STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366415	A. Building B. Wing	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Cape May	175 Cape May Drive Wilmington, OH 45177

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** 34291 Based on observation, medical record review, staff interview and policy review, the facility failed to ensure the physician was notified of a new skin condition. This affected one (#8) of four residents with skin impairments reviewed. The census was 21. Findings included: Medical record review for Resident #8 revealed an admitted [DATE]. His medical diagnoses included Parkinson's disease, muscle weakness, hypertension, hypertensive heart disease, foot drop left foot, and peripheral vascular disease. Review of annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact. His functional status was extensive assistance for bed mobility, transfers, and toileting. He was a supervision for eating. Review of wound documentation dated 04/03/23 revealed Resident #8 had an arterial wound on his left third toe that measured 1.0 centimeters (cm) by 1.5 cm by 0.1 cm that was eschar and dry. There wasn't any documentation of the left second toe in the record. Interview with Resident #8 on 05/30/23 at 10:24 A.M., revealed he stated he needed to take off his shoe because his toe hurt him. Observation and interview with Licensed Practical Nurse (LPN) #500 on 05/30/23 at 10:30 A.M., removed Resident #8's shoe and sock. On the tip of the second toe, there was an area observed to be a small black oval wound and on the tip of the third toe was a black spot. The nurse said Resident #8's wounds were something he wasn't aware of. Review of progress notes dated 05/30/23 and the morning of 05/31/23 revealed there was no documentation of a notification to the physician of the wounds. Interview with the LPN #500 on 05/31/23 at 9:53 A.M., confirmed he didn't notify the physician regarding the wound on the left second toe. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled Change of Condition dated 09/13/22, revealed to observe, record, and report any condition change to the nurse in charge and the attending physician so proper treatment can be implemented.

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, staff interview, Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual review, and policy review, the facility failed to complete and transmit a resident's discharge Minimum Data Set (MDS) assessment. This affected one (#11) of 12 residents reviewed for assessments. The facility census was 21. Findings include: Review of the Resident #11's medical record revealed an admission of 01/07/23, with diagnoses including: spondylolisthesis, constipation, other seizures, spinal stenosis lumbar region with neurogenic claudication, hypothyroidism, history of bariatric surgery status, difficulty in walking and lymphedema. Resident #11 discharged from the facility on 01/27/23. Review of Resident #11's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #11 required limited assistance with bed mobility, and transfers. Resident #11 required extensive assistance with dressing and toileting and supervision with personal hygiene. Resident #11 was independent with eating on the MDS. Review of Resident #11's progress note dated 01/27/23 revealed Resident #11 received a copy of the discharge plans and resident verbalized understanding. Resident #11 was placed in the car by the nurse and power of attorney and left in stable condition. Review of Resident #11's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the MDS assessment was in progress and was not transmitted. Interview with the Administrator on 05/31/23 at 10:46 A.M., verified Resident #11's discharge MDS assessment dated [DATE] was not completed or transmitted. Review of the policy titled MDS Completion and Assigned Selections dated 01/10/23 revealed the MDS nurse will electronically transmit the assessments and tracking forms according to the resident assessment instrument manual. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual v1.17.1, chapter two, page 2-37, dated 10/2019, revealed a Discharge Return Not Anticipated MDS assessment is required to be completed when a resident is discharged from a facility and is not expected to return to the facility within 30 days. The Discharge Return Not Anticipated MDS must be completed within 14 days after the discharge date and must be transmitted within 14 days after the MDS completion 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, medical record review, staff interview and policy review, the facility failed to ensure a skin assessment was completed in a timely manner. This affected one (#8) of four skin impairments reviewed. The census was 21. Findings included: Medical record review for Resident #8 revealed an admitted [DATE]. His medical diagnoses included Parkinson's disease, muscle weakness, hypertension, hypertensive heart disease, foot drop left foot, and peripheral vascular disease. Review of annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact. His functional status was extensive assistance for bed mobility, transfers, and toileting. He was a supervision for eating. Review of wound documentation dated 04/03/23 revealed Resident #8 had an arterial wound on his left third toe that measured 1.0 centimeters (cm) by 1.5 cm by 0.1 cm that was eschar and dry. There wasn't any documentation of the left second toe in the record. Interview with Resident #8 on 05/30/23 at 10:24 A.M., revealed he stated he needed to take off his shoe because his toe hurt him. Observation and interview with Licensed Practical Nurse (LPN) #500 on 05/30/23 at 10:30 A.M., removed Resident #8's shoe and sock. On the tip of the second toe, there was an area observed to be a small black oval wound and on the tip of the third toe was a black spot. The nurse said Resident #8's wounds were something he wasn't aware of. Review of progress notes dated 05/30/23 and the morning of 05/31/23 revealed there wasn't any notes or assessments regarding the left second toe. Interview with the LPN #500 on 05/31/23 at 9:53 A.M., revealed he was an agency nurse, and he didn't know how to put in an assessment of a wound and verified he did not assess the wound and put it in the chart for Resident #8's left second toe. Review of the policy titled Skin Integrity assessment dated [DATE], revealed the skin should be checked at least daily and report potential or actual changes in the skin integrity. Assessment of the skin should include type, stage if any, characteristic, presences of infection or pain, and type of dressing and treatment.