STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366426	A. Building B. Wing	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woods on French Creek Nursing & Rehab Center The	37845 Colorado Avenue Avon, OH 44011

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on observation, resident interview, resident representative interview, staff interview, and medical record review, the facility failed to implement and assess for appropriate interventions for a resident at risk for weight loss. This affected one (#2) of two residents reviewed for nutrition. The facility census was 69. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included dementia, rheumatoid arthritis, hypertensive heart disease, chronic pain syndrome, and anemia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was independent with set up for eating and had no significant weight changes. Review of a plan of care dated 10/06/22 revealed Resident #2 was at risk for alteration in nutrition status related to dementia, use of diuretics, decreased mobility, advanced age, and overall decline. Interventions included assistance with meals as needed, two handled cup with lid and straw for drinks, encourage the resident to dine in the dining room, offer meal substitutes when foods are refused, built-up utensils for all meals, and refer to dietitian or therapy as needed. Review of physician's orders revealed Resident #2 was ordered a no added salt diet with regular texture and thin consistency liquids, a two handled cup with lid and straw in drinks, and built-up utensils for all meals. There were no orders for nutritional supplements or snacks. Resident #2 had an order dated 03/15/23 for the diuretic furosemide 20 milligrams by mouth once per day every Wednesday and Friday. Review of documented weights for Resident #2 revealed on 08/04/22 a weight of 170.5 pounds, on 02/03/23 a weight of 158.2 pounds, on 07/02/23 a weight of 165.8 pounds, and on 08/12/23 a weight of 155.5 pounds. Resident #2 had 6.21 percent (%) weight loss in one month. Review of a nutrition risk tool dated 06/20/23 revealed Resident #2 was assessed at moderate risk for nutritional decline. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nutrition assessment dated [DATE] revealed Resident #2 was on a no added salt diet and required two handled cups with lids and straw. There was no note of snacks or nutritional supplements being provided. Resident #2 was documented to eat between 75 % and 100 % of meals. Resident #2's weight was noted to be overall stable with no significant weight change. Resident #2 was noted to have a history of fluid shifts with edema and use of diuretics. There were no indications Resident #2 was assessed for sleeping during meals. There were no changes made to the nutritional plan of care. Review of a physician progress note dated 06/25/23 revealed Resident #2 was seen for a check up on dementia, hypertension, and congestive heart failure. There were no acute symptoms noted during the exam. Medications were reviewed with no new orders. There was no indication Resident #2 was assessed for sleeping during meals. Review of a therapy screen for skilled services assessment dated [DATE] revealed Resident #2 was assessed at baseline and required no therapy services. Review of a nurse practitioner (NP) progress note dated 08/07/23 revealed Resident #2 was assessed for increased itching. The NP noted Resident #2 had stable weights and made no changes to the congestive heart failure plan of care. There was no indication Resident #2 was assessed for sleeping during meals. Review of progress notes from June 2023 through August 2023 revealed no indication of fluid shifts related to edema that may be attributing to weight changes, and revealed no indication Resident #2 was assessed for sleeping during meals. Observation on 08/14/23 at 8:59 A.M. revealed Resident #2 was sitting in a recliner chair in her room with a breakfast meal on tray table in front of her. Observation on 08/14/23 at 10:03 A.M. revealed Resident #2 continued to be sitting in a recliner chair in her room. Resident #2 continued to attempt to feed herself the breakfast meal. Further observation of the tray table revealed a breakfast tray that included two pieces of toast, beverages in two handled cups with lid and straw, and an open yogurt container. On the floor in front of Resident #2 was a spoon and fork. Resident #2 was attempting to put jelly on the toast. Interview with Resident #2 at time of observation revealed she was struggling to get jelly on toast. Resident #2 reported sometimes the staff will help her with meals. Observation on 08/15/23 at 10:14 A.M. revealed Resident #2 was in bed with a breakfast tray in front of her on the tray table. Resident #2 was noted to be sleeping and ate less than half of the breakfast tray. Observation on 08/15/23 at 12:14 P.M. revealed Resident #2 was seen in the dining room sleeping at the table. The lunch meal was delivered to Resident #2 at 12:18 P.M. Resident #2 was noted to continue to sleep at table. Resident #2 was awakened by staff several times from 12:14 P.M. to 12:52 P.M.; however, continued to fall asleep. Resident #2 did not eat the lunch meal; however, did eat dessert when it was placed in front of her. At 12:52 P.M., Registered Nurse (RN) #875 brought Resident #2 back to her room. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/15/23 at 12:59 P.M. revealed Resident #2 was sitting in her wheelchair in her room, and on the tray table in front of her was a sandwich cut in half. Resident #2 was observed to fall asleep between bites of sandwich. Interview on 08/15/23 at 2:26 P.M. with RN #875 confirmed Resident #2 slept through the lunch meal, and indicated it was common for Resident #2 to sleep during meals or between bites. Observation on 08/15/23 at 2:33 P.M. revealed Resident #2 continued to sit in her wheelchair in her room, continued sleeping, and on the tray table in front of her was half of a sandwich. Observation on 08/16/23 at 8:09 A.M. revealed Resident #2's breakfast was delivered. Observation on 08/16/23 at 8:38 A.M. revealed Resident #2 was sleeping in a recliner chair with her breakfast sitting in front of her on the tray table. Resident #2 had a two handled cup with a lid and straw. Resident #2's breakfast was untouched. Observation on 08/16/23 at 8:49 A.M. revealed State tested Nurse Aide (STNA) #864 was collecting breakfast trays and entered Resident #2's room. STNA #864 indicated Resident #2 did not eat anything yet and encouraged her to eat. Interview on 08/16/23 at 8:50 A.M. with STNA #864 confirmed Resident #2 slept through the breakfast meal and had not eaten. STNA #864 indicated she attempted to wake Resident #2 up three times already for breakfast. STNA #864 indicated Resident #2 does not use silverware appropriately and typically plays with the silverware or pushes stuff around on the tray with silverware. An interview was attempted on 08/16/23 at 8:53 A.M. with Resident #2; however, Resident #2 was still sleeping. Resident #2 briefly opened her eyes and did not respond to questions. Resident #2 was up in a reclining chair with untouched breakfast in front of her. Observation on 08/16/23 at 8:58 A.M. revealed Resident #2 fell back asleep and had not eaten any items on her tray. Interview on 08/16/23 at 9:06 A.M. with the Director of Nursing (DON) stated Resident #2 had general decline and was likely appropriate for hospice services. The DON indicated Resident #2 was not on any sedative medications that would cause sleeping during meals. Observation on 08/16/23 at 9:11 A.M. with Dietary #911 stated Resident #2's breakfast tray was collected and was untouched. Resident #2's meal intake was confirmed with Dietary #911. Dietary #911 indicated Resident #2 usually liked sweet foods and coffee; however, did not eat the donut or drink coffee on the tray. Interview on 08/16/23 at 9:12 A.M. with Licensed Practical Nurse (LPN) Unit Manager #912 and the DON confirmed Resident #2 was not on any sedative medications and confirmed Resident #2 lost 10.3 pounds in last month per the electronic medical record (EMR). LPN Unit Manager #912 and DON were unable to report if Resident #2 was assessed for sleeping during meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/16/23 at 9:29 A.M. with Registered Dietitian (RD) #913 confirmed Resident #2 had no orders for nutritional supplements or snacks between meals, and was unaware Resident #2 was sleeping through meals. RD #913 indicated Resident #2's weight loss was not significant (significant weight loss was identified as greater than five percent loss in one month) and confirmed weight change had not yet been assessed. Observation on 08/16/23 at 11:48 A.M. with LPN Unit Manager #912 revealed Resident #2 was on scale in shower room, and Resident #2 was sitting in a wheelchair. The scale indicated the weight was 217.0 pounds and the tag on Resident #2's wheelchair indicated it weighed 59.6 pounds. Resident #2's updated weight was 157.4 pounds and indicated a significant weight loss of 5.06 % over one month. Interview on 08/16/23 at 1:44 P.M. with RN #878 stated Resident #2 ate meals in both the dining room and her room. RN #878 indicated Resident #2 was known to fall asleep during meals. RN #878 confirmed Resident #2 did not have order for snacks or nutritional supplements in the case she did not eat a meal. Interview on 08/16/23 at 4:54 P.M. with Resident #2's daughter stated her mother had declined mentally and she was unaware if Resident #2 slept through meals. Resident #2's daughter indicated, to her knowledge, Resident #2 did not require assistance during meals. Resident #2 indicated it was common for Resident #2 to fall asleep during visits. Review of a facility policy titled, Weight Policy, dated 07/01/04, revealed residents experiencing weight changes would have appropriate measures taken to ensure resident maintains nutritional status. The policy identified significant weight changes were five percent change in 30 days. Interventions could include feeding programs, finger foods, therapy screening, and dietary supplements.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37095 Based on observation, staff interview, medical record review, review of a facility policy, the facility failed to administer medications as ordered. There were three medication errors observed out of 27 opportunities for a medication error rate of 11.1 percent (%). This affected two (#46 and #14) of four residents observed for medication administration. The census was 69. Findings include: 1. Observation of medication administration by Registered Nurse (RN) #878 for Resident #46 on 08/16/23 at 8:21 A.M. revealed one of the medications administered was a stool softener Senna 8.6 milligrams (mg) by mouth. RN #878 did not administer Resident #46 a Senna-docusate sodium combination pill during the procedure. Review of Resident #46's medical record, following administration of medication on 08/16/23, revealed there was no active order for Senna 8.6 mg. There was an active order dated 03/10/23 for a Senna-docusate sodium combination pill with a dosage of 8.6-50 mg to be given twice daily for constipation at 9:00 A.M. and 9:00 P.M. Interview with RN #878 on 08/16/23 at 9:44 A.M. verified the incorrect medication was administered to Resident #46, and stated she made the mistake because orders for the combination pill were usually written as Senna-Plus. 2. Observation of medication administration by RN #878 for Resident #14 on 08/16/23 at 8:32 A.M. revealed one of the medications administered was Senna 8.6 mg. No Senna-docusate sodium combination pill was given during the procedure. Additionally, RN #878 removed five pills of the anti-inflammatory medication dexamethasone two (2) mg, and split one of the five pills in half, and discarded the other half to create a total dose of nine (9) mg. The medications were then placed in a medication cup to be crushed. RN #878 confirmed Resident #14's physician order called for two and one-half tablets of dexamethasone four (4) mg to be given, so the pill was split to make the correct dose. When RN #878 announced she was ready to crush the pills, the surveyor intervened to verify two and one-half tablets of dexamethasone 4 mg would create a total dose of 10 mg, not 9 mg which was what RN #878 had ready for administration. Review of Resident #14's physician orders at that time revealed Resident #14's total dose of dexamethasone was to equal 10 mg. RN #878 then prepared the correct dosage and administered it to the resident. Review of Resident #14's medical record revealed an order dated 03/15/23 for two and one-half tablets of dexamethasone 4 mg creating a total dose of 10 mg to be given daily on Wednesdays and Thursdays at 8:00 A.M Further review of Resident #14's physician orders revealed no active order for Senna 8.6 mg. There was an active order dated 03/13/23 for a Senna-docusate sodium combination pill with a dosage of 8. 6-50 mg to be given twice daily for constipation at 8:00 A.M. and 8:00 P.M. Interview with RN #878 on 08/16/23 at 9:44 A.M. confirmed the active order for Resident #14's dexamethasone for two and one-half 4 mg tablets, and confirmed there was no order for Resident #14 to receive Senna 8.6 mg. RN #878 stated she made the mistake because orders for the Senna-docusate sodium combination pill were usually written as Senna-Plus. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration policy, dated 06/21/2017, revealed the medication name, strength, and quantity was to be verified for each medication before giving it to the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, staff and resident interviews, medical record review, and review of a facility policy, the facility failed to ensure resident medications were maintained in a safe and secure manner. This affected one (#39) of one residents reviewed for medication storage. The facility census was 69. Findings include: Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included unilateral primary osteoarthritis of the right hip, unspecified pulmonary hypertension, and primary generalized arthritis. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was alert and oriented to person, place, and time and was extensive assist for activities of daily living (ADLs). Review of Resident #23's August 2023 monthly physician orders revealed orders for the diuretic torsemide oral tablet 20 milligrams (mg), the blood pressure medication hydralazine oral tablet 50 mg, the antiemetic medication ondansetron oral tablet four (4) mg, the supplement vitamin D3 oral tablet, the pain medication aspirin 81 mg chewable oral tablet, the antihypertensive medication doxazosin mesylate two (2) mg oral tablet, the supplement potassium chloride extended-release tablet extended release 20 milliequivalents (mEq), the blood pressure medication carvedilol 3.125 mg oral tablet, the stool softener polyethylene glycol 17 gram powder, and the medication for heart failure isosorbide dinitrate 30 mg oral tablet. There were no orders to keep medications at Resident #39's bedside. Observation on 08/14/23 at 8:55 A.M. with Resident #39 revealed the resident had a white tissue on her bed with medication on to of it. Interview with Resident #39 at that time stated she had six to eight pills, but declined allowing the surveyor to count them. Resident #39 declined to name the pills after grabbing the tissue and closing her fist. Interview and observation on 08/14/23 at 8:58 A.M. with State tested Nurse Aide (STNA) #897 confirmed Resident #39's pills were left at bedside and were wrapped up in tissue in her closed fist. Interview on 08/14/23 at 8:59 A.M. with Resident #39 stated she held on to her pills and took them after breakfast. Interview on 08/14/23 at 9:05 A.M. with Licensed Practical Nurse (LPN) #831 confirmed Resident #39 pills were left in her room. LPN #831 stated Resident #39 liked to take her pills after breakfast with her apple sauce or orange juice. Follow-up interview on 08/14/23 at 10:00 A.M. with LPN #831 stated she provided Resident #39 with torsemide 20 mg oral tablet, hydralazine 50 mg oral tablet, vitamin D3 oral tablet, aspirin 81 mg chewable oral tablet, potassium chloride 20 mEq extended-release oral tablet, carvedilol 3.125 mg oral tablet, polyethylene glycol 17 grams powder, and isosorbide dinitrate 30 mg oral tablet. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Medication Administration, dated 06/21/17, revealed medications would be administered by legally authorized and trained persons in accordance to applicable state, local, and federal laws and consistent with accepted standards of practice. Review of the document revealed that tablets and capsules would be poured into the medication cup while remaining with resident while medication is swallowed. Review of the document also revealed to never leave a medication in a resident room without orders to do so, and to proceed to the next resident after all medications had been administered and documented. Review of the document revealed the facility did not implement the policy.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, resident interview, staff interview, medical record review, and review of a meal ticket, the facility failed to provide adaptive eating utensils as ordered and care planned. This affected one (#2) of two residents reviewed for nutrition. The facility census was 69. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included dementia, rheumatoid arthritis, hypertensive heart disease, chronic pain syndrome, and anemia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was independent with set up for eating. Review of a plan of care dated 10/06/22 revealed Resident #2 was at risk for alteration in nutrition status related to dementia, use of diuretics, decreased mobility, advanced age, and overall decline. Interventions included assistance with meals as needed, two handled cup with lid and straw for drinks, encourage the resident to dine in the dining room, offer meal substitutes when foods are refused, built-up utensils for all meals, and refer to dietitian or therapy as needed. Review of physician's orders revealed Resident #2 was ordered a no added salt diet with regular texture and thin consistency liquids, a two handled cup with lid and straw in drinks, and built-up eating utensils for all meals. Observation on 08/14/23 at 8:59 A.M. revealed Resident #2 was sitting in a recliner chair in her room with a breakfast meal on tray table in front of her. Observation on 08/14/23 at 10:03 A.M. revealed Resident #2 continued to be sitting in a recliner chair in her room. Resident #2 continued to attempt feed herself the breakfast meal. Further observation of the tray table revealed a breakfast tray that included two pieces of toast, beverages in two handled cups with lid and straw, and an open yogurt container. On the floor in front of Resident #2 was a spoon and fork. There were no noted built-up eating utensils in the room. Resident #2 was attempting to put jelly on the toast. Interview with Resident #2 at time of observation revealed she was struggling to get jelly on toast. Resident #2 reported sometimes the staff will help her with meals. Observation on 08/16/23 at 8:09 A.M. revealed Resident #2's breakfast was delivered. Observation on 08/16/23 at 8:38 A.M. revealed Resident #2 was sleeping in a recliner chair with her breakfast sitting in front of her on the tray table. Resident #2 had a two handled cup with a lid and straw, but no built-up eating utensils. Resident #2's breakfast was untouched. Observation on 08/16/23 at 8:49 A.M. revealed State tested Nurse Aide (STNA) #864 was collecting breakfast trays and entered Resident #2's room. STNA #864 indicated Resident #2 did not eat anything yet and encouraged her to eat. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/16/23 at 8:50 A.M. with STNA #864 confirmed Resident #2 slept through the breakfast meal and had not eaten. STNA #864 confirmed there were no built-up eating utensils on Resident #2's meal tray. STNA #864 indicated she attempted to wake Resident #2 up three times already for breakfast. STNA #864 indicated Resident #2 does not use silverware appropriately and typically plays with the silverware or pushes stuff around on the tray with silverware. Review of Resident #2's paper meal ticket dated 08/16/23 for breakfast meal revealed documentation for built-up eating utensils. Interview on 08/16/23 at 9:12 A.M. with Licensed Practical Nurse (LPN) Unit Manager #912 and the DON confirmed Resident #2 did not have built-up utensils on her meal ticket and there was a physician order in electronic medical record (EMR) for adaptive equipment. Interview on 08/16/23 at 9:29 A.M. with Registered Dietitian (RD) #913 confirmed there was an order in Resident #2's EMR for built-up silverware that was not on the meal tray ticket. Interview on 08/17/23 at 2:10 P.M. with the Administrator stated the order for Resident #2 to have built-up eating utensils did not show up on an order report and was missed during an adaptive equipment audit. The Administrator stated the therapy department indicated the order was likely made in error. The Administrator was unaware why the order was in place from 2019 to 2023 if the order was not needed.