STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365026	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wexner Heritage House	1151 College Avenue Columbus, OH 43209

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, interviews, and facility investigation review, this facility failed to ensure a resident with a Do Not Resuscitate Comfort Care (DNRCC) code status did not receive life saving measures or cardiopulmonary resuscitation (CPR) after a cardiac arrest. This affected one (Resident #3) of the one resident reviewed for appropriate code status. The facility census was 96. Findings include: Review of the medical record for Resident #3 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease, cirrhosis of the liver, and viral hepatitis B. Review of Resident #3's code status revealed a signed document dated [DATE] indicating a Do Not Resuscitate Comfort Care code status. Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily decision making abilities. Review of Resident #3's physician orders for [DATE] revealed an orders for a DNRCC code status. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated [DATE] at 4:25 P.M. created by Licensed Practical Nurse (LPN) #235 revealed, State tested Nursing Assistant (STNA) alerted this nurse that resident was laying across the bed having a hard time breathing. This nurse asked STNA to obtain vitals as approaching the resident's room. Upon entering resident's room resident was noted to be laying with her head off the side of the bed towards the door and her feet and legs off the bed between wall and door. This nurse asked resident what was going on resident stated she was having a hard time breathing. Resident was panting and this nurse stated she was going to call 911. This nurse went and got Assistant Director of Nursing (ADON) #223 to assess resident. Upon entering room with ADON #223 resident took a couple breaths then stopped breathing. This nurse ran to call 911 while ADON #223 stayed with resident and started CPR. After calling 911 this nurse returned to room where ADON #223 was administering CPR while another nurse was administering the Ambu bag and stated she needed someone to take over. This nurse took over chest compressions until another nurse took over for me and then this nurse took over administering the Ambu bag. This nurse continued Ambu bag until EMT's told me to stop and they took over. Director of Nursing (DON) called family to notify them and this nurse called MD to notify him. Interview on [DATE] at 3:30 P.M. with LPN #235 confirmed she was informed by a STNA that Resident #3 was experiencing respiratory distress. LPN #235 claimed she instructed the STNA to grab the vital machine while she ran to get ADON #223. When both herself and ADON #223 arrived back to Resident #3's room she was noted to have arrested. ADON #223 went to check this residents code status and asked LPN #235 what room she was in. LPN #235 provided the room number which after looking at the medical record associated with that room, it was noted this resident had a full code status. CPR was initiated and continued until emergency medical services arrived to take over. At that point LPN #235 went to made copies of Resident #3's medical information to go with her to the hospital. This was when it was realized the medical record in hand was for the wrong resident and the incorrect room number was provided to ADON #223. After reviewing the correct medical record it was noted that Resident #3 had a DNRCC code status. Resident #3 was rushed to the local hospital but did not survive. Interview on [DATE] at 4:00 P.M. with the Administrator and DON revealed the facility was made aware of this incident and an investigation was started. Part of the corrective action put in place included in-services, education, and audits on residents who arrested and if their code status was implemented. The DON revealed no additional concerns have occurred. The deficient practice was corrected on [DATE] when the facility implemented the following corrective actions: On [DATE], The Director of Nursing (DON) and the Administrator initiated an investigation into this incident and investigation included obtaining statements from all staff involved and reviewing Resident #3's medical record. On [DATE], The DON and ADON provided inservice and education with all nursing staff on Initiating CPR. On [DATE], The DON audited all charts to ensure correct code status was in place. On [DATE] and [DATE], The DON and/or designee will complete audits to monitor any initiated codes and each resident code status. These audits will be completed five times a week for two weeks, then three times a week for two weeks, and then weekly for four weeks. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance identified during investigation for Complaint Number OH00158440.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, hospital documents review, staff interview, and facility policy review, this facility failed to obtained ordered urine samples for testing due to cloudy urine. This affected one (Resident #196) of the five resident reviewed for care and treatment to prevent hospitalization . The facility census was 96. Findings include: Review of the medical record for Resident #196 revealed an admitted [DATE]. Diagnoses included end stage renal disease, Urinary tract infections, and the need for assistance with personal care. Review of the annual Minimal Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #196 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #196 was noted to have an impairment to her bilateral upper extremities and was dependent on staff for toileting and personal hygiene. Resident #196 required the use of an indwelling catheter for urine elimination and was always incontinent of bowel movements. Review of the progress note dated 9/12/2024 at 7:02 P.M. created by Licensed Practical Nurse (LPN) #165 revealed, This nurse verified appointment with urologist, and received verbal order to change Foley catheter and dip urine due to cloudy appearance of urine. Review of the progress note dated 09/13/2024 at 7:07 A.M. created by Registered Nurse (RN) #329 revealed, This nurse notified that resident had no urine output for entire night shift. Foley catheter checked and was found to be in the patient's vagina not bladder. Foley removed without difficulty. Physician office notified. Spoke with Physician Assistant (PA) #400 Review of the progress note dated 09/13/2024 at 7:08 A.M. created by RN #329 revealed, Foley catheter changed out this am. Immediate urine return noted. Approximately 350 milliliters (ml) of urine returned upon insertion. Patient did not have any of her latex free catheters left. Those are provided by Medicare. We do not stock her catheter in house. A 14 French 10 ml silicone coated latex Foley was used. No immediate allergic reaction observed. Spoke with PA #400 at the physician office and she stated that it was ok to leave the current Foley in as long as there is no allergic reaction noted but states that it will need to be switched out to a latex free one as soon as possible. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 09/21/2024 at 11:37 A.M. created by LPN #165 revealed, This nurse was notified by Certified Nursing Assistant that resident was nauseated, and something was wrong with her. This nurse evaluated resident. Resident had labored breathing at 30 respirations per minute and was loosely holding a bucket, her blood pressure was 193/102 millimeter of mercury (mmHg). This nurse asked resident what was wrong, resident stared at this nurse with tears in eyes. Tried to get resident to answer. Resident continued staring. Resident felt slightly clammy to touch. Notified Power of Attorney (POA). POA was present and stated send her to a local hospital. at 11:13 A.M. called 911. At 11:16 A.M. notified the on-call physician. Certified Nurse Practitioner (CNP) on the phone when Emergency Medical Technicians (EMT)s showed up. Resident vitals 97.1 degrees Fahrenheit, pulse was 74 beats per minute, respirations were 20 breaths per minute, blood pressure was 144/83 mmHg, and her oxygen saturations was at 93% room air. Glucose check read 186 milligrams per deciliter (mg/dl). Resident appeared to have calmed down. This nurse asked resident if she was feeling better and if she needed to go to the hospital. Resident stated she wanted to go to hospital to see what was wrong with her. House management was present. Review of Resident #196's medication administration record (MAR) and treatment administration record (TAR) for September 2024 revealed an order dated for 09/12/2024 for a urine culture only. May use dip stick. Per urologist one time only for cloudy urine for 1 day. Continued review revealed this order was not documented as being completed. A second order was noted to have been dated for 09/12/2024 that read, Urine culture per urologist one time only for cloudy urine, for one day. 09/12/2024 was noted to have been left blank on the MAR but 09/13/2024 was noted with a 9 nine which per the Chart Codes indicated, Other/See Progress Notes. Per review of Resident #196's progress notes for 09/13/2024 it was documented that the Foley catheter was not placed in the correct area and was reinserted which resulted in 350 ml of urine. No documentation was noted to indicate if the urine sample had been obtained. Continued review of Resident #196's completed labs revealed no completed urine testing for 09/12/2024 or thereafter. Review of hospital documents for Resident #196 dated 09/24/2024 revealed, [AGE] year-old female patient presented to the hospital on 09/21/2024 with transient confusion and suprapubic pain. Patient was noted to have acute complicated UTI due to chronic indwelling Foley, acute metabolic encephalopathy, which is resolved, and presented with lethargy, weakness, suprapubic pain. under Assessment/Plan 2. Confusion-Resolved due to a urinary tract infection (UTI) on Merrem (antibiotic) intravenous (IV) urine culture shows 3 colony types. Baclofen (muscle relaxant) 5 milligrams (mg) at bedtime which shouldn't be causing confusion. Chronic Foley changed monthly. Interview on 10/29/2024 at 2:00 P.M. with the Director of Nursing (DON) revealed he spoke with the nurse who was here the day on 09/13/2024 when the Foley catheter was changed due to being incorrect inserted which that nurse claimed she was not able to get enough urine to complete the test. When the DON asked this nurse if she called the physician to update them, she claimed that it was so long ago she could not recall if she did or not. Continued interview at 2:43 P.M. with the DON revealed for a urine test or urine dip test to be completed, there is not a lot of urine that is needed. The DON was informed that per progress note, there was 350 ml of urine noted after inserting the Foley. The DON claimed that would have been enough urine to complete this urine test and he was not sure why this test was not completed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Catheter Care, dated 11/02/2021 revealed It is the policy of this facility to provide resident care that meet the psychosocial, physical and emotional needs and concerns of the residents. This deficiency represents non-compliance investigated under Complaint Number OH00158440.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, interview, observations, and facility policy review, this facility failed to maintain infection control measures while completing catheter care. This affected one (Resident #196) of the one resident observed for catheter care. The facility census was 96. Findings include: Review of the medical record for Resident #196 revealed an admitted [DATE]. Diagnoses included end stage renal disease, Urinary tract infections, and the need for assistance with personal care. Review of the annual Minimal Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #196 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #196 was noted to have an impairment to her bilateral upper extremities and was dependent on staff for toileting and personal hygiene. Resident #196 required the use of an indwelling catheter for urine elimination and was always incontinent of bowel movements. Observation on 10/29/2024 at 11:58 A.M. of Certified Nursing Assistant (CNA) #307 completing catheter care for Resident #196 revealed multiple infection control concerns. CNA #307 was noted to wear a gown and gloves during this care but when cleaning the catheter tubing was noted to use alcohol wipes and wipe towards the body instead of away from the body. After catheter care was completed, CNA #307 proceeded to use the bed controller to readjust the bed to a comfortable position for the resident as well as cover her back up all while used same gloves that were used to complete peri care and catheter care. Assistant Director of Nursing (ADON) #223 was noted in Resident #196's room while this care was completed as well. Interview on 10/29/2024 at 12:00 P.M. with ADON #223 confirmed the catheter care was properly completed, and infection control measures was not maintained during this care. Review of the facility policy titled Infection Control-Hand Hygiene, dated 03/31/2022 revealed hand hygiene is requires before and after caring for a resident and or removal of gloves. This deficiency represents non-compliance identified during investigation for Complaint Number OH00158440.