/15/24 of a left foot ulcer with fat layer exposed, and additional diagnoses added on 08/05/24 of a left foot ulcer with bone involvement and an unspecified wound to the left lower leg. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 08/07/24 revealed Resident #9 had intact cognition. Further review of the MDS assessment revealed Resident #9 had a diabetic foot ulcer and skin tears and received applications of non-surgical dressings to his feet and to a site other than his feet. Review of the physician orders revealed an order dated 08/07/24 to cleanse the left foot with normal saline solution (NSS), pat dry, apply Medihoney and a foam dressing at bedtime every other day. Further review of the orders revealed skin assessments were to be completed on night shift weekly every Saturday and if any new skin areas were noted, the nurse was to complete a N Adv-skin only evaluation. Another order, dated 08/05/24, revealed Resident #9 was to wear an offloading shoe to his left lower extremity. Review of the care plan with date span of 05/30/23 through 10/09/24 revealed Resident #9 had the potential for altered skin integrity with development of a diabetic foot ulcer on 05/22/24, a vascular ulcer on the left medial great toe on 07/08/24, and a skin tear of the leg on 08/05/24. Interventions included adherence to enhanced barrier precautions, floating heels when in bed, inspection of skin during routine daily care, and application of treatments as ordered. Review of the weekly skin assessments revealed no documentation of assessment outcomes between 12/11/23 and 08/08/24. The three weekly documented skin assessments completed on 08/08/24, 08/15/24, and 08/22/24 revealed Resident #9 had fair to poor skin turgor, bilateral edema (unspecified upper, lower, or generalized), and no new skin areas of concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the N Adv - Skin only evaluation created on 02/02/24, 04/04/24, 04/18/24, 04/25/24, 05/02/24, 05/09/24, 05/16/24, 06/06/24, and 07/11/24 revealed each note stated that Resident #9's skin was warm and dry, skin color was within normal limits (WNL), skin turgor was normal, there were no external devices, and no skin issues. No other assessment criteria or details were included on these forms and there was no indication as to what new skin area, if any, was noted on the dates listed. Further review of the N Adv - Skin only evaluation forms revealed no documentation of the new skin areas noted per the care plan that developed on 05/22/24, 07/08/24, or 08/05/24. Review of the wound consultant progress note completed by Certified Nurse Practitioner (CNP) #206 on 05/22/24 revealed an initial evaluation of a left lateral diabetic foot ulcer measuring 1.4 centimeters (cm) by 0. 9 cm by 0.1 cm with a small amount of serous drainage and orders to cleanse with NSS, apply collagen to the wound bed, cover with a foam dressing, and change three times a week and as needed. Interventions recommended by CNP #206 included offloading and repositioning. Review of the wound consultant progress note completed by Certified Nurse Practitioner (CNP) #206 on 07/08/24 revealed the left lateral diabetic foot ulcer measured 1.5 cm by 1.3 cm by 0.1 cm with a moderate amount of serous drainage and new orders to cleanse with NSS, apply Medihoney, silver alginate, and abdominal pad (ABD), and wrap in Kerlix daily and as needed. Further review of the wound note revealed a new vascular ulcer to the left great toe with orders for the nurse to apply Skin Prep (barrier film) every shift. Review of the wound consultant progress note completed by CNP #206 on 07/15/24 revealed the left lateral diabetic foot ulcer measured 1.5 cm by 2 cm by 0.1 cm with a moderate amount of serous drainage and the vascular wound to the left great toe measured 0.5 cm by 0.5 cm with zero depth. Review of the wound consultant progress note completed by CNP #206 on 07/22/24 revealed the left lateral diabetic foot ulcer had worsened and measured 2.1 cm by 2.4 cm by 0.7 cm with purulent drainage. A wound culture was obtained, treatment orders were updated, and Resident #9 was ordered Doxycycline (antibiotic) 100 milligrams (mg) by mouth twice daily for seven days pending results of the wound culture. The vascular ulcer to the left great toe was assessed as stable during the wound CNP's visit on this date. Review of the wound culture lab report dated 07/23/24 revealed the following growth of organisms: - high growth of Enterococcus faecalis - high growth of Morganella morganii - high growth of Bacteroides fragilis - high growth of Proteus miribilis/Proteus vulgaris - high growth of Staphylococcus aureus (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the wound care visit notes from the new facility wound Nurse Practitioner (NP) #208 dated 08/05/24 revealed NP #208 provided wound assessment and care on 07/29/24 and on 08/05/24. Review of the visit note dated 08/05/24 revealed Resident #9's left lateral diabetic foot ulcer was improving after debridement performed on 07/29/24 and measured 1.16 cm by 1.29 cm by 0.1 cm with moderate serosanguinous drainage. Further review of the visit note revealed identification of a wound to the left anterior lower leg measuring 8.82 cm by 3.11 cm by 0.1 cm with an order to cleanse the left lower extremity wound with NSS, pat dry, apply Medihoney, and cover with a dry sterile dressing daily and as needed. Further review of the note revealed continued use of shoes could delay wound healing and the treatment plan moving forward was to discontinue footwear to the left foot and provide a surgical shoe for offloading. Observation on 08/26/24 at 8:23 A.M. revealed a bandage to Resident #9's left leg dated 08/23/24 with a large amount of light brown dried drainage soaked through the dressing. Further inspection of the left leg revealed one small open skin lesion just above the sock line seeping serous drainage just below the edge of the tape from the dressing and dried serosanguinous drainage the size of a nickel on his sock just below the anterolateral aspect of his ankle. An interview with Resident #9 at the time of the observation confirmed it had been a few nights since a nurse changed the dressing. Interview on 08/26/24 at 8:38 A.M. with Registered Nurse (RN) #219 confirmed the date on the dressing was 08/23/24 and it was soiled. At this time, Resident #9 stated the dressing only got changed when one nurse was on shift (Licensed Practical Nurse #232). Interview on 08/27/24 at 9:20 A.M. with the facility wound nurse, Assistant Director of Nursing (ADON) #218 confirmed the advanced skin assessments (N ADV - Skin only Evaluations) were to be opened and completed by the nurse whenever a new skin concern was found and should include location of the wound, wound type, and assessment of the wound status, including measurements. ADON #218 further confirmed this form would serve as the facility's initial wound assessment and if the complete wound assessment was not documented on this form, the facility did not have record of the initial wound assessment so the wound information would only be found by reviewing the Nurse Practitioner's visit progress notes. Observation on 08/27/24 at 10:29 A.M. with Resident #9 confirmed he was wearing his brown tie-up casual dress shoes on both feet and no offloading shoe. An interview conducted with Resident #9 during this observation confirmed he had no special shoe on his left foot, was wearing a regular shoe on his left foot, and did not have a surgical offloading shoe in his possession, as he also pointed out all his pairs of shoes that he stored under his bed. Interview on 08/27/24 at 10:41 A.M. with RN #219 confirmed he was unaware of the order for the offloading shoe and had not seen an offloading shoe being worn by Resident #9. Interview on 08/27/24 at 5:05 P.M. with ADON #218 confirmed there were two weeks another company provided wound care services and there were two weeks there was no wound physician or Nurse Practitioner following the residents with wound care needs. ADON #218 further confirmed that she had no knowledge of Resident #9 having an offloading shoe per orders. Interview on 08/28/24 at 10:4 A.M. with Physical Therapist (PT) #252 confirmed she had not seen Resident #9 in an offloading shoe for therapy sessions and had no knowledge of the order but assumed it could have been ordered to keep the pressure off the wound on his foot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/28/24 at 12:15 P.M. with ADON #218 confirmed wound NP #208 recommended Resident #9 should not wear shoes on his left foot and ordered an offloading shoe during the visit rendered on 08/05/24. ADON #218 further confirmed she did not know who put the order into the medical record or why nobody followed through by ordering the surgical offloading shoe but would follow-up with the new wound care practitioner. Review of the policy titled Wound Care last reviewed in August 2024 revealed wounds were to be cleansed, dressings applied per orders, and wound care related treatments applied as ordered. The policy further revealed treatments were to be documented in the electronic medical record, along with resident refusals and reasons for the refusal. 2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including respiratory failure with hypoxia, constipation, cognitive impairment of unknown etiology, protein-calorie malnutrition, anxiety disorder, unspecified dementia, hypertension, atherosclerotic heart disease, and depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment completed on 08/12/24 revealed Resident #18 had intact cognition and required supervision or touching assistance with bathing and personal hygiene. Further review of the MDS assessment revealed Resident #18 was not receiving dressings or wound care but did have applications of ointments to locations other than her feet. Review of the care plan dated 04/06/20 through 09/30/24 revealed Resident #18 had the potential for altered skin integrity due to decreased mobility, incontinence, and age-related fragile skin. Interventions included minimizing irritation and dryness, keeping skin clean and dry, linens clean, dry and wrinkle free, minimizing moisture exposure, observing for signs of skin breakdown, and alerting the charge nurse and notifying the physician as needed for treatment orders. Review of the physician orders revealed an order dated 03/03/24 for Resident #18 to have skin assessments completed weekly every Sunday night and if any new skin areas were noted, the nurse was to complete a N Adv-skin only evaluation. Further review of the orders revealed an order dated 08/06/24 for Telfa, Kerlix, and Coban to Resident #18's right lower leg once daily for blisters. There were no orders for cleansing the blisters or for any ointments. Another order, dated 08/21/24, revealed Resident #18 was to have all cotton elastic (ACE) wraps applied to her bilateral lower extremities from her toes to her knees every morning and removed every evening at bedtime. Review of the weekly skin assessments in the electronic medical record revealed the last assessment had been documented on 11/20/23. Review of the shower sheets from 07/11/24 through 08/27/24 revealed the state tested nurse aide (STNA) performing showers on those dates noted blisters on 08/06/24, 08/08/24, 08/11/24 and the shower sheets were co-signed by a nurse. No nursing assessment was provided on the shower sheets. The shower sheet dated 08/21/24 was filled out by the wound care nurse/Assistant Director of Nursing (ADON) #218, which noted a scab to the right LE. With no other accompanying wound details. The shower sheet dated 08/27/24 revealed the STNA providing Resident #18's shower noted a scab to the right LE which was co-signed by a nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes revealed a note dated 08/04/24 with the following note text: Resident concerned about right lower leg. states its painful and not healing. blisters noted to leg oozing purulent drainage. leg cleansed well. The note further revealed the physician was aware and there was no redness or warmth to the touch. Further review of the progress notes revealed there were no other notes regarding the blisters on Resident #18's right lower leg. Review of the progress notes revealed Resident #18 refused her bilateral ACE wraps on 08/27/24 and on 07/22/24. Review of the documents in the electronic medical record revealed no wound care provider progress notes related to the blisters on Resident #18's right lower leg. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for the month of August 2024 revealed nurses documented wound care had been completed as ordered daily each morning from 08/06/24 through 08/27/24 and the ACE wraps were applied daily from 08/01/24 through 08/28/24 except for no documentation on 07/07/24 and a noted resident refusal on 08/27/24. Observation on 08/25/24 at 12:34 P.M. revealed Resident #18 had a black, dried dime-sized scab on her right shin and a pea-sized open lesion just below the scab. Further observation revealed the right lower extremity was slightly more edematous than the left lower extremity. An interview conducted with Resident #18 at the time of the observation confirmed she was supposed to have cream to her right shin wounds, but never got it. Resident #18 further stated she felt it had been infected at one point, but nobody would take a swab to rule it out. Resident #18 further stated her right shin burned at times, more so at night. There were no ACE wraps noted at the time of this observation and interview. Observation on 08/26/24 revealed Resident #18 had a dressing wrapped in Coban to her right shin, but no ACE wraps to either lower extremity. Interview on 08/27/24 at 10:49 A.M. with Registered Nurse (RN) #219 after observing Resident #18 with no dressing to her right lower leg confirmed Resident #18 had an order for a dressing because she preferred her wound to be covered. RN #219 further stated it was his assessment the healing blisters should be left open to air and confirmed when nurses did apply a dressing, Resident #18 yelled to have the dressing removed after a few hours because she was non-compliant and dangled her legs all day, causing increased fluid retention. During the interview, RN #219 was unable to say what the etiology was for the blisters. Interview on 08/27/24 at 9:20 A.M. with the facility wound nurse, Assistant Director of Nursing (ADON) #218 confirmed the advanced skin assessments (N ADV - Skin only Evaluations) were to be opened and completed by the nurse whenever a new skin concern was found and should include location of the wound, wound type, and assessment of the wound status, including measurements. ADON #218 further confirmed this form would serve as the facility's initial wound assessment. Interview on 08/27/24 at 5:05 P.M. with ADON #218 confirmed there were two weeks another company provided wound care services and there were two weeks there was no wound physician or Nurse Practitioner following the residents with wound care needs. ADON #218 further confirmed that she was uncertain of the date of onset or the etiology of Resident #18's skin concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/28/24 at 7:47 A.M. of Resident #18 revealed she was sitting in her wheelchair with no ACE wraps to her bilateral lower legs and her blisters were open to air. Resident #18 confirmed she was not approached about having her ACE bandages applied on this date and pointed to her dresser, which contained a roll of Coban and padded foam, stating she did not have ACE wraps in her room. Interview on 08/28/24 at 8:14 A.M. with STNA #247 confirmed Resident #18 was not wearing her bilateral ACE wraps and she did not know where the ACE wraps were kept. Interview on 08/28/24 at 8:09 A.M. with Licensed Practical Nurse (LPN) #315 confirmed she did not receive report that Resident #18 refused application of her ACE wraps and was unaware she was not wearing them. A follow-up interview with LPN #315 on this date at 8:28 A.M. confirmed Resident #18 was not wearing her bilateral ACE wraps as ordered and the Medication Administration Record reflected documentation they had been applied. Interview on 08/28/24 at 12:03 P.M. with ADON #218 revealed she just learned about Resident #18's blisters today or late yesterday and was uncertain as to the etiology or date of onset. During the interview, ADON #218 confirmed the order did not indicate the reason for the bilateral ACE wraps and she did not know why they were to be worn. ADON #218 confirmed Resident #18 had not been seen on weekly wound rounds and she was never made aware when the new skin concern was found. During the interview, ADON #218 confirmed staff had been reeducated on not signing off on treatments they had not administered, and it had been an ongoing concern that the facility was addressing. Review of the policy titled Wound Care last reviewed in August 2024 revealed wounds were to be cleansed, treatments applied, and dressings applied per orders. The policy further revealed treatments were to be documented in the electronic medical record, along with resident refusals and reasons for the refusal. 33019 3. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, asthma, dementia, diabetes mellitus, congestive heart failure, and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/05/24, revealed Resident #34's Brief Interview for Mental Status (BIMS) score was 14, which indicated intact cognition. There were no behaviors or rejection of care. The assessment indicated the resident had skin tears. Review of the Care Plan, dated 10/16/23, revealed Resident #34 was at risk for impaired skin integrity related to impaired mobility, diabetes mellitus, edema of the lower extremities, and age-related fragile skin with the intervention to apply geriatric (geri) sleeves (skin protection sleeves). Review of physician order, dated 10/24/23, revealed the order for thrombo-embolic deterrent hose (TED) hose to be applied to bilateral lower extremities, to be on in the A.M. and off in the P.M. Further review revealed the physician order, dated 01/15/24, for geri sleeves to be worn on the bilateral upper extremities to protect against skin tears, to be on in the A.M. and off in the P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 08/27/24 at 9:10 A.M. and again at 11:00 A.M. revealed Resident #34 was not wearing geri sleeves on his upper extremities or TED hose on his lower extremities as ordered by the physician. During interview on 08/27/24 at 11:01 A.M., State-tested Nursing Assistant (STNA) #300 confirmed Resident #34 was not wearing his geri sleeves or TED hose. STNA #300 stated would apply both as soon as possible. During interview on 08/27/24 at 11:02 A.M., Licensed Practical Nurse (LPN) #269 confirmed Resident #34 was not wearing geri sleeves on his upper extremities or TED hose on his lower extremities as ordered by the physician. During interview on 08/28/24 at 11:07 A.M., the Director of Nursing confirmed Resident #34 should be wearing geri sleeves and TED hose as ordered by the physician. 34297 4. Review of Resident #45's physician orders revealed an order dated 04/25/23 for the percutaneous endoscopic gastrostomy (PEG) site t-drain dressing to be changed twice daily every shift. Observation on 08/26/24 at 8:42 A.M. with Licensed Practical Nurse (LPN) #269 of Resident #45's PEG tube medication administration revealed a PEG tube t-drain dressing was not in place. Interview on 08/26/24 at 8:50 A.M. with LPN #269 confirmed Resident #45's PEG tube t-drain dressing was not in place as ordered. Review of the Gastrostomy/Jejunostomy Site Care policy revised October 2011 revealed the purpose of the procedure was to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection.

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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** 34297 Based on observation, record review and interview, the facility failed to ensure Residents #4 and #19's pressure ulcer wound care was completed as ordered. This affected two (#4 and #19) of two residents reviewed for pressure ulcer wounds. Findings include: 1. Review of Resident #4's medical record revealed the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure with hypercapnia, multiple sclerosis and chronic pain syndrome. Review of Resident #4's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #4's skin care plans revealed an intervention dated 07/24/24 for treatments as ordered by the physician. Resident #4 was discharged to the hospital on 07/21/24 and returned on 07/24/24. Review of Resident #4's Pressure Ulcer Risk Assessment form dated 07/23/24 revealed the resident's pressure sore risk was 15 or low risk of developing pressure ulcer wounds. Review of Resident #4's hospital discharge paperwork dated 07/24/24 revealed new orders to clean the sacrum wound with normal saline, apply aquacel ag (provides rapid and sustained antimicrobial activity), 4 x 4, cover with foam dressing, change daily and as needed and an order to clean the right buttock wound with soap and water, apply Medihoney (medical-grade honey-based dressing to treat wounds and burns) to wound bed and cover with foam dressing change daily and as needed. Review of Resident #4's medical record revealed no evidence the aquacel ag to the resident's sacrum was implemented from 07/24/29 to 07/29/24. Observation on 08/25/24 at 2:43 P.M. with Assistant Director of Nursing (ADON) Wound Nurse #218 of Resident #4's right buttock and sacral wound care revealed the nurse setup a clean field on the resident's overbed table, washed her hands, put on gloves, removed the undated soiled dressings on the right buttock and sacral pressure wounds, placed the soiled dressings in the trash, cleansed the wounds on the right buttock and sacrum with normal saline and 4 x 4's, removed her gloves, washed her hands, applied Santyl (enzymatic debriding agent) on a 4 x 4 dressing and then used the 4 x 4 dressing to place the Santyl into the wound beds of both the right buttock and sacrum pressure wounds and then covered the right buttock and sacral wounds with dry dressings. Interview on 08/25/24 at 2:47 P.M. with ADON Wound Nurse #218 confirmed she did not remove her gloves and complete hand hygiene after she removed the visibly soiled dressing from Resident #4's right buttock prior to completing the rest of the wound care for the resident. ADON Wound Nurse #218 also confirmed she did not complete appropriate hand hygiene between Resident #4's right buttock pressure ulcer wound care and the Sacral pressure ulcer wound care. (continued on next page)

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	365634	A. Building B. Wing	08/28/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/26/24 at 12:19 P.M. with ADON Wound Nurse #218 confirmed Resident #4's pressure ulcer wound care treatment order dated 07/24/24 to clean the sacrum wound with normal saline, apply aquacel ag, 4 x 4, cover with foam dressing, change daily and as needed was not implemented from 07/25/24 to 07/29/24. 2. Review of Resident #19's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, hypothyroidism and major depressive disorder. Review of Resident #19's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #19's physician orders revealed an order dated 06/17/24 to lightly pack triad infused gauze into the wound bed and cover with a foam dressing daily and as needed (discontinued 08/26/24). Review of Resident #19's pressure ulcer risk assessment dated [DATE] revealed the resident's pressure sore risk was 11 or moderate risk of developing pressure ulcer wounds. Review of Resident #19's care plans revealed an intervention revised 07/24/24 to provide for wound care as ordered. Review of Resident #19's Weekly Wound Round Notes form dated 08/19/24 revealed the resident had an inferior sacral pressure ulcer wound Stage 4 (in house acquired) dated 05/22/24 which measured 0.6 cm length by 0.3 cm width by 0.1 cm depth. The document stated it was an older Stage 4 pressure wound that had re-opened. Observation on 08/25/24 at 4:25 P.M. with Assistant Director of Nursing (ADON) Wound Nurse #218 of Resident #19's sacral wound revealed no dressing was implemented on the pressure ulcer wound. Interview on 08/25/24 at 4:30 P.M. with ADON Wound Nurse #218 confirmed Resident #19's pressure ulcer dressing was not in place as ordered. Interview on 08/25/24 at 4:35 P.M. with State tested Nurse Aide (STNA) #220 revealed he had provided incontinence care for Resident #19 around 2:00 P.M. and the resident did not have a pressure ulcer dressing on her sacral wound. STNA #220 confirmed he did not report this to the nurse. Review of the Wound Care policy dated August 2021 revealed to verify the physician order, review resident care plan, assemble equipment and supplies, place a barrier on the bedside table to establish a clean field, wash and dry hands, position resident, put on exam glove and loosen tape to remove old dressing and discard the old dressing, remove gloves and wash hands, put on new gloves, cleanse the wound as ordered, apply treatments as indicated, dress wound and mark tape with initials, date and time of dressing applied. This deficiency represents non-compliance investigated under Complaint Number OH00156815.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview, and review of facility policy, the facility failed to ensure resident comprehensive care plans were updated and individualized, or that staff were aware of the resident's current smoking status and interventions. This affected four residents (#9, #13, #17 and #31) of six residents (#9, #13, #17, #31, #52, and #59) who were reviewed for smoking. The facility also failed to ensure Resident #53 was free of accidents hazards. This affected one out of three residents reviewed for falls (#8, #53, and #59). The facility census was 68. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus with other circulatory complications, diabetic neuropathy, intervertebral disc degeneration of the lumbar region, fibromyalgia, depressive disorder, diabetic foot ulcer, unspecified wound to the left lower leg, and stage three kidney disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 08/07/24 revealed Resident #9 had intact cognition and was on a scheduled pain regimen. Further review of the MDS assessment revealed Resident #9 had no impairments of his upper or lower extremities limiting his range of motion and he used a walker and a wheelchair to aid in mobility. Review of the physician orders revealed an order dated 05/26/23 stating it was permitted for Resident #9 to sign himself out and go to the resident smoking area to smoke as needed. Review of the [NAME] Manor Resident Smoking Agreement signed 03/22/24 revealed Resident #9 had permission to leave the building for personal smoke breaks by signing out at the nurse's station leave of absence (LOA) binder and signing back in upon return from the smoke break. Resident #9 was to return his lighter and smoking materials to the nurse upon his return from LOA and he understood he was not allowed to keep the smoking materials in his room or on his person. The document further stated no LOAs were permitted after 10:00 P.M. without the administrator's approval. Review of the document titled [NAME] Manor LOA Smoking Rules dated 08/19/24 revealed Resident #9 agreed to the following rules: - Sign-out in the LOA binder each visit - Smoke in designated area only (near the picnic tables) - No smoking on walkway or sidewalks - Always dispose of cigarettes in the ashtray - Sign-in in the LOA binder each visit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 05/30/23 through 10/09/24 revealed Resident #9 used tobacco. Interventions included conducting smoking safety evaluations on admission and as needed, providing Resident #9 with education on the smoking policy, and orienting Resident #9 to the facility's smoking times and procedures. The care plan goal was for Resident #9 to adhere to the smoking policies of the facility. The care plan did not specify smoking times, whether Resident #9 was deemed safe for independent or unsupervised smoking, Resident #9's history of noncompliance with the smoking policy, or that storage of Resident #9's smoking materials was permitted in his room. Interview on 08/26/24 at 8:23 A.M. with Resident #9 confirmed he was a smoker, kept his lighter and his cigarettes in his room, and could go out front and smoke by the picnic tables whenever he wanted, if he signed the LOA book at the front desk first. Observation during this interview revealed a red lockbox inside a clear drawer of a storage dresser where Resident #9 revealed he kept his smoking materials. Interview on 08/27/24 at 9:50 A.M. with Social Services Director/Activity Coordinator #279 confirmed smoking materials were kept in individual lockboxes and that all the lock boxes, including the one for the residents she referred to as LOA smokers were to be locked in a designated cabinet near the smoking area, which was maintained and kept secured by facility staff. Observation on 08/27/24 at 10:10 A.M. of the cabinet used to store all resident smoking materials did not contain the lockbox or smoking materials for Resident #9. When informed the lockbox was observed to be in Resident #9's room, Social Services Director #279 confirmed Resident #9 liked to take multiple smoke breaks within an hour, and perhaps the Administrator gave him permission to keep his own smoking materials so he would not have to wait on facility staff to get his supplies each time. She further verbalized no knowledge whether Resident #9's care plan permitted the storage of Resident #9's smoking materials in his room. Interview on 08/27/24 at 10:58 A.M. with Interim Activities Coordinator #263 confirmed all resident smoking materials were to be kept in the locked cabinet by facility staff and was unaware of any individualized resident care plan that directed otherwise. Review of the policy titled Resident Smoking Policy for Resident Signature revealed residents were permitted to smoke in designated areas, at designated times, and with supervision. Further review of the policy revealed no smoking materials were permitted to be with the residents, either on their person or in their rooms. The policy further revealed reeducation on facility smoking procedures would occur after the first infraction of the rules, but subsequent infractions could result in involvement of the Ombudsman, one to one supervision, or the potential of an immediate or 30-day discharge notification. 2. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), protein-calorie malnutrition, alcohol abuse, right shoulder pain, nicotine dependence, depression, anxiety disorder, polyneuropathy, colostomy status, and syncope and collapse. Review of the admission Minimum Data Set (MDS) 3.0 assessment revealed Resident #13 had moderate cognitive impairment, had no range of motion limitations in his upper or lower extremities and used a wheelchair for mobility. Further review of the MDS assessment revealed Resident #13 used tobacco. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders revealed no orders related to smoking. Review of the admission smoking assessment completed on 07/16/24 revealed no concerns related to safe smoking. Review of the updated smoking and safety assessment completed on 08/26/24 revealed Resident #13 followed policy on location and time of smoking and was capable of lighting own cigarettes & smoking safely, ok with LOA's [leave of absence] to smoke. Review of the care plan focus dated 08/06/24 revealed Resident #13 was at risk for injury related to smoking. Interventions included verbalization of adherence to the facility's smoking policy and keeping all smoking materials at the nurse's station. There were no care plan interventions related to rolling his own cigarettes, nor did the care plan specify whether Resident #13 was in independent smoker or required additional supervision or interventions. Observation on 08/25/24 at 10:40 A.M. revealed Resident #13 had a pack of cigarettes laying on his bedside table in his room and he was holding an unlit cigarette. During this observation, Resident #13 confirmed he kept his cigarettes and lighter in the drawer by his bed. Interview on 08/27/24 at 9:50 A.M. with Social Services Director/Activity Coordinator #279 confirmed smoking supplies were kept in individual lockboxes and that all the lock boxes, including the one for the residents she referred to as LOA smokers were to be locked in a designated cabinet near the smoking area, which was maintained and kept secured by facility staff. At the time of the interview, Social Services Director #279 was uncertain whether Resident #13 was considered an LOA smoker. Observation on 08/27/24 at 10:10 A.M. of the cabinet used to store all resident smoking materials did not contain the lockbox for Resident #13 but did contain two bags of tobacco and boxes of rolling paper. During the observation, Social Services Director #279 verbalized no knowledge of any care plan interventions involving storage of smoking materials in Resident #13's room. Further interview revealed Resident #13 was permitted to roll his own cigarettes while sitting at a table in the activity hall, then, to her knowledge, was to store them in the designated cabinet with all the other smoking materials. Interview on 08/27/24 at 10:58 A.M. with Interim Activities Coordinator #263 confirmed all resident smoking materials were to be kept in the locked cabinet by facility staff and was unaware of any individualized resident care plan directing otherwise. Review of the policy titled Resident Smoking Policy for Resident Signature revealed residents were permitted to smoke in designated areas, at designated times, and with supervision. Further review of the policy revealed no smoking materials were permitted to be with the residents, either on their person or in their rooms. 3. Review of the medical record for Resident #17 revealed an admitted [DATE] with diagnoses including spondylolysis of the cervical region, hypertension, migraines, major depressive disorder, schizophrenia, need for assistance with personal care, type two diabetes mellitus, neuropathy, nystagmus, chronic obstructive pulmonary disease (COPD), and nicotine dependence. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 06/06/24 revealed Resident #17 had intact cognition, no behaviors, and no wandering. Further review of the MDS assessment revealed Resident #17 had no limitations related to range of motion in her upper or lower extremities and was ambulatory with use of a cane or crutch. Review of the orders revealed a physician order dated 12/11/23 that it was ok for resident to have LOA smoking breaks. Review of the LOA Smoking Agreement signed on 03/22/24 revealed Resident #17 was permitted to sign-out on LOA for smoke breaks, but she was not to take any LOA smoke break after 10:00 P.M. and was to return her lighter and smoking materials to the nurse. This document contained Resident #17's acknowledgement she could not keep the smoking materials in her room. Review of the [NAME] Manor LOA Smoking Rules document, signed by Resident #17 on 08/19/24 revealed she agreed to the following rules: - Sign out in LOA binder each time - Smoke only in designated area (near picnic tables) - No smoking on walkways or sidewalks - Dispose of cigarettes in the ashtray - Sign-in LOA binder each time There was no verbiage permitting the storage of smoking materials in Resident #17's room. Review of the care plan last revised on 08/26/24 revealed Resident #17 was at risk for injury related to smoking and needed frequent reminders where the designated smoking area was. Care plan interventions included verbalization of safe smoking practices, adherence to the smoking policy, and keeping smoking items at the nurse's station. The care plan did not identify whether Resident #17 was deemed safe as an independent smoker or if she required supervision or other safe smoking interventions. Observation and interview on 08/25/24 at 11:15 A.M. with Resident #17 revealed all other smoking residents had specific smoking times and a designated area, but she and one other male resident were allowed to smoke out front whenever they wanted and kept their smoking materials in a lockbox in their rooms. At the time of the interview, Resident #17 pointed to a lockbox sitting on top of her dresser and stated that was where she was told she needed to keep her lighter and cigarettes. Interview on 08/27/24 at 9:50 A.M. with Social Services Director/Activity Coordinator #279 confirmed smoking supplies were kept in individual lockboxes and that all the lock boxes, including the one for the residents she referred to as LOA smokers were to be locked in a designated cabinet near the smoking area, which was maintained and kept secured by facility staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/27/24 at 10:10 A.M. of the cabinet used to store all resident smoking materials did not contain the lockbox for Resident #17. During the observation, Social Services Director #279 verbalized no knowledge of any care plan interventions involving the storage of smoking materials in Resident #17's room. Interview on 08/27/24 at 10:58 A.M. with Interim Activities Coordinator #263 confirmed all resident smoking materials were to be kept in the locked cabinet by facility staff and was unaware of any individualized resident care plans directing otherwise. Review of the policy titled Resident Smoking Policy for Resident Signature revealed residents were permitted to smoke in designated areas, at designated times, and with supervision. Further review of the policy revealed no smoking materials were permitted to be with the residents, either on their person or in their rooms. 39333 4. Medical record revealed Resident #31 was admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses including but not limited to dementia, anxiety disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #31 had severely impaired cognition and required physical assistance from staff for activities of daily living. Review of the care plan dated 04/04/22 for Resident #31 revealed Resident #31 had the potential for smoking safety issues related to being an active smoker. Interventions included but were not limited to providing a smoking apron during smoking to prevent accidental injury. Observation on 08/26/24 at 1:07 P.M. revealed Resident #31 was smoking during a supervised smoke break. Dietary Manager (DM) # 238 was observing the smokers. DM #238 stated Resident #31 required one on one supervision when smoking because she was an elopement risk. DM #238 verified that Resident #31 was not wearing a smoking apron. Interview on 08/28/24 at 10:12 A.M. with Business Office Manager (BOM) #293 verified Resident # 31's care plan indicated she should wear a smoking apron. 5. Medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including but not limited to dementia, restlessness, and agitation. Review of Resident #53's care plan dated 11/08/23 revealed Resident #53 was at risk for falls and potential injury related to impaired balance and poor decision-making skills. Interventions included but were not limited to nonskid socks to be worn at all times. may be removed for hygiene. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 had severely impaired cognition and required physical assistance from staff for activities of daily living (ADL). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/25/24 at 10:47 A.M. revealed Resident #53 sitting at a table with socks on his feet, the socks were not nonskid. Interview with State tested Nursing Assistant (STNA) #247 verified Resident #53 was not wearing non skid socks at the time of observation. Review of the facility policy with a revision date of August 2024 titled, Falls and Fall Risk Managing, revealed that resident-centered approaches would be implemented to manage falls and fall risk.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on observation, record review, and interview, the facility failed to ensure a resident's oxygen flow rate was set as ordered by the physician. This affected one (Resident #34) of two residents reviewed for respiratory care. The facility identified nine residents who received oxygen therapy. Findings include: Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, asthma, dementia, diabetes mellitus, congestive heart failure, and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/05/24, revealed Resident #34's Brief Interview for Mental Status (BIMS) score was 14, which indicated intact cognition. There were no behaviors or rejection of care. The resident received oxygen therapy. Review of the Care Plan, dated 10/16/23, revealed Resident #34 was at risk for alteration in air exchange with the intervention to administer oxygen as ordered. Review of physician order, dated 10/04/23, revealed an order for oxygen at two liters per minute to be infused via nasal cannula. Observations on 08/27/24 at 9:10 A.M. and at 11:00 A.M. revealed Resident #34's oxygen flow rate was set at three liters per minute via nasal cannula. During interview on 08/27/24 at 11:02 A.M., Licensed Practical Nurse (LPN) #269 confirmed Resident #34's oxygen flow rate was incorrectly infusing at three liters per minute and should be infusing at two liters per minute. During interview on 08/28/24 at 11:07 A.M., the Director of Nursing confirmed Resident #34's oxygen flow rate should be infused as ordered by the physician.

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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. 39333 Based on observation and staff interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary condition. This had the potential to affect 110 of 111 residents receiving food from the kitchen. Resident #45 was identified as receiving no food from the kitchen. The facility census was 68. Findings include: Initial tour of the kitchen on 08/25/24 from 8:10 A.M. to 8:32 A.M. with Dietary Manager (DM) #238 revealed the floor was dirty with food splatter, pieces of paper, and dried food debris especially underneath equipment. The microwave had food splatter on all sides of the microwave and had burnt food on the bottom. The grill had food residue on it and the grill pan was filled with french fries and food pieces. The prep table that the grill was sitting on had food debris on it. Dietary Manager (DM) #238 stated that the grill was electric and there was no power for it, so they did not use it for cooking. Observation inside the walk-in refrigerator revealed an undated food container on the floor with no label to identify what was inside of it. In addition, there was a container of soup, black olives and sliced tomatoes that were not labeled or dated. DM #238 verified the findings at time of observation. Observation inside the walk-in freezer revealed a bag of pepper steak that was open, not labeled, dated or wrapped properly. There was bag of breaded patties that was not labeled or dated. DM #238 verified the findings at time of observation. Review of the undated policy Food Safety and Sanitation Review revealed a checklist to ensure the kitchen was clean and sanitary. The policy indicated the checklist should always be followed in the dietary department. Review of the checklist revealed it was divided in the subgroups by food procurement, food storage, food preparation, and general sanitation. Under the food storage section it indicated that all food must be covered, label, and dated. The general sanitation subgroup indicated all equipment must be cleaned either after use or daily basis. Review of a list provided by the facility revealed Resident #45 received no food from the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to ensure contact isolation was maintained as ordered for Resident #50. This affected 12 residents who resided on the B unit where Resident #50 resided (Residents #1, #3, #4, #20, #28, #29, #30, #39, #54, #58, #59 and #115). Facility census was 68. Findings include: Review of Resident #50's medical record revealed the resident was admitted on [DATE] with diagnoses including hemiplegia and heimparesis, bipolar disorder and polyneuropathy. Review of Resident #50's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #50's physician orders revealed an order dated 08/30/24 for contact isolation due to active herpes simplex virus (HSV) outbreak. Observation of the signage of Resident #50's door on 08/25/24 at 2:40 P.M. revealed the resident was in enhanced barrier precautions. Interview on 08/25/24 at 3:04 P.M. with the Director of Nursing (DON) confirmed the signage on Resident #50's door was inaccurate and the resident should have been in contact isolation precautions instead of enhanced barrier precautions. The DON confirmed contact precautions required the staff to don personal protective equipment (PPE) when entering the resident's room and enhanced barrier precautions required the staff to use PPE only if they were providing direct care. Review of the Infectious Diseases policy revised January 2023 revealed the goal was to protect the residents, families and staff from harm resulting from exposure to an emergent infectious disease while they were in the facility. Review of the facility census revealed Residents #1, #3, #4, #20, #28, #29, #30, #39, #50, #54, #58, #59 and #115 resided on the B unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365634	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McCrea Manor Nsng and Rehab Ctr LLC	2040 McCrea Street Alliance, OH 44601

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 34297 Based on observation and interview, the facility failed to ensure Resident #34's room was maintained in good repair. This affected one (#34) of 22 residents reviewed for environmental concerns. Facility census was 68. Findings include: Observation of Resident #34's room on 08/28/24 at 1:00 P.M. with Maintenance Director #2115 revealed four holes in the drywall which appeared recessed behind the resident's recliner and the electrical outlet was damaged and recessed into the wall. Interview on 08/28/24 at 1:02 P.M. with Maintenance Director #2115 confirmed Resident #34's room was not maintained in good repair.