STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365081	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Healthcare Center	7800 Jandaracres Drive Cincinnati, OH 45248

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on record review, interview and policy review, the facility failed to ensure the Power of Attorney (POA) was contacted when a resident experienced a change of condition. This affected one (Resident #72) of three residents reviewed for notification of a change in condition. The census was 117. Findings included: Review of the medical record revealed Resident #72 was admitted on [DATE]. Medical diagnoses included non-traumatic chronic subdural hemorrhage, hypertension, peripheral vascular disease, renal insufficiency, cerebrovascular accident (CVA), malignant neoplasm of prostate, seizure disorder, and non-Alzheimer's dementia. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was severely cognitively impaired. His functional status was substantial/maximal assistance for eating, dependent for toileting, bed mobility, and transfers. He was always incontinent for bowels and bladder. Review of the progress notes documented on 04/25/24 Resident #72 slept all day, refused his food and his medications. He was sent out to the hospital by License Practical Nurse (LPN) #178 for a change of condition. There was no documentation in the medical record that Resident #72's POA was notified of his hospitalization . During an interview on 06/10/24 at 3:17 P.M., the Director of Nursing (DON) stated LPN #178 was out of the country for vacation and couldn't be contacted. She stated the expectation would be for the nurse to call the POA first then proceed to call another family on the list of contacts if the POA couldn't be reached. Review of the policy titled Notification of Change in Condition, undated, revealed the facility must inform the resident, consult with the resident's physician and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there is a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. This deficiency represents non-compliance investigated under Complaint Number OH00153997.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on record review, observation interview and policy review, the facility failed to ensure privacy was provided. This affected one (Resident #7) of one resident reviewed for privacy. The census was 117. Findings included: Medical record review for Resident #7 revealed an admitted [DATE]. His medical diagnoses included peripheral vascular disease, diabetes, and dementia. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #7 was moderately cognitively impaired. He required maximum assistance for toileting and bed mobility. During an observation on 06/10/24 at 1:07 P.M., Resident #7's door was open with a full view from the hall. Resident #7 in bed with the blanket and sheets off the resident. The curtain was not pulled and Resident #7's roommate was sitting on his side of the room. State tested Nursing Aide (STNA) #206 was asking the resident if he had soiled his brief and was feeling the brief to check for wetness. During an interview on 06/10/24 at 1:15 P.M.,STNA #206 confirmed she didn't provide privacy for the resident during the time she was checking his brief for wetness. She stated she should have provided privacy for the resident. During interview on 06/11/24 at 10:13 A.M., Resident #7 stated he would like to be provided privacy when care was being provided. Review of the policy titled Resident Rights, undated, revealed to have the resident's privacy respected when treatment, medication, or care is being administered including, door closed, or privacy curtain drawn. This was an incidental deficiency discovered during the course of the 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34291 Based on observation, record review and interview, the facility failed to ensure a homelike environment was maintained. This affected two (Residents #2 and #86) of three residents reviewed for homelike environment. The census was 117. Findings include: 1. During an interview on 06/10/24 at 11:19 A.M., Resident #2 stated housekeeping hasn't come into clean the bathroom yet. He stated the blood was coming from his roommate's urine. During an observation on 06/10/24 at 11:19 A.M., Residetn #2's bathroom had bloody urine in the toilet and drips of blood down the side of the toilet going down to the floor. There was a strong smell of urine. At 2:11 P. M. housekeeper went into the bathroom and removed her gloves, dropping one on the floor. The housekeeper didn't pick up the glove and didn't clean the blood from the toilet. There were still the blood and strong smells of urine in the bathroom. During an observation at 3:39 P.M., there was still bloody urine in the toilet and running down the side of the toilet to the floor and the glove was on the floor. There was a strong smell of urine in the bathroom. During an obervation on 06/11/24 at 7:40 A.M., REsident #2's bathroom still had not been cleaned. The toilet still had blood running down the side of it and the glove was still on teh floor. The bathroom had a strong odor of urine. During an interview on 06/11/24, Housekeeper #263 verified the state of Residetn #2's bathroom. She stated she doesn't clean up blood in the resident's bathrooms and would leave it. She stated it would be a State tested Nurse Aide (STNA's) job to clean up the blood in the bathroom. 2. During an observation on 06/10/24 at 9:52 A.M. there was a strong smell of urine in Resident #85's bathroom. The resident said she could smell the urine. Subsequent observations at 11:33 A.M. and 2:07 P. M. revealed a strong odor of urine was coming from the bathroom. On 06/11/24 at 7:47 A.M. and 9:35 A.M. there was a strong odor of urine in the bathroom. During an interview on 06/11/24 at 9:35 A.M., Resident #85 stated the housekeepers didn't clean the bathroom and it smells of urine. During an interview on 06/11/24 at 9:40 A.M., STNA #211 confirmed there was a strong odor of urine in the bathroom. She stated the urine has seeped into the tiles of the floor and it hadn't been cleaned. This deficiency represents non-compliance investigated under Complaint Numbers OH00154568 and OH00154583.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 34291 Based on observation, record review, interview and policy review, the facility failed to ensure personal hygiene was provided for residents. This affected three (Residents #72, #79, and #102) of three residents reviewed for personal hygiene. The census was 117. Findings include: 1. Review of the care plan for Resident #72, dated 10/28/23, revealed he had activities of daily living (ADL) deficits and required assistance with ADL. During observation Observations on 06/10/24 at 11:36 A.M., 06/11/24 at 9:00 A.M. and on 06/12/24 at 2:30 P.M. revealed Resident #72 had jagged nails that came over his fingers and had a yellow brownish substance under his nails. During interview on on 06/12/24 at 2:30 P.M., Licensed Practical Nurse (LPN) #237 confirmed Resident #72's nails were long, jagged, and had a yellowish brownish substance under them. 2. During an observation on 06/12/24 at 2:28 P.M., Resident #89 had long, jagged nails that had a yellowish, brownish substance under the nails. During an interview on 06/12/24 at 2:30 P.M., LPN #237 confirmed Resident #89's nails were long jagged and dirty under the nails. She stated they needed to trimmed and cleaned. 3. Review of care plan for Resident #102 dated 12/29/23 revealed he had ADL deficits and required assistance with ADL. During observation of a dressing change on 06/12/24 at 10:19 A.M., Resident #102 feet were yellowed and in between his toes was yellowish and scaly. During an interview on Interviews with on 06/12/24 at 10:30 A.M., State tested Nurse Aide (STNA) #211 and Registered Nurse (RN) #161 confirmed the resident's feet and in between the toes were yellowed and scaly and stated it doesn't look like they have been washed recently. Review of the policy titled Skin Care, undated, revealed daily hand washing will be completed with nail care to include cleaning and trimming or filing of sharp edges to prevent infection and damage to skin from scratching Residents/patients will receive skin care daily. Skin care includes, but is not limited to: foot care and moisturizing. This deficiency represents non-compliance investigated under Complaint Numbers OH00154564 and OH00154583.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, record review, interview and policy review, the facility failed to ensure a wound was cleaned properly. This affected one (Resident #102) of three residents reviewed for pressure ulcers. The facility identified nine residents with pressure ulcers. The census was 117. Findings include: Medical record review for Resident #102 revealed an admitted [DATE]. His medical diagnoses included neurogenic bladder, paraplegic, and depression. Review of care plan for Resident #102, dated 11/07/23, revealed the resident had altered skin integrity related to spinal fusion and has a stage pressure ulcer to the sacrum. Intervention was to provide peri-care as needed to avoid skin breakdown due to incontinence. Review of physician orders dated 02/29/24 for Resident #102 were to cleanse the wound to the sacrum with wound cleanser or saline. Apply silver alginate inside the wound and secure with super absorbent foam followed by a ABD pad and to use Zinc Oxide on the skin around the wound to secure the ABD pads. During an observation on 06/12/24 at 10:19 A.M., Registered Nurse (RN) #161 cleansed inside of the wound, but did not clean the zinc oxide residue from around the wound. RN #161 completed the dressing change and placed more zinc oxide around the wound on the residue. During an interview on 06/12/24 at 10:30 A.M., RN#161 confirmed he didn't clean the zinc oxide residue on the buttocks or around the wound on the sacrum of Resident #102 during the dressing change. Review of policy titled Wound Care, undated, revealed to cleanse the area with wound cleanser or normal saline. This is an incidental deficiency discovered during the course of this complaint investigation.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44083 Based on observation, interview and record review, the facility failed to provide the food portions and liquids as planned by a Registered Dietitian. This affected nine (Residents #7, #11, #39, #50, #57, #72, #81, #89 and #98) residents. The facility total census was 117. Findings include: Record reviews of Residents #7, #11, #39, #50, #57, #81, #89 and #98 revealed a physician order for puree diet. Review of the breakfast spreadsheet reviewed the puree meal was to be served of six ounces of puree oatmeal, two ounces of puree sausage, and two ounces of puree bread. During an observation on 06/13/24 at 8:22 A.M., [NAME] #139 served four ounces of puree oatmeal, four ounces of puree sausage and three ounces of puree bread. During an interview on 06/13/24 at 11:27 A.M., [NAME] #139 verified she had not followed the spread sheet for puree potions. She verified she had served too little portions of the oatmeal and too much of the bread and sausage. [NAME] #139 stated she does not always follow the spreadsheet, which could affect residents on specialty ordered diets. 34291 2. Review of care plan for Resident #72, dated 12/06/23, revealed he was at risk for nutrition an hydration status. Intervention was to provide and serve diet as ordered. Review of the menu dated 06/11/24 for breakfast revealed residents were to receive either eight ounces of mile, six ounces of tea or coffee and four ounces of orange juice. During an observation on 06/11/24 at 9:00 A.M., Resident #72 was not served any milk, tea or coffee. During an observation on 06/12/24 at 9:15 A.M., Resident #72 again was not served any milk, tea or coffee. During an interview with on 06/12/24 at 9:20 A.M., Dietician #264 confirmed Resident #72's meal ticket included beverages, but he was not served them. Review of facility policy titled, Food Quality dated, 2023, revealed the facility will serve food to meet the resident's needs. This deficiency represents non-compliance investigated under Complaint Number OH00154764.

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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. 44083 Based on record review, interview and policy review, the facility failed to prepared fortified foods according to the recipe for increased nutritional value . This affected six (Residents #19, # 46, #47, #50, #79 and #89) of six residents ordered a fortified meal. The census was 117. Findings include: Review of the fortified oatmeal recipe included oatmeal, whole milk, powder milk, sugar, and margarine. During an interview on 06/13/24 at 7:44 A.M., [NAME] #139 stated she prepares fortified oatmeal with powdered milk and butter to make it fortified. [NAME] #139 stated she does not use a recipe to know how to prepare fortified foods, including oatmeal, because she has worked at the facility so long. She stated she could not decipher the recipe because it was made for 100 portions, and she only had six residents with fortified orders. Review of facility policy titled Fortified Food Program, undated and Food Quality and Palatability dated 2023, revealed the facility will prepare food to conserve nutritive value and follow the fortified food recipes as a therapeutic intervention. This deficiency represents non-compliance investigated under Complaint Number OH00154764.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, record review, interview and policy review, the facility failed to ensure thickened liquids were served as ordered. This affected four (Residents #72, #79, #89 and #98) of four residents reviewed for thickened liquid diets. The census was 117. Findings include: 1. Review of care plan for Resident #72 dated 12/06/23 revealed he was at risk for nutrition and hydration status. Review of physician orders dated 06/03/24 for Resident #72 revealed the resident's diet was dysphagia mechanical texture, and honey thickened liquids. During an observation on 06/12/24 at 9:00 A.M., Resident #72 was served orange juice that was not honey consistency. During an interview on 06/12/24 at 9:20 A.M., Dietician #264 confirmed the meal ticket said honey thickened liquids and the orange juice on the tray was not thickened. Review of facility policy titled, Food Quality dated, 2023, revealed the facility will serve food to meet the resident's needs. 44083 2. Record review of Specified Resident, (SR) #89 revealed the resident was to receive a puree consistency diet and nectar thick liquid consistency. Record review for Resident #79 revealed the resident was to receive a mechanical soft consistency diet and nectar thick liquid consistency. Record review for Resident #98 revealed the resident was to receive a puree consistency diet with honey thickened liquid consistency During an observation on 06/13/24 at 9:00 A.M. and at 9:40 A.M., State tested Nurse Aides, (STNA)s #135 and #231 were preparing thickened liquids. The thickener powder was in a bowl marked thickener without any instructions of the portions to prepare a nectar or and honey thick liquid consistency During an observation on 06/13/24 at 9:35 A.M., Resident #79 and #98's breakfast meal tickets revealed the liquids were to be thickened. Resident #79 was to receive nectar thickened liquids and the liquids of coffee were thickened to honey. Resident #98 was to receive honey thickened consistency and were thickened at a nectar consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 06/13/24 at 10:07 A.M., Resident #89's breakfast meal ticket revealed the resident was to receive nectar thick liquids. Observation of the thickened coffee and milk on the meal tray revealed the liquids were of honey thicken consistency. During an interview on 06/13/24 at 9:00 A.M., STNA #135 verified they did not have any measuring instructions or measuring device to portion the thickener to prepare a nectar or honey thick liquid consistency. STNA #135 stated she had used the pre-portioned thicker in a packet at her previous job and did not know how much thickener to use if it was not pre-portioned. During an interview on 06/13/24 at 9:40 A.M., STNA #231 verified she had prepared the thickened liquids for Residents #79, #89 and #98. She stated she just put in enough thickener in the liquids until it looked right and if not, added more. She stated she did not know the definition between a nectar or honey thick consistency. During [NAME] interview on 06/13/24 at 10:07 A.M., Resident #89 stated he does not always receive thickened liquids, and sometimes it is very thick, and staff have to feed it to him with a spoon. Resident #89 stated last night at the supper meal, his liquids were not thickened and he coughed. Review of the International Dysphagia Diet Standardization Initiative, (IDDSI), website, https://iddsi.org, dated 2019, honey thick consistency is defined as liquids that stick to side of a cup and coat a spoon and pour very slowly. Nectar thick liquids are defined as pourable like eggnog or tomato juice. This deficiency represents non-compliance investigated under Complaint Number OH00154764.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34291 Based on observation, record review, interview and policy review, the facility failed to ensure staff changed gloves , performed hand hygiene and wore the proper personal protective equipment. This affected five (Residents #7, #10, #102, #53 and #38) residents. The census was 117. Findings include: 1. During an observation on 06/10/24 at 1:07 P.M., State tested Nursing Aide (STNA) #206 checked Resident #7 for incontinence while wearing gloves. She left the resident's room with her gloves on. She went down the hallway, removed her gloves and disappeared out of view. During an interview on 06/10/24 at 1:15 P.M., STNA #206 stated she doesn't remove her gloves in the room after caring for a resident and will go down the hall remove the gloves and wash her hands down at a sink in the hall. She confirmed she didn't know the process, but should have removed her gloves and washed her hands before leaving the resident's room. 2. During an observation on 06/11/24 at 9:15 A.M. Registered Nurse (RN) #262 donned gloves to prepare medications for Resident #10. She removed medications from the medication cart, and during dispensing, touched the medications with her gloved hands. She poured a liquid medication, then touched the computer mouse, touched the blood pressure cuff. Without removing gloves she got back into the medication cart and dispensed more medications into a cup, and touched the medications with her gloved hands. She then administered the medications to the resident. During an interview on 06/11/24 at 9:17 A.M., RN #262 stated she didn't want to touch the medications with her bare hands so she wore gloves to dispense the medications. She confirmed her gloved hands touched the medications, her cart, the packages of the medications that other hands had touched, the computer, the handle on the drawer of the cart, and blood pressure cuff. 3. Review of physician orders dated 03/13/24 for Resident #102 revealed Multi-drug Resistant Organism (MDRO) enhanced barrier precaution every shift for resident care. Observation on the door of the resident's room on 06/12/24 at 10:15 A.M. revealed a sign for Enhanced Barrier Precautions (EBP) with instructions to wear gown, gloves, and mask when providing care. During an observation of a wound dressing change on 06/12/24 at 10:19 A.M., RN #161 was not wearing a gown and STNA #211 was not wearing a mask or a gown. During an interview on 06/12/24 at 10:30 A.M., RN #161 and STNA #211 stated they knew what EBP meant, but they forgot to put on the proper personal protective equipment on for the wound care. 44083 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 06/13/24 at 9:45 A.M. at the breakfast meal in the dining room, Resident #38 was seated in a wheelchair at the dining room table with the meal tray on the table. The meal plate included one slice of toast and butter in a packet. With ungloved hands, STNA #231 opened the butter packet, picked up the toast, and applied the butter to the toast. During an interview on 06/13/24 at 9:45 A.M, STNA #231 verified she picked up the toast with no hand covering. She verified she should not have touched the toast without a glove or touched the toast with a bare hand. She stated she was in a hurry. 5. During an observation on 06/13/24 at 9:45 A.M. at the breakfast meal in the dining room, Resident #53 was seated in a wheelchair at the dining room table with the meal tray on the table. The meal plate included one slice of toast, butter and jelly in a packet. With ungloved hands, STNA #220, opened the butter and jelly, picked up the toast and applied the butter and jelly to the toast. During an interview on 06/13/24 at 9:45 A.M, STNA #220 verified she had picked up the toast with her uncovered hand. She stated she had asked Resident #53 for permission to handle the toast without a glove. STNA #220 verified she should have used a glove to butter the toast. Review of facility policy, Infection Prevention Infection Control, dated 06/06/23, revealed residents have a right to an environment that promotes health and reduces risk of acquiring infections. Review of the policy titled Enhanced Barrier Precautions, undated, stated refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include: Wound care: any skin opening requiring a dressing. Review of the policy titled Gloves, dated 07/01/17, revealed gloves are worn when there is potential contact with blood, body fluid, tissue from mucous membranes, non-intact skin or contaminated surfaces or equipment is anticipated. Remove gloves at resident door way, before leaving the room. As a general rule gloves should not be worn outside the immediate care giving area unless for a specific procedure such as cleaning or disinfecting procedure. Areas to avoid glove use include but are not limited to: hallways and common and public areas. This was an incidental deficiency discovered during the course of this complaint investigation.