STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365178	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenwood Terrace Healthcare Center	7450 Keller Road Cincinnati, OH 45243

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on resident and staff interview, observation, record review, and policy review, the facility failed to develop comprehensive care plans for pain management to include indwelling medical devices. This affected one (Resident #69) of ten residents reviewed for care plans. The facility census was 87. Findings include: Review of the medical record revealed Resident #69 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, chronic kidney disease, obesity, and non-pressure chronic ulcer of the let hell and mid-foot. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #69 was cognitively intact, had no behaviors, did not reject care, and did not wander. Review of the hospitals' After Visit Summary dated 05/21/24 revealed Resident #69 had a Past Surgical History including thoracic laminectomy with paddle lead and rechargeable battery in left hip performed 03/14/22. Review of the care plan dated 05/09/24 revealed Resident #69 had complaints of acute and chronic pain and was at risk for pain. Interventions included administering nonpharmacological interventions for pain, complete pain assessments routinely and as needed, and follow physician orders for complaints of pain. There were no information and instructions on how to care for an implanted spinal cord stimulator Observation on 11/19/24 at 1:02 P.M. revealed Resident #69 had a spinal cord adapter with a blue cord and paddle visible in his room among personal items stored on top of a nightstand located adjacent to the wall in the right corner of the room. During an interview on 11/19/24 at 1:02 P.M., Resident #69 stated he had three separate back surgeries and had an implanted spinal cord stimulator which he recharged with an adapter himself. Due to back pain, he was unable to tolerate lying in bed and was advised by his surgeon to sleep in his recliner chair. Resident #69 stated he had told nursing staff he was unable to tolerate being in the bed and preferred to sleep in the recliner chair. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 3:17 P.M., the Director of Nursing (DON) stated if a resident had a spinal cord stimulator on admission, the facility would contact the provider for instructions on how to care for it. The device would be included in a care plan for implantable devices or pain management. The DON verified Resident #69's care plan did not include information about an implanted spinal cord stimulator. During an interview on 11/19/24 at 3:50 P.M., Licensed Practical Nurse #168 stated she completed the care plans for every resident after admission. LPN #168 stated she reviewed hospital documents provided on admission or researched recent hospital stays if she had access to determine resident care needs. LPN #168 stated she interviewed residents upon admission for mental status and to address mental health needs. LPN #168 verified Resident #168 was not care-planned for a spinal cord stimulator because she was unaware that Resident #168 had it. Review of the undated policy titled Plan of Care Overview revealed the facility provided a resident-centered care plan to meet the psychosocial, physical , and emotional needs and concerns of residents. This deficiency represents noncompliance investigated under Complaint Number OH00159893.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42492 Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure medications were stored in appropriate containers in the medication cart. This had the potential to affect three (Residents #59, #61, and #62) of three residents prescribed iron on the 500-Hall. The facility census was 87. Findings include: Review of the medical record revealed Resident #59 had physician orders for ferrous sulfate 325 milligrams (mg) by mouth twice daily with meals for anemia. Review of the medical record revealed Resident #61 had physician orders for ferrous sulfate 325 mg by mouth in the morning with breakfast for anemia. Review of the medical record revealed Resident #62 had physician orders for ferrous sulfate 325 mg by mouth once daily with breakfast for anemia. Observation on 11/18/2024 at 10:17 A.M. revealed the 500-Hall medication cart had an unlabeled plastic medication cup containing multiple green round tablets. During an interview on 11/18/24 at 10:17 A.M., Licensed Practical Nurse (LPN) #162 verified the cup full of green pills she identified as iron were not labeled and were not appropriately stored in the medication cart. Review of the policy titled Storage of Medications dated 08/2020 revealed medications and biologicals were stored safely, securely, and properly according to manufacturer recommendations. This was an incidental finding discovered during the course of the complaint investigation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42492 Based on observation, staff interview, and policy review, the facility failed to ensure staff prepared food in a sanitary manner. This affected one (Resident #3) of one resident reviewed during tray line service. The facility census was 87. Findings include: Observation on 11/18/24 at 12:32 P.M. revealed Dietary Manager #142 touched two hamburger buns with bare hands during lunch meal preparation. During an interview on 11/18/24 at 12:55 P.M., Dietary Manager #142 verified she had used her bare hands to open hamburger buns while preparing Resident #3's lunch tray. Dietary Manager #142 acknowledged she was not supposed to touch food with her bare hands. Review of the policy titled Food Preparation dated 09/2017 revealed all staff used serving utensils appropriately to prevent cross contamination. This was an incidental finding discovered during the course of the complaint investigation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observations, interviews, medical record review, and policy review, the facility failed to implement appropriate infection prevention procedures during medication administration. This affected two (Residents #63 and #79) of five residents reviewed for medication administration. The facility census was 87. Findings include: 1. Review of the medical record revealed Resident #79 was admitted to the facility on [DATE]. Diagnoses included major depressive disorder and mixed hyperlipidemia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #79 had physician's orders for routine morning medications including Amlodipine (treats high blood pressure) 10 milligrams (mg) by mouth once daily and Galantamine (treats dementia) eight mg by mouth once daily. Observation of medication administration on 11/18/24 at 9:36 A.M. revealed while preparing medications for administration, Registered Nurse (RN) #136 popped Resident #79's Amlodipine from the pill card into her bare hand before dropping the pill into the medication cup and picked up Galantamine eight mg with her bare hand and placed it in the medication cup after the pill had dropped onto the top of the medication cart. During an interview on 11/18/24 at 9:48 A.M., RN #136 confirmed she had touched Resident #79's Amlodipine and Galantamine medications with her bare hands. 2. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE]. Diagnoses included chronic diastolic congestive heart failure, major depressive disorder, generalized anxiety disorder, and stage III chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had severely impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #63 had physician orders for routine morning medications including Namenda (treats Alzheimer's disease) 10 milligrams (mg) by mouth once daily, Zoloft (antidepressant) 100 mg by mouth once daily, Acetaminophen (treats minor pain and aches) 325 mg by mouth three times daily, and Cyanocobalamin (vitamin) 1,000 micrograms (mcg) by mouth once daily. Observation of medication administration on 11/18/24 at 9:59 A.M. revealed while preparing medications for administration, Registered Nurse (RN) #228 popped Resident #63's Namenda 10 mg and Zoloft 100 mg medications from the pill card into her bare hand before dropping the pills into the mediation cup and used bare fingers to fish out Acetaminophen 325 mg and Cyanocobalamin 1,000 mcg pills from house stock bottles. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 10:05 A.M., RN #228 confirmed while preparing Resident #63's morning medications, she had touched multiple medications with her bare hands and stated she did not normally do that. Review of the undated policy titled Medication Administration revealed licensed medical professionals do not touch medication during administration and discard dropped medications. This was an incidental finding discovered during the course of the complaint investigation.