STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366036	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendora Health Care Center	1552 North Honeytown Road Wooster, OH 44691

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 22653 Based on observations, medical record review, and interview, the facility failed to implement fall interventions per resident care plans for one (Resident #12) of three residents reviewed for accidents. The facility also failed to ensure one resident, Resident #1 received thickened liquids as ordered. This affected one resident, Resident #1, of three residents reviewed for nutrition. The facility census was 36. Findings include: 1. Review of Resident #12's medical record revealed diagnoses including atherosclerotic heart disease, hypertension, history of falling, depression, visual loss in both eyes, mild dementia, generalized muscle weakness and abnormalities of gait and mobility. Review of a care plan initiated 08/05/24 revealed Resident #12 was at risk for falls related to confusion and lack of awareness of safety needs. An intervention was initiated for a fall mat to the exit side of the bed and to verify placement. On 08/23/24 an order was written for a fall mat to the exit side of bed and to verify placement every shift. A fall risk assessment dated [DATE] revealed Resident #12 remained at risk for falls. Risk factors identified included a history of falls in the prior 90 days, behaviors, need for assistance with elimination, use of devices for ambulation, co-morbidities and medication use. Observations on 09/15/24 at 10:14 A.M. and 2:08 P.M. and on 09/16/24 at 11:22 A.M. revealed Resident #12 was lying in a low bed. No mat was observed on either side of the bed. On 09/16/24 at 12:27 P.M., Resident #12 was able to identify other fall interventions but stated he did not use mats on the floor. On 09/16/24 at 1:52 P.M., Resident #12 was lying in bed without fall mats in place. On 09/16/24 at 12:35 P.M., State tested Nursing Assistant (STNA) #155 verified there was no fall mat in Resident #12's room. STNA #155 stated she was unaware there was an order for a fall mat. STNA #155 stated aides used report sheets to inform them of care and special instructions for residents' care. Review of the report sheet with STNA #155 revealed there was no instructions to use a fall mat for Resident #12. 2. Record review for Resident #1 revealed an admitted [DATE]. Diagnosis included pneumonitis due to inhalation of food and vomit. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was moderately cognitively impaired. Resident #1 required set up or clean up assistants with meals. (continued on next page)

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan updated 04/09/24 revealed Resident #1 was at nutritional risk. Interventions included to provide the diet as ordered. Review of the physician orders for Resident #1 revealed an order dated 05/21/24 for Heart Healthy diet, pureed texture, nectar consistency, Resident may request thin water 30 minutes after PO intake. No thin water with PO intake for aspiration precaution. Review of the Nutritional Risk assessment dated [DATE] at 12:15 A.M. completed by Dietitian #164 revealed Resident #1 received a mechanically altered diet with thickened liquids related to difficulty swallowing, coughing with meals. Remains on Nectar-thick liquids. Observation on 09/18/24 at 11:49 A.M. revealed Resident #1 was in the dining room for the lunch meal. Observation revealed State tested Nursing Assistant (STNA) #136 was passing the residents their drinks while in the dining room. STNA #136 asked Resident #1 what she would like to drink, juice or chocolate milk. Interview on 09/18/24 at 11:51 A.M. with STNA #136 revealed Resident #1 could have any fluids she wanted to drink; she was not on thickened liquids. Interview on 09/18/24 at 1:00 P.M. with Resident #1 revealed she use to get thickened liquids, but she didn't like it, she had not received thickened liquids for long time. Resident #1 had a glass of ice water next to her on her bedside table. Interview on 09/18/24 at 1:10 P.M. with STNA #144 confirmed she refilled Resident #1's ice water cup while Resident #1 was in the dining room. STNA #144 revealed Resident #1 did not receive thickened liquids. LPN #137, who was nearby and overheard the conversation, confirmed Resident #1 was to receive nectar thickened liquids. Interview on 09/18/24 at 2:00 P.M. with STNA #124 revealed she frequently cared for Resident #1 and Resident #1 received thin liquids including with her meals. STNA #124 revealed it was not in her task (electronic medical record for STNA's) that Resident #1 was to have any thickened liquids. Review of the task record confirmed Resident #1 did not have thickened liquids documented in the task record. Interview on 09/18/24 at 2:04 P.M. with STNA #136 revealed Resident #1 was on thickened liquids for one day only 06/25/24 through 06/26/24. STNA #136 revealed the order hasn't been changed so we give her regular liquids, she can have regular liquids, the diet card she gets with her meals hasn't been updated, it says nectar thick liquids, but she can have regular. Observation on 09/23/23 at 8:55 A.M. revealed Resident #1 was sitting up in bed eating her breakfast. Resident #1 had a partially filled glass of water on her breakfast tray. The water was not thickened. Interview on 09/23/24 at 8:56 A.M. with STNA #119 confirmed Resident #1's water was not thickened. This deficiency represents non-compliance investigated under Complaint Number OH00157039.