STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on closed medical record review, review of an emergency medical transportation record, review of facility policy, and interviews, the facility failed to provide goods and services to Resident #105 to prevent an incident of neglect resulting in the resident ' s death. This resulted in Immediate Jeopardy and actual harm/death beginning on [DATE] at approximately 8:18 P.M. when Resident #105, who had advance directives for a full code status was noted to exhibit behaviors and then subsequently requested (at around 12:00 A.M. on [DATE]) the use of an as needed bronchodilator (Albuterol) inhalation medication (used to treat or prevent bronchospasm and increase air flow to lungs) without further assessment or monitoring. On [DATE] at 12:37 A.M. Resident #105 was yelling and howling in his room; at which time Licensed Practical Nurse (LPN) #410 asked the resident to close his door. No additional assessment or monitoring of the resident was completed. State tested Nursing Assistant (STNA) #450 delivered the resident ' s breakfast tray to his room at approximately 8:00 A.M. and assumed the resident was sleeping. On [DATE] at 8:30 A.M. LPN #339 assumed the resident was sleeping and did not attempt to wake the resident for medication administration or breakfast nor did the LPN return to provide care at any time prior to the resident being found deceased . There was no evidence LPN #339 administered the resident ' s morning medications as ordered, assessed Resident #105 or notified the physician Resident #105 had not taken his morning medication. On [DATE] at 12:30 P.M. STNA #359 delivered Resident #105 ' s lunch tray at which time it was identified the resident had not consumed any breakfast and the resident was not breathing. In addition, the resident was noted to have been in the same condition/position as when staff provided his breakfast tray. A code blue was called (for staff to initiate cardiopulmonary resuscitation (CPR)) and emergency medical services were called. The resident ' s pants were observed to be wet from urine and rigor mortis (postmortem rigidity, a recognizable sign of death that causes a person ' s body to stiffen. Rigor mortis begins as early as four hours after death and peaks around 12 hours) was noted to have occurred. CPR was ineffective and the resident was pronounced deceased by Emergency Medical Services (EMS). This affected one resident (#105) of four residents reviewed for death. The facility census was 102. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2024
NAME OF PROVIDER OR SUPPLIER Madison Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 7600 S Ridge Rd Madison, OH 44057	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:02 A.M. the Administrator, Director of Nursing (DON), Mobile Operations Director #457, Regional Director of Operations #458 and Regional Director of Clinical Services #459 were notified Immediate Jeopardy began [DATE] when the facility failed to properly identify, assess and monitor a change in Resident #105 ' s condition. The lack of monitoring and overall cumulative effect of different individual failures in the provision of care and services by staff resulted in an environment of neglect for Resident #105. On [DATE] at approximately 12:30 P.M. staff identified the resident was not breathing; however, upon further investigation rigor mortis was identified resulting in CPR efforts being unsuccessful due to the amount of time the resident had been without oxygen and blood flow. The resident was pronounced deceased by EMS staff. The Immediate Jeopardy was removed [DATE] when the facility implemented the following corrective actions: On [DATE] at 1:54 P.M. LPN #410 was educated on the medication administration policy. On [DATE] at 10:30 A.M., immediate education was provided to nine nurses in the center by the DON regarding Abuse/Neglect policy, Resident Care policy, Medication Administration policy, Notification of Change policy, Medical Emergency Response policy ad Stop Watch protocol. On [DATE] at 10:30 A.M. immediate education was provided to 16 STNAs in the center by the DON regarding Abuse/Neglect, Resident Care policy, Medical Emergency Response policy and Stop and Watch policy. On [DATE] from 11:00 A.M. to 1:00 P.M. the Administrator, Regional Director of Clinical Services #459, and Regional Director of Operations # 458 provided education to 20 nurses over the phone regarding Abuse/Neglect, Resident Care policy, Medication Administration policy, Notification of Change policy, Medical Emergency Response Policy and Stop and Watch protocol. All staff who were not contacted were removed from the schedule until education was provided. On [DATE] from 11:00 A.M. to 1:10 P.M. the administrator, Regional Director of Clinical Services #459, and Regional Director of Operations #458 provided education to 42 STNAs over the phone regarding Abuse/Neglect, Resident Care policy, [NAME] Emergency Response policy and Stop and Watch protocol. All staff that could not be contacted were removed from the schedule until education could be provided. On [DATE] from 10:35 A.M. to 2:50 P.M. the facility conducted comprehensive assessment utilizing the Monthly Long Term Care Assessment (UDA) on all residents. This was completed by the DON, unit managers, or mobile DON. On [DATE] at 11:18 A.M. Medication Administration Records from the date of [DATE] were reviewed by Regional Director of Clinical Services #459 in the facility regarding any medication that was not administered. Follow up completed as indicated. On [DATE] at 11:22 A.M. Medication Administration Records from [DATE] were reviewed by Regional Director of Clinical Services #459 for all residents in the facility regarding refusal of medication. Follow up completed as indicated. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:06 P.M. and Ad hoc Quality Assessment and Performance Improvement meeting was held. Staff in attendance at the meeting included the Administrator, the DON, Regional Director of Clinical Services #459, and Regional Director of Operations #458. The Medical Director was notified of the Immediate Jeopardy concern. On [DATE] the DON/Unit Manager/Designee completed observations with non-interviewable residents for concerns related to potential neglect. Any concerns would be addressed as indicated. On [DATE] the DON and Unit Managers met with interviewable residents regarding any resident concerns related to potential neglect. Any concerns were addressed as indicated. On [DATE] the facility implemented a plan to conduct ongoing monitoring/audits regarding completed medication administration documentation three times weekly for four weeks to ensure all residents received medication as ordered. At the end of the four-week audit, a QAPI meeting would be held to determine if extension of medication administration documentation audits were indicated. On [DATE] the facility implemented a plan to conduct ongoing monitoring of progress note reviews for all resident in the facility five times weekly for four weeks for change in condition. Follow-up would be completed as indicated for change in condition. At the end of the four-week audit period a QAPI meeting would be held to determine if extension of progress note review was indicated. On [DATE] the facility implemented a plan for ongoing monitoring/audits regarding comprehensive assessments for five residents weekly for four weeks utilizing the UDA for any change in condition. At the end of the four-week audit period a QAPI meeting would be held to determine if extension of the comprehensive assessments was indicated. Although the Immediate Jeopardy was removed [DATE], the facility remains out of compliance at a severity level 2 (the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action and monitoring for effectiveness and on-going compliance. Findings include: Review of the closed medical record for Resident #105 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), hypothyroidism, Vitamin D deficiency, muscle weakness, cirrhosis of liver, type two diabetes without complications, hyperlipidemia, obesity, schizophrenia, tobacco use, difficulty walking, constipation, gastro-esophageal reflux, schizoaffective disorder bipolar type. Record review revealed Resident #105 was pronounced deceased in the facility on [DATE]. Review of a nursing note dated [DATE] at 11:20 A.M. written by LPN #418 revealed Resident #105 was readmitted after a stay at a psychiatric hospital stay for a diagnosis of psychosis. The note indicated the resident was in good spirits. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed Resident #105 was hospitalized from [DATE] to [DATE] for treatment of psychosis. New orders at the time of re-admission included when the resident displays aggressive, verbal outbursts, slamming doors, staff would attempt snack, TV, or quiet time in room. Medication orders upon re-admission included but were not limited to Albuterol (inhalation medication), Budesonide inhaler, Calcium Carbonate and Acetaminophen. Review of the physician ' s orders revealed an order dated [DATE] at 11:28 A.M. to notify physician of any sign or symptoms of lower respiratory symptoms such as coughing and fever every shift and document on the treatment administration record. Review of Resident #105 current care plan revealed Resident #105 had advance directives indicated he wished to receive cardiopulmonary resuscitation (CPR) in the event of cardiac arrest. Interventions included if code status changed it would be posted in resident ' s chart and physician orders, if resident was choking perform Heimlich maneuver and proceed with CPR if needed. Notify family on change in condition, nursing would provide chest compressions when the resident was in cardiac arrest, and call ambulance for transport to hospital. Review of Resident #105 ' s current care plan revealed Resident #105 had potential for complications related to COPD. Interventions included assessing difficulty breathing on exertion, assess for sign and symptoms of hypoxia, elevate head of bed to promote optimal air exchange, encourage cough and deep breathing, give aerosol or bronchodilator as ordered. Observe and document any side effects and effectiveness. Give oxygen as ordered by physician. Observe signs and symptoms of anxiety and administer medications if indicated. Review of Resident #105 ' s current care plan (initiated [DATE]) revealed Resident #105 required assistance for activities of daily living (ADL) related to cognitive impairment, muscle weakness, and behavior and mood fluctuations. Interventions included assist in choosing appropriate clothing as needed, assist with oral care per facility policy, encourage and allow resident to complete self-care, keep call light in reach while in bed, provide assistive devices to increase ADL self-care, provide incontinence care with routine rounds and as needed, Resident #105 preferred meals to be left on meal tray, set up and assist as needed for completion of ADLs. The care plan revealed staff would assist as needed with daily hygiene. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 12, indicating the resident exhibited moderate cognitive impairment. The assessment revealed Resident #105 displayed delusions but had no behavior symptoms exhibited and he did not reject care. The assessment revealed the resident required set-up or clean up assistance with eating, oral hygiene, toilet hygiene and showers. Set-up or clean up assistance was needed to roll on back on the bed, sit to stand on the side of the bed and transfer to and from the bed. The resident was not receiving hospice care. Review of a behavior note dated [DATE] at 8:18 P.M. and authored by LPN #410 revealed Resident #105 spoke in a loud threatening voice because as needed Ativan that was discontinued. Record review revealed no additional information contained related to this incident, evidence of a resident assessment or interventions provided at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a behavior note dated [DATE] at 12:37 A.M. and authored by LPN #410, revealed Resident #105 was yelling and howling in his room. The note indicated LPN #410 asked Resident #105 to shut his door. Resident #105 slammed the door and responded with profanity to LPN #410. Resident was yelling aggressively and had a demanding demeanor. Further record review revealed no evidence LPN #410 returned to Resident #105 ' s room to check on the resident related to this incident. Review of the nursing note dated [DATE] at 8:30 A.M. authored by LPN #339 revealed the resident appeared to be sleeping in a supine position in bed. Per nursing judgement, nurse allowed Resident #105 to sleep longer. Review of the resident ' s physician orders, and medication administration records revealed on [DATE] the resident was scheduled to receive the following medications: famotidine, paliperidone palmitate intramuscular suspension (antipsychotic), polyethylene glycol powder, carbamazepine (anticonvulsant), lithium carbonate (antipsychotic), klonopin and benztropine mesylate which were scheduled to be administered between 7:00 A.M. and 11:00 A.M. Record review revealed on [DATE] there was no documented evidence any of the medications were administered to the resident as ordered. Review of a nursing note dated [DATE] at 1:33 P.M. and authored by LPN #339 revealed Resident #105 appeared pale and non-responsive laying in supine position on bed. Resident #105 had no respiration and no pulse. Code Blue was called and 911 was notified. The nursing progress note revealed at 12:35 P.M. paramedics arrived at 12:45 P.M. Resident #105 was declared dead. Further review of the medical record revealed no additional progress notes had been completed/documented on [DATE] between 8:30 A.M. and 1:33 P.M. Review of the Emergency Medical Services response record dated [DATE] revealed a call was received by the facility at 12:31 P.M. Upon arrival, Resident #105 was observed lying in bed. Staff stated the resident was up at night punching walls and slamming doors. Staff assumed he was taking a nap. The report revealed the nurse checked on the resident in the afternoon and found the resident pulseless and not breathing. Upon assessment from the fire department, rigor mortis and dependent lividity were seen. Review of Resident #105 ' s Certificate of Death revealed a date of death of [DATE] with final disease condition resulting in death documented as COPD. No autopsy was performed. Interview on [DATE] at 4:58 P.M. with Unit Manager LPN #321 revealed Resident #105 had been back from the hospital for a few days before he passed away. LPN #321 revealed he/she had received a brief text message from LPN #410 the night shift of [DATE] about Resident #105 ' s behaviors. Unit Manager LPN #321 verified the physician was not notified of behaviors that night. The content of the message and/or any follow-up care/intervention was not provided during the onsite investigation. Review of the Medication Administration Record (MAR) revealed the order for Albuterol Sulfate Inhalation Aerosol two puffs orally every four hours as needed for COPD. There was no written documentation the medication was provided or administered on [DATE] or [DATE] (as noted in the staff interview below). Additionally, review of Treatment Administration Record (TAR) revealed observation of lower respiratory symptoms every shift was not signed as completed on [DATE]. An interview with the DON on [DATE] at 4:34 P.M. verified the MAR and TAR contained no evidence the assessments were completed, or medication was administered as per LPN #410 ' s interview. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:30 P.M. with LPN #410 revealed he texted Unit Manager #321 on [DATE] about Resident #105 ' s behaviors (specific content of text message not provided). LPN #410 verified the physician was not called regarding the resident ' s behaviors. During the interview, LPN #410 revealed Resident #105 had self-administered his Albuterol inhalation around midnight of [DATE]. However, the LPN denied completing any type of respiratory status assessment prior to Albuterol administration, verified there was no documentation contained on the MAR to reflect the administration of the medication and verified Resident #105 was not assessed as to whether the as needed (prn) Albuterol inhalation medication was effective. Additionally, LPN #410 verified he did not open the resident ' s door that night during the shift to assess or look in on Resident #105. LPN #410 also verified the morning shift nurse was not informed Resident #105 had requested and received the as needed Albuterol inhaler during the shift. Interview on [DATE] at 3:30 P.M. with LPN #339 revealed on [DATE] at 8:30 A.M. she knocked on Resident #105 ' s door to administer medications and assumed the resident was sleeping. LPN #339 verified she did not go back to Resident #105 ' s room to attempt medication administration and did not return to the resident ' s room until 12:30 P.M. when the Code Blue was called. LPN #339 verified she did not (physically) touch or assess the resident at any time during the morning of [DATE]. Interview on [DATE] at 3:09 P.M. with Registered Nurse (RN) #360, who responded to the code, revealed rigor mortis had set in for Resident #105 by the time the Code Blue was called on [DATE] at 12:30 P.M., indicating Resident #105 had been deceased for some time. RN #360 stated she observed Resident #105 lying on top of the bed covers, that were not wrinkled, with no shirt on and the resident ' s head and arms were raised (stiff) off the bed levitating. Interview on [DATE] at 3:30 P.M. with LPN #411, who responded to the code, revealed Resident #105 had stiff hands and his head was up but no pillow was under the head at the time the Code Blue was called on [DATE]. LPN #411 stated the front of Resident #105 ' s pants were wet. Interview on [DATE] at 4:00 P.M. with STNA #450, who was assigned to provide care for Resident #105 during the day shift of [DATE], revealed she delivered Resident #105 ' s breakfast tray at 8:00 A.M. on [DATE]. STNA #450 reported she thought the resident was sleeping at that time and verified she did not attempt to wake him up or announce his breakfast tray had arrived or check to see if the resident was breathing. STNA #450 revealed after dropping off the breakfast tray, she did not see the resident again until his lunch tray was passed. The STNA revealed at lunch time, the resident ' s breakfast tray was untouched, and he was in the same position on top of his bed as he had been when she took his breakfast tray in. Interview on [DATE] at 1:35 P.M. STNA #359 revealed when she delivered Resident #105 ' s lunch tray around 12:30 P.M. on [DATE] and noticed the resident ' s breakfast tray was untouched and the resident was not moving. STNA #359 stated she notified STNA #450 and LPN #339 immediately. Interview on [DATE] at 3:20 P.M. with LPN #438, who responded to the code, revealed rigor mortis had set in at the time the Code Blue was called on [DATE], indicating Resident #105 had been deceased for some time. LPN #438 observed Resident #105 ' s fingers were bent, and his hands were above his body. LPN #438 observed Resident #105 ' s pants to be wet and the room smelled of urine. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As part of the EMS report, there was a photograph of Resident #105 dated [DATE]. The photograph showed Resident #105 lying on top of a made bed with no shirt and jeans on. Resident #105 ' s fingers were observed to be bent and his elbows were levitated off the bed. At the time the picture was taken Resident #105 ' s head was on a pillow. Review of facility policy titled, Abuse, Neglect and Exploitation, dated [DATE] revealed neglect was defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, or emotional distress. Review of facility policy titled, Resident Care, revealed nursing standards of practice would be utilized to promote physical, mental, and emotional status of resident. This deficiency represents non-compliance investigated under Complaint Number OH00154310.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on medical record review and interview, the facility failed to ensure medications were administered per physician order resulting in a significant medication error. This affected one (Resident #105) of three residents reviewed for medication administration. The facility census was 103. Findings include: Review of the medical record for Resident #105 revealed an admitted [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), hypothyroidism, Vitamin D deficiency, muscle weakness, cirrhosis of liver, type two diabetes without complications, hyperlipidemia, obesity, schizophrenia, tobacco use, difficulty walking, constipation, gastro-esophageal reflux, and schizoaffective disorder bipolar type. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 12, indicating cognitive impairment. Resident #105 displayed delusions. Resident #105 did not reject care. Setup or clean up assistance was needed for eating, oral hygiene, toilet hygiene, and showers. Review of the plan of care date initiated 02/11/24, revealed Resident #105 had potential for mood swings related to schizophrenia. Interventions included administer medication as ordered and observe for effectiveness and for adverse reactions. Review of physician orders revealed an order dated 03/18/24 for Famotidine (gastric ulcer drug) 20 milligrams (mg) to be given by mouth daily from 7:00 A.M. to 11:00 A.M., an order dated 05/22/24 for Paliperidone Palmitate intramuscular (IM) suspension (antipsychotic) administered daily from 7:00 A.M. to 11 A.M., an order dated 05/22/24 for Polyethylene Glycol powder (laxative) to be given daily from 7:00 A.M. to 11:00 A.M., an order dated 05/22/24 for Carbamazepine tablet 200 mg (anticonvulsant) to be administered from 7:00 A.M. to 11:00 A.M., an order dated 05/22/24 for Lithium Carbonate 300 mg (antipsychotic) to be administered at 7:00 A.M. to 11:00 A.M., an order dated 05/22/24 for Klonopin tablet 1 mg at 7:00 A.M. to 11:00 A.M., and an order dated 05/22/24 for Benztropine Mesylate .5 mg (antiparkinsonian) at 7:00 A.M. to 11:00 A.M. Review of the Medication Administration Record (MAR) dated 05/25/24 revealed the morning medication of Famotidine, IM Paliperidone Palmitate suspension, Polyethylene Glycol powder, Carbamazepine, Klonopin, and Benztropine Mesylate was not administered to Resident #105 as ordered between 7:00 A.M. and 11:00 A.M. on 05/25/24. Review of the nursing note dated 05/25/24 at 8:30 A.M. written by Licensed Practical Nurse (LPN) #339 revealed Resident #105 appeared to be sleeping in a supine position in bed. Per nursing judgement, she allowed Resident #105 to sleep longer (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/03/24 at 3:30 P.M. with LPN #339 revealed she knocked on Resident #105's door at on 05/25/24 at 8:30 A.M. and assumed the resident was sleeping. Resident #105's morning medications did not get administered. LPN #339 verified she did not go back to Resident #105's room until 12:30 P.M. when a Code Blue was called for the resident, who was found unresponsive. LPN #339 verified she did not provide morning mediation to Resident #105. Interview on 06/11/14 at 4:34 P.M. with the Director of Nursing (DON) verified Resident #105's MAR reflected Resident #105 did not receive morning medications as ordered on 05/25/24. Review of facility nursing education dated 06/11/24 revealed all MARS were to be signed off and medications should be administered within ordered time frames. Medication administration should be attempted three times, if a resident does not take the medication after three attempts the nurse must notify the physician. Review of the facility policy titled, Medication Administration, dated 08/22/22 revealed medications were administered as ordered by the physician and in accordance with professional standards of practice. This deficiency was a result of an incidental finding discovered during the complaint investigation.