STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365044	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcat Cincinnati	4001 Rosslyn Drive Cincinnati, OH 45209

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, staff interviews, review of facilities Self-Reported Incidents (SRIs), and facility policy review, the facility failed to ensure their policy regarding injuries of unknown origins was implemented when a resident was found with injuries. This affected one (#11) of the two residents reviewed for abuse. The facility census was 84. Findings include: Review of the medical record revealed Resident #11 was admitted on [DATE] with diagnoses of Alzheimer's disease, restlessness and agitation, peripheral vascular disease and repeated falls. Review of the facility's Incidents and Accidents Log from 08/12/24 to 11/06/24 revealed an incident documented for an injury of unknown origin dated 09/06/24 for Resident #11. The entry was struck out on 11/04/24 by the Interim Director of Nursing (DON). Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #11 had severe cognitive impairment and was frequently incontinent of bowel and bladder. The resident required was dependent on staff for toileting and required maximal assistance with transfers. Review of a struck-out nurse's progress note for Resident #11 dated 09/06/24 at 10:17 A.M., authored by Licensed Practical Nurse (LPN) #401, revealed at 8:40 A.M., staff were passing the breakfast trays and did not see Resident #11. The staff looked and found her in Resident #8609's room. Upon entering the room, this writer noticed a scratch on Resident #11's left eyebrow and left cheek. When asked what happened, Resident #11 smiled, and looked forward to the television. This progress note was struck out by interim DON on 11/04/24 at 11:05 A.M. due to incorrect documentation. Review of a fax cover sheet dated 09/06/24 at 10:51 A.M., revealed the physician was notified of the injuries to Resident #11. The physician verified the receipt of the notification on 09/07/24. Review of a struck-out nurse's progress note for Resident #11 dated 09/06/24 at 11:05 A.M., authored by LPN #401, revealed Resident #11 had a new skin concern which consisted of an abrasion/scratch on the resident's left cheek which measured 0.5 centimeters (cm) and 1.0 cm on the left eyebrow. The areas were cleansed and allowed to air dry. The resident did not complain of pain and a pain assessment was completed. Notifications were made to the family and the physician on 09/06/24. No new orders were received, and care plan was initiated. This progress note was struck out by Interim DON #300 on 11/04/24 at 11:05 A.M. due to incorrect documentation. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of an abuse/neglect screening for Resident #11 on 09/06/24 at 11:23 A.M. authored by LPN #401 was struck out by Interim DON on 11/04/24 at 11:05 due to incorrect documentation. Review of a Neurological (Neuro) checks 72-Hour Occurrence Follow Up dated 09/06/24 at 11:42 A.M., revealed the form was initiated by LPN #401 and marked as incomplete. Review of a nurse's progress noted for Resident #11 dated 09/06/24, authored by LPN #401, revealed Resident #11 was found in the room of Resident #8609 standing in front of the shelves. LPN #401 noticed two scratches on the resident's face. When questioned about Resident #11's face, Resident #8609 just looked off at the television without answering. Review of an Incident Witness statement completed on 09/06/24 by Certified Nursing Assistant (CNA) #501 revealed Resident #11 was found in Resident #8609's room and Resident #11 had a scratch on her left cheek and left eyebrow. Review of a nurse's progress note for Resident #11 dated 09/07/24 at 5:25 P.M., revealed upon starting the shift (7:00 A.M.), Resident #11 did not have bruising or swelling to the face. At approximately 5:26 P.M., the staff observed slight bruising and swelling to Resident #11's face. The staff applied cold compress periodically to swelling and bruising. Review of a nurse's progress note for Resident #11 dated 09/07/24 at 6:41 P.M., revealed the nurse attempted to apply cold compress to the resident's left side of face and the resident refused. The guardian and physician were notified, no signs of discomfort or pain and the resident was able to eat with no problems. An assessment was completed with no concerns. Review of a nurse's progress note for Resident #11 dated 09/09/24 at 7:27 P.M., revealed this writer spoke with resident's power-of-attorney (POA) / daughter to discuss interventions put in place to ensure the resident's safety. Review of a nurse's progress note for Resident #11 dated 09/10/24 at 7:30 A.M. revealed resident was on 15-minute checks. Interview with interim DON on 11/06/24 at 10:25 A.M., revealed she started employment with the facility on 09/28/24. Interim DON stated she struck out all documentation related to Resident #11's injury of unknown origin on 09/06/24 after she was told by Assistant Director of Nursing (ADON) #333 the injury of unknown origin involving Resident #11 on 09/06/24 did not happen. The Interim DON verified that the facility did not implement their policy regarding injuries of unknown origin when Resident #11 was discovered with injuries on 09/06/24. Interview with ADON #333 on 11/06/24 at 10:30 A.M., revealed she went with the previous Administrator to assess the injuries to Resident #11, and stated the resident had no such injury as described in the progress notes on 09/06/24. When asked about the progress notes which described the specific injuries, bruising and swelling to Resident #11's face, ADON #333 stated that was wrong information documented by the nurses and offered no further explanation, information or documentation. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with LPN #401 on 11/18/24 at 8:50 A.M., revealed she and CNAs #501 and #590 found Resident #11 in Resident #8609's room on 09/06/24 with new scratches to her left cheek and left eyebrow. LPN #401 stated on 09/06/24 she made notifications to ADON #333, the physician and family and initiated the abuse/neglect screening document. LPN #401 stated on 11/04/24 she attended a meeting with the facility's administration and asked why she deleted documentation related to Resident #11's injury of unknown origin. LPN #401 stated she did not delete any documentation related to Resident #11. Interview with CNA #501 on 11/18/24 at 9:10 A.M. verified Resident #11 was found in the room of Resident #8609 with new scratches on her left cheek and left eyebrow. Review of the facility policy titled, Abuse Prevention and Reporting, dated 09/24, revealed employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment, injuries of unknown origin or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the state agency immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. Any incident or allegation involving abuse, neglect, exploitation, injuries of unknown origin, mistreatment or misappropriation of resident property will result in an investigation. This deficiency represents noncompliance investigated under Complaint Number OH00158062.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, staff interviews, review of facilities Self-Reported Incidents (SRIs), and facility policy review, the facility failed to timely report an injury of unknown origin to the state agency. This affected one (#11) of the two residents reviewed for abuse and injury of unknown origin. The facility census was 84. Findings include: Review of the medical record revealed Resident #11 was admitted on [DATE] with diagnoses of Alzheimer's disease, restlessness and agitation, peripheral vascular disease and repeated falls. Review of the facility's Incidents and Accidents Log from 08/12/24 to 11/06/24 revealed an incident documented for an injury of unknown origin dated 09/06/24 for Resident #11. The entry was struck out on 11/04/24 by the Interim Director of Nursing (DON). Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #11 had severe cognitive impairment and was frequently incontinent of bowel and bladder. The resident required was dependent on staff for toileting and required maximal assistance with transfers. Review of a struck-out nurse's progress note for Resident #11 dated 09/06/24 at 10:17 A.M., authored by Licensed Practical Nurse (LPN) #401, revealed at 8:40 A.M., staff were passing the breakfast trays and did not see Resident #11. The staff looked and found her in Resident #8609's room. Upon entering the room, this writer noticed a scratch on Resident #11's left eyebrow and left cheek. When asked what happened, Resident #11 smiled, and looked forward to the television. This progress note was struck out by interim DON on 11/04/24 at 11:05 A.M. due to incorrect documentation. Review of a fax cover sheet dated 09/06/24 at 10:51 A.M., revealed the physician was notified of the injuries to Resident #11. The physician verified the receipt of the notification on 09/07/24. Review of a struck-out nurse's progress note for Resident #11 dated 09/06/24 at 11:05 A.M., authored by LPN #401, revealed Resident #11 had a new skin concern which consisted of an abrasion/scratch on the resident's left cheek which measured 0.5 centimeters (cm) and 1.0 cm on the left eyebrow. The areas were cleansed and allowed to air dry. The resident did not complain of pain and a pain assessment was completed. Notifications were made to the family and the physician on 09/06/24. No new orders were received, and care plan was initiated. This progress note was struck out by Interim DON #300 on 11/04/24 at 11:05 A.M. due to incorrect documentation. Review of an abuse/neglect screening for Resident #11 on 09/06/24 at 11:23 A.M. authored by LPN #401 was struck out by Interim DON on 11/04/24 at 11:05 due to incorrect documentation. Review of a Neurological (Neuro) checks 72-Hour Occurrence Follow Up dated 09/06/24 at 11:42 A.M., revealed the form was initiated by LPN #401 and marked as incomplete. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nurse's progress noted for Resident #11 dated 09/06/24, authored by LPN #401, revealed Resident #11 was found in the room of Resident #8609 standing in front of the shelves. LPN #401 noticed two scratches on the resident's face. When questioned about Resident #11's face, Resident #8609 just looked off at the television without answering. Review of an Incident Witness statement completed on 09/06/24 by Certified Nursing Assistant (CNA) #501 revealed Resident #11 was found in Resident #8609's room and Resident #11 had a scratch on her left cheek and left eyebrow. Review of the facility's SRIs on the state agency's website revealed the facility did not timely create an SRI or thoroughly investigate Resident #11's injury of unknown origin discovered on 09/06/24. Review of a nurse's progress note for Resident #11 dated 09/07/24 at 5:25 P.M., revealed upon starting the shift (7:00 A.M.), Resident #11 did not have bruising or swelling to the face. At approximately 5:26 P.M., the staff observed slight bruising and swelling to Resident #11's face. The staff applied cold compress periodically to swelling and bruising. Review of a nurse's progress note for Resident #11 dated 09/07/24 at 6:41 P.M., revealed the nurse attempted to apply cold compress to the resident's left side of face and the resident refused. The guardian and physician were notified, no signs of discomfort or pain and the resident was able to eat with no problems. An assessment was completed with no concerns. Review of a nurse's progress note for Resident #11 dated 09/09/24 at 7:27 P.M., revealed this writer spoke with resident's power-of-attorney (POA) / daughter to discuss interventions put in place to ensure the resident's safety. Review of a nurse's progress note for Resident #11 dated 09/10/24 at 7:30 A.M., revealed the resident was on 15-minute checks. Interview with interim DON on 11/06/24 at 10:25 A.M., revealed she started employment with the facility on 09/28/24. Interim DON stated she struck out all documentation related to Resident #11's injury of unknown origin on 09/06/24 after she was told by Assistant Director of Nursing (ADON) #333 the injury of unknown origin involving Resident #11 on 09/06/24 did not happen. The Interim DON verified that the facility did not submit an SRI to the state agency timely. Interview with ADON #333 on 11/06/24 at 10:30 A.M., revealed she went with the previous Administrator to assess the injuries to Resident #11, and stated the resident had no such injury as described in the progress notes on 09/06/24. When asked about the progress notes which described the specific injuries, bruising and swelling to Resident #11's face, ADON #333 stated that was wrong information documented by the nurses and offered no further explanation, information or documentation. Interview with LPN #401 on 11/18/24 at 8:50 A.M., revealed she and CNAs #501 and #590 found Resident #11 in Resident #8609's room on 09/06/24 with new scratches to her left cheek and left eyebrow. LPN #401 stated on 09/06/24 she made notifications to ADON #333, the physician and family and initiated the abuse/neglect screening document. LPN #401 stated on 11/04/24 she attended a meeting with the facility's administration and asked why she deleted documentation related to Resident #11's injury of unknown origin. LPN #401 stated she did not delete any documentation related to Resident #11. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with CNA #501 on 11/18/24 at 9:10 A.M. verified Resident #11 was found in the room of Resident #8609 with new scratches on her left cheek and left eyebrow. Review of the facility policy titled, Abuse Prevention and Reporting, dated 09/24, revealed any allegation of abuse, neglect, mistreatment, injuries of unknown origin or any incident that results in serious bodily injury will be reported to the state agency immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. This deficiency represents noncompliance investigated under Complaint Number OH00158062.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, review of the facility incident log, review of facility Self-reported Incidents (SRI's), staff interview, and review of the facility policy, the facility failed to thoroughly investigate an injury of unknown source. This affected one (#11) of the two residents reviewed for abuse and injury of unknown origin. The facility census was 84. Findings include: Review of the medical record revealed Resident #11 was admitted on [DATE] with diagnoses of Alzheimer's disease, restlessness and agitation, peripheral vascular disease and repeated falls. Review of the facility's Incidents and Accidents Log from 08/12/24 to 11/06/24 revealed an incident documented for an injury of unknown origin dated 09/06/24 for Resident #11. The entry was struck out on 11/04/24 by the Interim Director of Nursing (DON). Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #11 had severe cognitive impairment and was frequently incontinent of bowel and bladder. The resident required was dependent on staff for toileting and required maximal assistance with transfers. Review of a struck-out nurse's progress note for Resident #11 dated 09/06/24 at 10:17 A.M., authored by Licensed Practical Nurse (LPN) #401, revealed at 8:40 A.M., staff were passing the breakfast trays and did not see Resident #11. The staff looked and found her in Resident #8609's room. Upon entering the room, this writer noticed a scratch on Resident #11's left eyebrow and left cheek. When asked what happened, Resident #11 smiled, and looked forward to the television. This progress note was struck out by interim DON on 11/04/24 at 11:05 A.M. due to incorrect documentation. Review of a fax cover sheet dated 09/06/24 at 10:51 A.M., revealed the physician was notified of the injuries to Resident #11. The physician verified the receipt of the notification on 09/07/24. Review of a struck-out nurse's progress note for Resident #11 dated 09/06/24 at 11:05 A.M., authored by LPN #401, revealed Resident #11 had a new skin concern which consisted of an abrasion/scratch on the resident's left cheek which measured 0.5 centimeters (cm) and 1.0 cm on the left eyebrow. The areas were cleansed and allowed to air dry. The resident did not complain of pain and a pain assessment was completed. Notifications were made to the family and the physician on 09/06/24. No new orders were received, and care plan was initiated. This progress note was struck out by Interim DON #300 on 11/04/24 at 11:05 A.M. due to incorrect documentation. Review of an abuse/neglect screening for Resident #11 on 09/06/24 at 11:23 A.M. authored by LPN #401 was struck out by Interim DON on 11/04/24 at 11:05 due to incorrect documentation. Review of a Neurological (Neuro) checks 72-Hour Occurrence Follow Up dated 09/06/24 at 11:42 A.M., revealed the form was initiated by LPN #401 and marked as incomplete. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nurse's progress noted for Resident #11 dated 09/06/24, authored by LPN #401, revealed Resident #11 was found in the room of Resident #8609 standing in front of the shelves. LPN #401 noticed two scratches on the resident's face. When questioned about Resident #11's face, Resident #8609 just looked off at the television without answering. Review of an Incident Witness statement completed on 09/06/24 by Certified Nursing Assistant (CNA) #501 revealed Resident #11 was found in Resident #8609's room and Resident #11 had a scratch on her left cheek and left eyebrow. Review of the facility's SRIs on the state agency's website revealed the facility did not timely create an SRI or thoroughly investigate Resident #11's injury of unknown origin discovered on 09/06/24. Review of a nurse's progress note for Resident #11 dated 09/07/24 at 5:25 P.M., revealed upon starting the shift (7:00 A.M.), Resident #11 did not have bruising or swelling to the face. At approximately 5:26 P.M., the staff observed slight bruising and swelling to Resident #11's face. The staff applied cold compress periodically to swelling and bruising. Review of a nurse's progress note for Resident #11 dated 09/07/24 at 6:41 P.M., revealed the nurse attempted to apply cold compress to the resident's left side of face and the resident refused. The guardian and physician were notified, no signs of discomfort or pain and the resident was able to eat with no problems. An assessment was completed with no concerns. Review of a nurse's progress note for Resident #11 dated 09/09/24 at 7:27 P.M., revealed this writer spoke with resident's power-of-attorney (POA) / daughter to discuss interventions put in place to ensure the resident's safety. Review of a nurse's progress note for Resident #11 dated 09/10/24 at 7:30 A.M., revealed the resident was on 15-minute checks. Interview with interim DON on 11/06/24 at 10:25 A.M., revealed she started employment with the facility on 09/28/24. Interim DON stated she struck out all documentation related to Resident #11's injury of unknown origin on 09/06/24 after she was told by Assistant Director of Nursing (ADON) #333 the injury of unknown origin involving Resident #11 on 09/06/24 did not happen. The Interim DON verified that the facility did thoroughly investigate Resident #11's injuries of unknown origin on 09/06/24. Interview with ADON #333 on 11/06/24 at 10:30 A.M., revealed she went with the previous Administrator to assess the injuries to Resident #11, and stated the resident had no such injury as described in the progress notes on 09/06/24. When asked about the progress notes which described the specific injuries, bruising and swelling to Resident #11's face, ADON #333 stated that was wrong information documented by the nurses and offered no further explanation, information or documentation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with LPN #401 on 11/18/24 at 8:50 A.M., revealed she and CNAs #501 and #590 found Resident #11 in Resident #8609's room on 09/06/24 with new scratches to her left cheek and left eyebrow. LPN #401 stated on 09/06/24 she made notifications to ADON #333, the physician and family and initiated the abuse/neglect screening document. LPN #401 stated on 11/04/24 she attended a meeting with the facility's administration and asked why she deleted documentation related to Resident #11's injury of unknown origin. LPN #401 stated she did not delete any documentation related to Resident #11. Interview with CNA #501 on 11/18/24 at 9:10 A.M. verified Resident #11 was found in the room of Resident #8609 with new scratches on her left cheek and left eyebrow. Review of the facility policy titled, Abuse Prevention and Reporting, dated 09/24, revealed any incident or allegation involving abuse, neglect, exploitation, injuries of unknown origin, mistreatment or misappropriation of resident property will result in a thorough investigation. This deficiency represents noncompliance investigated under Complaint Number OH00158062.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, observation, staff and resident interviews, review of facility policy and review of guidelines from the National Pressure Injury Advisory Panel (NPIAP), the facility failed to adequately assess residents' skin, initiate prompt and timely treatment for residents' with pressure ulcers (a pressure ulcer is a localized injury of the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), provide ongoing monitoring of pressure ulcers and failed to timely implement physician ordered interventions to prevent the development of pressure ulcers and/or aid in the healing of existing pressure ulcers. This resulted in Actual Harm when two Residents (#75 and #05) were admitted to the facility without pressure ulcers but were at risk for the development of pressure ulcers and subsequently developed avoidable, facility acquired pressure ulcers which were not identified until they had reached an advanced stage. Resident #75 developed a pressure ulcer on 06/04/24 which was first identified as a stage III (full-thickness skin loss in which adipose [fat] is visible) pressure ulcer on his right heel. Resident #75 developed another pressure ulcer on 08/20/24 which was first identified as a stage III pressure ulcer on his right flank. Resident #75 developed a third avoidable pressure ulcer on 09/11/24 which was first identified as a stage III pressure ulcer on the resident's sacrum. Additionally, Resident #05 was noted with skin breakdown by the licensed nurses on 07/13/24 and 07/16/24, and was not evaluated by the wound physician until 07/30/24 when Wound Care Physician (WCP) #198 diagnosed the resident with a stage III pressure ulcer on the resident's sacrum. This affected two (#75 and #05) of three residents reviewed for pressure ulcers. The facility identified six residents with pressure ulcers. The facility census was 84. Findings include: 1) Review of the medical record for Resident #75 revealed the resident was admitted on [DATE]. Diagnoses included dementia, chronic kidney disease stage IV, diabetes mellitus type II and protein-calorie malnutrition. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] for Resident #75, revealed the resident was cognitively impaired, was dependent on staff for all activities of daily living (ADLs), Section M (Skin Conditions) revealed Resident #75 did not have a pressure ulcer/injury, was at risk of developing pressure ulcers/injuries and needed pressure relieving devices for the chair and bed. Review of the medical record for Resident #75 from 03/05/24 through 06/01/24, revealed no documentation of a plan of care, any skin risk assessments completed, and physician or Non-Physician Provider (NPP) visits completed for the resident. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nurse progress note dated 06/01/24 for Resident #75 and authored by Licensed Practical Nurse (LPN) #410, revealed the resident had an area to the right heel measuring 7 centimeters (cm) in length by 4 cm in width by no depth. The area was dark brown in color and the surrounding tissue was red and blanchable with no warmth. The Medical Director (MD) #199 and Wound Care Nurse (WCN) #490 were notified. An order was received to apply skin prep to the resident's right heel two times a day and the doctor would be in on Monday. WCN #490 relayed the resident would be placed on the next weekly wound physician rounds. Treatment was applied, the resident was repositioned, and the family was notified. Review of a handwritten physician order dated 06/03/24 for Resident #75, located in the hard/paper chart, revealed the resident was ordered to wear bilateral heel protectors while in the bed or wheelchair. Review of a nurse progress note dated 06/04/24 for Resident #75 and authored by LPN #491, revealed the resident was seen by Wound Care Physician (WCP) #198 for a facility acquired stage III pressure injury to resident's right heel with an onset date of 06/01/24. Measurements were 2.7 centimeters (cm) in length by 2. 7 cm in width by 0.1 cm in depth and minimal exudate (drainage) was present with no signs or symptoms of infection. WCP #198 gave orders for daily treatment of the wound and recommended the use of a low air loss (LAL) mattress and consult with physical therapy/occupational therapy for wound offloading needs of the resident's heels while in a wheelchair. Review of a physician order in the electronic medical record (EMR) dated 06/14/24 for Resident #75 by MD #199, revealed an order for Resident #75 to have an LAL mattress. Review of the June 2024, July 2024, August 2024 and September 2024 medication administration records (MAR) and treatment administration records (TAR) for Resident #75, revealed the daily dressing changes on the right heel were being completed as ordered. The MAR and TAR revealed no documented evidence that the heel protectors ordered on 06/03/24 and the LAL mattress ordered on 06/14/24 were ever implemented. Review of the weekly wound round visits by WCP #198, revealed Resident #75 was not assessed again by WCP #198 until 08/20/24, when the resident was evaluated for a newly acquired pressure ulcer. Review of a Wound Assessment and Plan visit note dated 08/20/24 for Resident #75 and authored by WCP #198, revealed the resident developed a new facility acquired Stage III pressure injury on his right flank which measured 21 cm in length by 14.2 cm in width by an unable to determine depth. There was 40 percent (%) granulation (new tissue), five % slough (peeling skin) and 55 % eschar (blackened/dead skin) with a moderate amount of exudate (drainage) and no signs and symptoms of infection. WCP #198 performed a sharp debridement (a medical procedure that involves removing dead, infected, or damaged tissue from a wound to help it heal) procedure to remove the eschar and slough. WCP #198 gave orders for daily treatment of the wound, weekly visits and ordered for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank). Review of a Wound Assessment and Plan visit note dated 09/03/24 for Resident #75 and authored by WCP #198, revealed the stage III pressure ulcer on the resident's right flank pressure injury measured 11.5 cm length by 8.5 cm width by 0.1 cm depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and ordered a LAL mattress for wound off-loading. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a Wound Assessment and Plan visit note dated 09/11/24 for Resident #75 and authored by WCP #198, revealed the resident developed a new facility acquired stage III pressure injury on his sacrum which measured 7.5 cm in length by 3.3 cm in width by 0.1 cm in depth. WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended a LAL mattress for wound off-loading. The right flank stage III pressure injury measured 8.6 cm in length by 6.2 cm in width by 0.1 cm in depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and ordered for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank). Review of Resident #75's only documented Braden Scale - for Predicting Pressure Sore Risk, dated 09/15/24, revealed the resident was at very high risk for developing pressures ulcers. Review of a Wound Assessment and Plan visit note dated 09/17/24 for Resident #75 and authored by WCP #198, revealed the resident's right flank stage III pressure ulcer measured 3.9 cm in length by 4.4 cm in width by 0.1 cm in depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank) and for the resident to have a LAL mattress. The sacrum pressure injury measured 3.2 cm in length by 4.9 cm in width by 0.1 cm in depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound. The resident had a new diabetic ulcer on her right heel which measured 0.6 cm in length by 0.6 cm in width by 0.1 cm in depth. WCP #198 gave orders for daily treatment of the wound, weekly wound care visits and recommended for the resident to have a LAL mattress. Review of a Wound Assessment and Plan visit note dated 09/24/24 for Resident #75, and authored by WCP #198, revealed the resident's right flank pressure injury measured 6.9 cm in length by 1.3 cm in width by 0.1 cm in depth (an increase in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and ordered for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank) and for the resident to have a LAL mattress. The resident's right heel diabetic ulcer measured 3.6 cm in length by 3.4 cm in width by 0.1 cm in depth (an increase in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended the resident to have a LAL mattress. The sacrum pressure injury measured 6.3 cm in length by 1.3 cm in width by 0.1 cm in depth (an increase in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended the resident to have a LAL mattress. Review of a Wound Assessment and Plan visit dated 10/01/24 for Resident #75 and authored by WCP #198, revealed the resident's right flank pressure injury measured 4.9 cm in length by 1.6 cm in width by 0.2 cm in depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and ordered for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank) and for the resident to have a LAL mattress. The right heel diabetic ulcer measured 2.1 cm in length by 1.5 cm in width by 0.1 cm in depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended for the resident to have an LAL mattress. The sacrum pressure ulcer measured 6.3 cm in length by 1.3 cm in width by 0.1 cm in depth (no changes). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended the resident to have a LAL mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a Wound Assessment and Plan visit dated 10/08/24 for Resident #75 and authored by WCP #198, revealed the resident's right flank pressure injury measured 4.5 cm length by 1.7 cm width by 0.2 cm depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank) and for the resident to have a LAL mattress. The right heel diabetic ulcer measured 2.3 cm length by 0.7 cm width by 0.1 cm depth (an increase in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended the resident to have a LAL mattress. The sacrum wound was healed. A preventative wound recommendation was for the resident to have a LAL mattress. Review of a Wound Assessment and Plan visit dated 10/15/24 for Resident #75 and authored by WCP #198, revealed the resident's right flank pressure injury measured 4.1 cm in length by 1.4 cm in width by 0.2 cm in depth (a decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank) and for the resident to have a LAL mattress. The right heel diabetic ulcer was healed. Review of a physician order dated 10/17/24 for Resident #75, revealed the resident was ordered to have weekly skin assessments every Wednesday and notify the physician for any new impairments. Review of a Wound Assessment and Plan visit note dated 10/22/24 for Resident #75 and authored by WCP #198, revealed the resident's right flank pressure injury measured 2.1 cm in length by 1.1 cm in width by 0.2 cm in depth (decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank) and for the resident to have a LAL mattress. Review of a Wound Assessment and Plan note dated 11/05/24 for Resident #75 authored by WCP #198, revealed the resident's right flank pressure injury measured 2.0 cm in length by 1.0 cm in width by 0.1 cm in depth (decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank) and for the resident to have a LAL mattress. Interview with MDS Coordinator #395 on 11/06/24 at 10:35 A.M., revealed she assisted in updating the residents' care plans. MDS Coordinator #396 verified she never placed any specific off-loading interventions on Resident #75's plan of care and if the staff needed to know of any specific interventions for Resident #75, they would have to go into the physician's orders to view them. MDS Coordinator #395 indicated the facility did not utilize any type of quick reference Kardex system. MDS Coordinator #395 verified there was no LAL mattress, or bilateral heel protectors assessed on the MDS. Interview with LPN #420 on 11/06/24 at 11:35 A.M. who reported being Resident #75's regular nurse, revealed she had no knowledge of the order dated 06/14/24 for Resident #75 to have a LAL mattress. LPN #420 stated she was aware of the bilateral heel protectors for the resident because the order was reflected on the MAR. LPN #420 verified the LAL mattress was not in place on Resident #75's bed when the resident developed the stage III pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation of Resident #75's room on 11/06/24 at 11:45 A.M. with CNA #575, revealed the resident was seated in a wheelchair with no heel protectors in place and the resident's bed did not have a LAL mattress in place. Interview with CNA #575 at the same time revealed she was unaware Resident #75 had physician orders for a LAL mattress and bilateral heel protectors. Interview with the Interim Director of Nursing (DON) on 11/06/24 at 1:33 P.M., revealed Resident #75 was ordered to have bilateral heel protectors on 06/03/24 and there was no documented evidence that the bilateral heel protectors were ever implemented. The Interim DON verified the resident was ordered to have a LAL mattress on 06/14/24 which wasn't implemented until 11/06/24 when the surveyor questioned it. The Interim DON verified Resident #75 developed an avoidable facility acquired stage III pressure ulcer on the right heel on 06/04/24 and was not assessed again by WCP #198 until 08/20/24 when the resident developed another facility acquired stage III pressure ulcer on the resident's right flank. The Interim DON verified Resident #75 developed a third stage III pressure ulcer on the resident's sacrum on 09/11/24. The Interim DON acknowledged Resident #75's pressure ulcers should have been identified before they had reached an advanced stage. The Interim DON stated the facility did not have a Kardex type system in place for the staff to use as a quick reference for any physician ordered care interventions for the residents. The Interim DON stated the staff would have to access the physician orders in order to find out if there were any ordered interventions in place for the residents. The Interim DON stated the CNAs did not have access to the physician orders and would have no way of knowing about any specific interventions unless the nursing staff relayed the information. Observation of Resident#75's room on 11/06/24 at 3:45 P.M., revealed the resident was in bed and had a LAL mattress on the bed and was wearing bilateral heel protectors. Review of a Wound Assessment and Plan visit note dated 11/27/24 for Resident #75 and authored by WCP #198, revealed the resident's right flank pressure injury wound measured 2.7 cm in length by 11.3 cm in width by 0.1 cm in depth (decrease in size). WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended for physical therapy/occupational therapy to consult for wound offloading needs (to offload the resident's right upper extremity off of the right flank). Attempted interview with WCP #198 on 12/02/24 at 3:23 P.M. and again on 12/04/24 at 9:05 A.M. with no success. Interview with Regional Director of Rehabilitation (RDR) #800 on 12/04/24 at 1:04 P.M. revealed the facility had been through three different therapy providers since June 2024 with the most recent change in therapy providers taking place on 11/11/24. RDR #800 verified WCP #198 had ordered physical therapy/occupational therapy to be consulted for Resident #75's wound offloading needs. RDR #800 verified there was no documented evidence Resident #75 had been evaluated by therapy for the off-loading needs. Follow-up interview with the Interim DON on 12/04/24 at 4:42 P.M., verified Resident #75 was ordered to have a therapy consultation for off-loading needs on 08/20/24 by WCP #198. Interim DON verified the facility did not have any therapy records for Resident #75 prior to the 11/11/24 transition because the therapy records did not transition over to the new therapy provider. The Interim DON stated the facility recently parted ways with WCP #198 due to several issues and it was not an amicable departure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2) Review of the medical record for Resident #05 revealed the resident was admitted on [DATE]. The resident was discharged to the hospital on 06/19/24 and readmitted to the facility on [DATE]. Diagnoses included cerebral infarction (stroke) with hemiplegia affecting dominant side, left femur fracture, and displaced fracture of second cervical vertebrae. Review of the admission History and Physical dated 06/14/24 for Resident #05 revealed the only identified skin impairment was a surgical incision for a repaired left femur fracture. Review of the MDS five-day assessment dated [DATE] for Resident #05, Section M (Skin Conditions) revealed the resident did not have a pressure ulcer/injury, was at risk of developing pressure ulcers/injuries and needed pressure relieving devices for the bed and chair due to a surgical incision. Review of the plan of care dated 06/20/24, revealed Resident #05 had a focus area for skin impairments due to impaired mobility, recent left hip replacement, and osteoarthritis. Interventions included, but not limited to, pressure reduction cushion to wheelchair per facility protocol, apply moisture barrier cream after incontinent care, turn and reposition frequently, follow facility policies/protocols for the prevention/treatment of skin breakdown, instruct/assist to shift weight in wheelchair frequently, and LAL mattress to bed and check placement and function per facility protocol. Review of the June 2024, July 2024, August 2024 and September 2024 MARs and TARs revealed no documented evidence Resident #05 had an order for a LAL mattress or had one in place. Review of a nurse progress note dated 07/05/24 at 6:00 P.M. for Resident #05 and authored by LPN #499, revealed the resident readmitted to the facility from the hospital at 1:30 P.M. There was an area to the resident's coccyx, pink in color, measured 3.0 cm in length by 1.5 cm in width by 0 cm in depth. A dry dressing was applied after cleaning with normal saline. There is no documented evidence that the physician or other provider was notified of the new area identified on the resident's coccyx. Review of the hospital Continuity of Care discharge form dated 07/05/24, revealed when Resident #05 was discharged from the hospital, the only wound present was a surgical incision to the left hip. Resident #05 was hospitalized from 06/19/24 to 07/05/24 due to acute respiratory failure with hypoxia. Review of the re-admission History and Physical dated 07/08/24 for Resident #05, revealed the only documented skin impairment, was a surgical incision for the repaired left femur fracture. Review of a nurse progress note dated 07/13/24 at 7:00 A.M. for Resident #05 authored by RN #397, revealed Resident #05 was alert, oriented, had normal breathing with no shortness of breath reported and no other complaints. Dressing to left hip continued with no breakthrough drainage noted. Resident #05 noted with skin breakdown to coccyx area which measured 5 cm in length by 3 cm in width and a dressing was applied. The Foley catheter was patent and draining dark colored urine. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nurse progress note dated 07/16/24 for Resident #05 authored by RN #396 revealed the resident was resting in bed with normal vital signs. The nurse was called to the resident's room to observe the skin breakdown on the resident's coccyx area. The color was pink and dark/scabbed in some places which were noted on admission. The area was cleansed with normal saline. The resident reportedly had three episodes diarrhea. Nurse Practitioner (NP) called and ordered for the resident to have a one-time dose of Imodium (anti-diarrhea). The resident's daughter was notified of the diarrhea and the medication. There was no documented evidence of the NP being notified of the skin breakdown. Review of the nurse progress notes from 07/17/24 to 07/30/24 for Resident #05, revealed no additional documentation of the resident's skin breakdown on his coccyx. Review of the weekly skin assessments from 07/17/24 to 07/30/24 for Resident #05 revealed no documented evidence of any skin assessments being completed. Review of a physician order dated 07/17/24 for Resident #05, revealed the resident was ordered to have weekly skin assessments and to notify physician if a new skin impairment developed. Review of a Wound Assessment and Plan note dated 7/30/24 for Resident #05 and authored by WCP #198 revealed the resident was evaluated and diagnosed with a new facility acquired stage III pressure ulcer on his sacrum. The new pressure ulcer measured 3.4 cm in length by 2.0 cm in width and unable to determine depth. The wound had 20 % granulation, 70 % slough, 10% eschar, minimal exudate, and no signs and symptoms of infection. The resident's wound was debrided to remove excess eschar and slough tissue. Post debridement wound bed had 35 % slough and eschar remaining and post debridement wound bed measurement 3.3 cm in length by 2.2 cm in width by 0.5 cm in depth. WCP #198 gave orders for daily treatment of the wound, weekly visits and recommended the resident to have a LAL mattress. Review of a nurse progress note dated 07/31/24 for Resident #05 and authored by WCN #490, revealed the resident was seen by WCP #198 during the weekly wound care rounds on 07/30/24. The resident had a stage III sacrum pressure injury which measured 3.4 cm in length x 2.0 cm in width and unable to determine depth. Resident was ordered to have his sacrum cleansed with normal saline, hydrogel gauze applied, covered with dry dressing and changed daily and as needed. The resident and family are aware of the new orders and voiced understanding. Review of the physician orders dated 07/31/24 for Resident #05, revealed an order to cleanse the resident's sacral wound with normal saline, apply hydrogel gauze to wound bed, cover with dry dressing, change daily every night shift and as needed. Review of a Wound Assessment and Plan for Resident #05 dated 08/06/24, 08/13/24 08/20/24 08/27/24, 09/03/24, 09/11/24, 09/17/24, 09/24/24, 10/01/24, 10/08/24, 10/15/24, 10/22/24, and 11/05/24 and authored by WCP #198, revealed the resident was ordered to have a LAL mattress. Review of a physician order dated 10/22/24 for Resident #05, revealed the resident was ordered a LAL mattress due to resident being a high-risk for skin breakdown. Interview with the Interim DON on 11/06/24 at 3:00 P.M., revealed the staff had to look at the physician orders or the MARs and/or TARs to view any specific resident care interventions which was not practical. The Interim DON stated the CNAs did not have access to the physician's orders to view any specific interventions ordered for the residents. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 11/18/24 at 12:10 P.M. revealed Resident #05 was in bed and had an LAL mattress in place. Interview with the Interim DON on 11/18/24 at 12:16 P.M. verified Resident #05 was at risk for developing pressure ulcers and was diagnosed with a facility acquired stage III pressure injury located on the resident's sacrum on 07/30/24. The Interim DON verified the pressure ulcer was not identified until it had reached a stage III. The interim DON verified Resident #05's LAL mattress was ordered on 07/30/24 by WCP #198 and not put in place until 10/22/24. Interview with WCN #490 on 11/18/24 at 12:33 P.M., verified Resident #05 was at risk for developing pressure ulcers when the resident developed a facility acquired pressure ulcer on his sacrum and it was not identified until it reached a stage III. WCN #490 verified WCP #198 ordered a LAL mattress on 07/30/24 and it was not put in place until 10/22/24. Interview via phone with RN #396 on 12/02/24 at 7:51 P.M. verified there was no documented evidence that the physician or the facility administration was notified when she observed Resident #05's skin breakdown on the coccyx. RN #396 stated she had no recollection of the resident's wounds. Interview via phone with LPN #499 on 12/02/24 at 8:03 P.M. verified there was no documented evidence that the physician or the facility administration was notified when she observed Resident #05's skin breakdown on the coccyx. LPN #499 stated she had no recollection of the resident's wounds. Interview via phone with RN #397 on 12/03/24 at 2:28 P.M. verified there was no documented evidence that the physician or the facility administration was notified when he observed Resident #05's skin breakdown on the coccyx. RN #397 stated he had no recollection of the resident's wounds. Review of the facility policy titled, Skin Condition Assessment and Monitoring-Pressure and Non-Pressure, last updated October 2024, revealed the purpose of the policy is to establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines include pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. The facility policy also states that residents identified will have a weekly skin assessment completed by a licensed nurse. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the NPIAP, 2019 edition, pages 75 to 81, indicate skin and soft tissue assessment is the basis of pressure injury prevention and treatment. Skin and tissue assessment is an essential component of any pressure injury risk assessment and should be conducted as soon as possible after admission, as a component of a full risk assessment (see the guideline chapter on Risk Factors and Risk Assessment). Each time the individual's clinical condition changes, a comprehensive skin and tissue assessment should be conducted to identify any alterations to skin characteristics or integrity, and to identify any new pressure injury risk factors. Finally, a comprehensive skin and soft tissue assessment should be conducted on discharge, to ensure that an appropriate pressure injury prevention and treatment plan is in place. A comprehensive skin and soft tissue assessment consists of a head-to-toe assessment with particular focus on skin overlying bony prominence's including the sacrum, ischial tuberosities, greater trochanters and heels. In addition to comprehensive skin assessment, a brief skin assessment of the pressure points should be undertaken during repositioning. Check the pressure points on which the individual has been positioned to identify any alterations in condition and to evaluate the effectiveness of the repositioning regimen. Presence of persistent erythema can indicate a need to increase frequency of repositioning. Check pressure points onto which the individual will be repositioned to ensure that the skin and tissue has fully recovered from previous loading. The NPIAP Pressure Injury Stages, revealed if necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). This deficiency represents noncompliance investigated under Complaint Number OH00158062 and Complaint Number OH00160225.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, staff interview, and review of facility policy, the facility failed to ensure a resident's medications were ordered timely upon admission. This affected one Resident (#8601) of three residents reviewed for admissions. The facility census was 84. Findings include: Review of the medical record revealed Resident #8601 was admitted on [DATE]. Diagnoses included malignant neoplasm of unspecified bronchus or lung, hepatic encephalopathy, diabetes mellitus type II, obesity and pleural effusion. The resident was discharged on [DATE] after the family took the resident to an appointment and never returned the resident to the facility. Review of a nurse's progress note dated 08/12/24 for Resident #8601, revealed the resident was admitted to the facility from the hospital at 2:34 P.M. via private transport by family. Resident #8601 was alert and oriented and able to comprehend use of call-light, telephone, bed and television controls. A complete head-to-toe assessment was completed which revealed the resident had no skin abnormalities or discoloration. Resident #8601's blood pressure was 140/77 millimeters of mercury (mmHg) with a pulse of 73 beats per minute. Resident #8601 was resting in bed watching television. Review of the physician orders for Resident #8601 dated 08/12/24 revealed the resident was ordered the following medications: Allopurinol 300 milligrams (mg) daily in the morning for gout, escitalopram oxalate 20 mg daily in the morning for mood stabilizer, folic Acid one mg daily in the morning for supplement, magnesium oxide 400 mg daily in the morning for supplement, spironolactone 50 mg daily in the morning as diuretic, lactulose oral solution 20 grams (gm) in 30 milliliters (mL) give 15 mL two times daily for ammonia reducer, rosuvastatin calcium 10 mg daily at bedtime for cholesterol, Melatonin three mg daily at bedtime for insomnia, mirtazapine 7.5 mg, daily at bedtime for insomnia, olanzapine 10 mg daily at bedtime for sleep/nausea, and omeprazole delayed release 20 mg daily at bedtime for digestion. Review of August 2024 Medication Administration Record (MAR) for Resident #8601 dated 08/12/24, revealed the resident did not receive her physician ordered bedtime medications on which consisted of rosuvastatin calcium 10 mg, Melatonin three mg, mirtazapine 7.5 mg, olanzapine 10 mg, omeprazole delayed release 20 mg, and lactulose oral solution 20 gm/30 mL. Review of Resident #8601's progress notes dated 08/12/24 and 08/13/24, revealed no documented evidence the physician was notified when Resident #8601's medications were not administered. Review of the facility's Pyxis (emergency medication system) formulary dated 08/12/24 revealed Resident #8601's physician ordered Melatonin, mirtazapine, omeprazole, folic Acid, magnesium oxide and spironolactone were available in the Pyxis or from the facility's Over the Counter (OTC) stock medication supply. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365044	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcat Cincinnati	4001 Rosslyn Drive Cincinnati, OH 45209

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of August 2024 MAR for Resident #8601 dated 08/13/24, revealed the resident did not receive her physician ordered morning medications which consisted of Allopurinol 300 mg, Escitalopram Oxalate 20 mg, Folic Acid one mg, Magnesium Oxide 400 mg, Spironolactone 50 mg, and Lactulose oral solution 20 gm./30 mL. Review of the Minimum Data Set (MDS) discharge assessment dated [DATE] revealed Resident #8601 had moderate cognitive impairment Interview with the Interim Director of Nursing (DON) on 11/04/24 at 11:35 A.M. verified Resident #8601 did not receive her physician ordered medications at bedtime on 08/12/24 and morning medications on 08/13/24. Interview with the Interim DON on 11/05/24 at 10:02 P.M. verified Resident #8601 missed her evening medications on 08/12/24 and morning medications on 08/13/24. The Interim DON verified the physician was not notified when Resident #8601 did not receive her medications as ordered the night of 08/12/24 and the morning of 08/13/24. The Interim DON verified there were no nursing notes made, or an incident report completed related to Resident #8601 not receiving her medications as ordered. Interview with Consulting Pharmacist #1010 on 11/05/24 at 10:16 A.M. revealed the cut-off time was 11:00 A. M. for a routine 10:00 P.M. pharmacy delivery. Consulting Pharmacist #1010 stated if the facility would have ordered Resident #8601's medications STAT (immediately) the medications would have been delivered in four hours. Review of a policy titled, Medication Administration General Guidelines, dated 10/24, revealed medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route, and right time. The Medication Administration policy also states, if a medication and/or treatment error occurs, the licensed nurse will: immediately notify the physician, describe the error and the resident's response in the Nurse's notes, complete an incident report, identify the error on the 24-Hour Report, and monitor the resident's status. This deficiency represents non-compliance investigated under Complaint Number OH00159322.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on observation, staff interview, resident interview, and policy review, the facility failed to ensure food was served warm and palatable. This had the potential to affect all but two Residents (#32 and #75) who did not receive food from the facility's kitchen. The facility census was 84. Findings include: Review of the medical record revealed Resident #73 was admitted on [DATE]. Diagnoses included hypertension, osteoarthritis, unspecified dementia, peripheral vascular disease and protein-calorie malnutrition. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #73 had intact cognition and was always incontinent of bowel and bladder. The resident required no assistance with eating. Review of the dinner menu for 11/04/24 revealed the residents received chili mac, cornbread, salad and peaches. Observation of meal line service on 11/04/24 from 4:55 P.M. to 5:11 P.M., revealed the dinner meal consisted of chili mac, cornbread, salad, green beans, and carrots. Cooking temperatures obtained at this time by using a facility thermometer reveled the chili mac was at 190 degrees Fahrenheit, cornbread at 140 degrees Fahrenheit, green beans at 181 degrees Fahrenheit and carrots at 175 degrees Fahrenheit. Food and beverage items prepared for this meal were confirmed to be consistent with the printed menu. Further observation continued as dietary staff plated the dinner meal from a steam table in the kitchen. As the tray line neared an end, the surveyor requested a test tray be prepared and placed on the Fountains nursing unit food cart. Observation was made as the test tray was prepared, placed on the cart at 5:11 P.M., and transported by Dietary Aide #605 to the Fountains nursing unit where it arrived at 5:13 P.M. The test tray remained on the cart in view of the surveyor, until all other trays were distributed to residents. The test tray was removed from the cart at 5:36 P.M. by Dietary Manager #600 who used a facility thermometer that confirmed the temperatures of the chili mac, cornbread, and milk. The chili mac was 96 degrees Fahrenheit, cornbread 92 degrees Fahrenheit and milk 50 degrees Fahrenheit. Dietary Manager #600 verified the test tray temperatures and the surveyor and Dietary Manager #600 taste-tested the chili mac and cornbread which were found to be at an unsatisfactory temperature, bland in taste and presentation of food items on the plate was not pleasing to the eye. Dietary Manager #600 verified the chili mac and cornbread were not hot by the time the test tray was served, and the plating was not pleasing to the eye. Interview on 11/04/24 from 5:50 P.M. to 6:00 P.M. with Residents #50, #73 and #18 verified their chili mac was cold and bland. Interview on 11/05/24 at 4:44 P.M. with Assistant Director of Nursing (ADON) #333 verified there are two residents (#32 and #75) who did not receive food from the facility's kitchen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy titled, Monitoring Food Temperatures for Meal Service, dated 09/23, revealed food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures. This deficiency represents noncompliance investigated under Complaint Number OH00158984.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 49771 Based on observation and staff interview, the facility failed to ensure the phone system was maintained in a safe and functional manner. This had the potential to affect all 84 residents residing in the facility. The facility census was 84. Findings include: Observations from 11/13/24 to 11/19/24 revealed 15 attempts to reach facility personnel on the facility phone system. No personnel answered the phone and the following message was received, Hello, you have reached the ARC of Cincinnati. It is our pleasure to serve you today. Please leave a message and we will be happy to return your call as soon as possible. Thank you and have a good day. There was no option to transfer to an individual, department or nursing unit. Attempts to reach facility staff were unsuccessful on the following dates and times: 11/13/24 at 9:01 A.M., 9:02 A.M., 9:06 A.M., 9:47 A.M., 10:12 A.M., 10:42 A.M., 12:43 P.M. and 2:14 P.M.; 11/14/24 at 9:13 A.M.; 11/15/24 at 9:09 A.M. and 10:12 A.M.; 11/19/24 at 10:39 A.M., 10:42 A.M., 12:54 P.M., 12:56 P.M. and 1:35 P.M. Phone interview on 11/18/24 at 12:45 P.M. with the Administrator revealed she learned the phone system was not functional on 11/17/24. Phone interview on 11/18/24 at 12:54 P.M. with Receptionist #195 verified the phone system had not been functional since at least 11/14/24 when she was alerted by a family member that individuals, departments or nursing units could not be reached. This deficiency is based on an incidental finding discovered during the course of this complaint investigation.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49771 Based on observation and staff interview, the facility failed to ensure a safe, functional, and homelike environment for the residents. This affected 23 (#03, #07, #10, #11, #12, #22, #23 #26, #28, #31, #37, #39, #40, #46, #52, #54, #55, #61, #64, #69, #76, #78 and #84) residents residing in the Fountains Nursing Unit. The facility census was 84. Findings include: Observation of the Fountains Nursing Unit on 11/05/24 from 11:00 A.M. to 11:25 A.M. with Maintenance Director #200 revealed the following: a) Resident #23's room had an area of damaged, brown and black discoloration drywall approximately five feet long and four inches wide directly to the right of the resident's window. a) The therapy gym had six ceiling tiles with brown ring stains. c) The common area outside of Resident #84's room had two ceiling tiles with brown ring stains. d) The common area outside of Residents #64 and #28's room had one ceiling tile broken with a brown ring stain. e) The common area outside of Residents #03 and #55's room had two ceiling tiles with brown ring stains. f) The common area outside of Residents #07 and #54's room had three ceiling tiles with brown ring stains. g) The common area outside of Resident #40's room had two ceiling tiles with brown stains. h) The common area outside of Resident #55's room had one ceiling tile with a brown ring stain. Interview on 11/05/24 at 11:25 A.M. with Maintenance Director #200 verified the conditions of the Fountains Nursing Unit. This deficiency represents non-compliance investigated under Complaint Number OH00158062.