STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366378	A. Building B. Wing	08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covington Skilled Nursing & Rehab Center	100 Covington Drive East Palestine, OH 44413

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38094 Based on interview and record review, the facility failed to ensure closed resident accounts were refunded within 30 days. This affected two (Resident's #145 and #261) of two residents reviewed for closed accounts. The facility census was 44. Findings include: 1. Review of the medical record for Resident #145 revealed the resident was admitted on [DATE] and discharged [DATE]. Diagnoses include Alzheimer's disease, essential hypertension, type II diabetes with diabetic neuropathy, muscle weakness, malignant neoplasm of breast, major depressive disorder, and presence of cardiac pacemaker. Review of the Discharge Minimum Data Summary (MDS) 3.0 assessment dated [DATE] revealed Resident #145 was moderately cognitively impaired, required limited assistance for activities of daily living (ADL). Review of Resident #145's care plan dated 02/15/22 revealed care areas for nutrition, pacemaker, alteration/potential alteration in cardia output, breast cancer, and discharge planning to return home to live with her son. Review of the census for Resident #145 revealed the resident's payer source was Medicare until 05/11/22 when the resident became private pay. She was transferred from a private to a semi-private room on 05/24/22. Review of the 06/01/22 monthly statement for Resident #145 revealed statement for 06/01/22 with charges for May 11-31, 2022, for $6,930- and 30-days room and board July 1-30, 2022, for $9,900, totaling $16,830. Review of the 07/01/22 statement for Resident #145 revealed new charges of $3,960 and $2,070, payments of $16,830, credits for $6,930, $910, and $6,000 with an ending credit balance (overpayment) of $7,810. (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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/03/22 at 9:25 A.M. with Business Office Manager (BOM) #650 verified if a resident or their representative paid for a private room and then was transferred to dual occupancy room, they would be due a refund. She reported no knowledge of any instances of this happening since she started in her position in November 2021. When asked about the Resident #145, she verified the resident was due a refund and stated the facility was waiting for all insurance claims to be processed, despite the resident being private pay. She could not specify a time frame for when the refund would be issued. Review of the Review of Ohio 2019 Admission Agreement revealed if an over payment has occurred, the amount of overpayment would be refunded within 30 days. Interview with the Administrator on 08/03/22 at 11:45 A.M. verified the refund should have been processed within 30 days, per the facility policy. 46195 2. Review of medical record for Resident #261 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included psychotic disorder, unspecified dementia, type two diabetes mellitus, and atrial fibrillation. Review of the facility business records for Resident #261 revealed Resident #261 had $1,459.55 in his facility account. A check numbered 1940 for $1459.55 was written to Resident #261's son on 02/09/22. Interview on 08/08/22 at 10:55 A.M. with the Administrator and Regional Director of Operations #671 verified Resident #261 was discharged on [DATE] and Resident #261's funds were conveyed outside of the required timeframe of 30 days. This deficiency substantiates Master Complaint Number OH00133633.

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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 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** 41526 Based on record review and interview, the facility failed to ensure a representative of the Office of the State Long-Term Care Ombudsman was notified of facility initiated discharges. This affected 19 residents (Residents #35, #46, #244, #245, #246, #247, #248, #249, #250, #251, #252, #253, #254, #255, #256, #257, #258, #259 and #260). The facility census was 44. Findings include: 1. Review of the medical record for Resident #46 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included traumatic subdural hemorrhage without loss of consciousness, fall, dementia with behavioral disturbance, essential primary hypertension, and closed fracture of unspecified part of neck of right femur. Review of the Discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 was discharged with return not anticipated. Review of nursing progress notes dated 06/13/22 revealed Resident #46 was transported to the hospital for a change in condition, and then admitted . Interview on 08/03/22 at 8:44 A.M. with Administrator verified the facility did not timely notify a representative of the Office of the State Long-Term Care Ombudsman of the facility initiated discharge of Resident #46 on 06/13/22. The Administrator provided a folder and a facility admission/discharge report dated 08/03/22 for review. 2. Review of the facility admission/discharge report, dated 08/03/22, for residents discharged from 02/01/22 to 08/03/22 revealed the following residents received a facility-initiated discharge to a hospital: Resident #36 was discharged on [DATE] Resident #255 was discharged on [DATE] Resident #256 was discharged on [DATE] Resident #257 was discharged on [DATE] Resident #258 was discharged on [DATE] Resident #259 was discharged on [DATE] Resident #260 was discharged on [DATE] Attached to the admission/discharge report was a fax confirmation report of pages received, dated 08/03/22 at 7:73 A.M. to the ombudsman office regarding discharge notices. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the folder contained a facility admission/discharge report, dated 02/17/22, for residents discharged from 01/01/21 to 12/31/21 revealed the following residents received a facility-initiated discharge to a hospital: Resident #254 was discharged on [DATE] Resident #244 was discharged on [DATE] and again on 06/12/21 Resident #245 was discharged on [DATE] Resident #246 was discharged on [DATE] Resident #247 was discharged on [DATE] Resident #248 was discharged on [DATE] Resident #249 was discharged on [DATE] Resident #250 was discharged on [DATE] Resident #251 was discharged on [DATE] Resident #252 was discharged on [DATE] Resident #253 was discharged on [DATE] Attached to the admission/discharge report was a fax confirmation report of pages received, dated 02/22/22 at 1:17 P.M. to a representative of the Office of the State Long-Term Care Ombudsman regarding discharges. Interview on 08/03/22 at 8:52 A.M. with Administrator verified the above reports were sent to the representative of the Office of the State Long-Term Care Ombudsman for the facility initiated discharges for the year 2021 on 02/22/22 and for discharges from 02/01/22 through the current date on 08/03/22. Administrator confirmed it was not timely notification as required. This deficiency substantiates Complaint Number OH00131608.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on observation, interview, and record review the facility failed to ensure Resident #28's hearing aid was replaced in a timely manner. This affected one (Resident #28) of one resident reviewed for hearing. The facility census was 44. Findings include: Review of the medical record revealed Resident #28 was admitted on [DATE] with diagnoses including muscle weakness, osteoarthritis, spinal stenosis, major depressive disorder, and a history of COVID-19. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 had moderate difficulty hearing and wore hearing aids, required extensive assist of two staff for activities of daily living (ADL), use of a wheelchair for mobility and was on hospice. Review of Resident #28's care plan of 08/03/22 revealed care areas included communication deficit related to a hearing deficit as evidenced by highly impaired hearing and requiring two hearing aids. Interventions included audiology consult as needed, monitoring effectiveness of communication strategies and hearing aids and monitoring/documenting/reporting hearing impairment. Review of the nursing progress note of 06/03/22 at 10:03 A.M. revealed per midnight report- residents hearing aid shattered last evening. Called son to inquire about who Resident #28 sees for audiology. Resident #28's son stated he hasn't seen anyone in Ohio since he got the hearing aids in Tennessee. This nurse then asked if residents son had a preference as to whom his father sees for hearing aid replacement- he stated he does not have a preference. Information communicated to scheduling to have resident set up with an audiologist. Observations on 08/02/22 at 8:45 A.M., 08/03/22 at 8:59 A.M. and 08/03/22 at 2:40 P.M. revealed Resident #28 was very hard to engage in conversation and was not wearing hearing aids. He had difficulty hearing accurately, and understanding simple phrases and commands, even at a loud volume. The facility provided an appointment sheet dated 06/06/22 appointment as soon as possible (ASAP) with audiologist for broken hearing aide, spoke with resident's son; states he is waiting for audiology apt visit with 360. Interview on 08/04/22 at 10:05 A.M. with Resident #28' son reported it was reported to him when his father's hearing aid was crushed, over eight weeks ago, and it seemed to be taking a pretty long period of time to get it replaced. Not having the hearing aid makes it difficult to communicate when he and his family visit, which is about three times a week. He tried to put the other hearing aid in, but his father's hearing loss required both hearing aids for effective communication. The son reported the care was good, but some of the appointments, like for a replacement hearing aid, could have been handled better. He was told the facility would schedule an audiology appointment to replace the hearing aid. He verified no other options were discussed with him and his father had not received a replacement hearing aid. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/04/22 at 10:43 A.M. with State tested Nursing Assistant (STNA) #626 revealed as he was getting Resident #28 up on 06/03/22, he found the hearing aid in pieces on the floor, next to the bed. It appeared that it was either crushed by the mechanical lift or stepped on. The STNA immediately reported it to the nurse and called the resident's son who said he would like to get the hearing aid replaced. Review of the February 2018 policy Hearing Impaired Resident, Care of revealed staff will help residents who have lost or damaged hearing devices in obtaining services to replace a hearing aid. Review of the audiologist list for 08/16/22 revealed Resident #28 was on the list to be seen on that date. This deficiency substantiates Complaint Number OH00131608.