STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365342	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Inn of Cadiz Inc	308 West Warren Street Cadiz, OH 43907

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 28704 Based on observation, record review, incident log review, procedure review and interview, the facility failed to maintain hot water temperatures below 120 degrees Fahrenheit (F). This had the potential to affect 16 residents (#6, #8, #11, #13, #14, #15, #18, #19, #20, #21, #23, #24, #25, #26, #28 and #30) identified by the facility as cognitively impaired and independent with mobility of 34 residents who reside on the 200 and 300 halls. The census was 55. Findings include: Record review revealed Resident #6 and #8 were moderately impaired for daily decision-making and resided on the long-term unit (200 hall). Resident #11, #13, #14, #15, #18, #19, #20, #21, #23, #24, #25, #26, #28 and #30 were severely impaired for daily decision-making and resided on the locked Alzheimer's unit (300 hall). On 06/17/24 at 10:15 A.M., observation of the second floor mechanical room with Maintenance Director (MD) #89 revealed two hot water tanks. One hot water tank was set to 140 degrees Fahrenheit (F) and the second tank did not have a temperature display visible. MD #89 verified the first hot water tank was set to 140 degrees (F) to ensure hot water was delivered to the 200 and 300 units. Further interview revealed resident room hot water temperatures were not to exceed 120 degrees (F). On 06/17/24 between 10:18 A.M. and 10:59 A.M., MD #89 was observed testing the following resident room bathroom sink hot water temperatures. MD #89 verified the readings at the time of the observation which included the following: a. Resident #6's water temperature was 121.1 degrees (F). b. Resident #8, #11, #25, #26 and #28's water temperature was 121.2 degrees (F). c. Resident #13, #14 and #15's water temperature was 121.4 degrees (F). d. Resident #18 and #24's water temperature was 120.8 degrees (F). e. Resident #19's water temperature was 120.9 degrees (F). f. Resident #20, #21 and #23's water temperature was 121.7 degrees (F). (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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Resident #30's water temperature was 120.6 degrees (F). Review of Ambulatory with Cognitive Impairment resident list provided by the facility revealed Resident #6, #8, #11, #13, #14, #15, #18, #19, #20, #21, #23, #24, #25, #26, #28 and #30 were independent with mobility and cognitively impaired. On 06/17/24 between 10:33 A.M. and 10:47 A.M., Resident #11, #13, #14, #15, #18, #19, #20, #21, #23, #24, #25, #26, #28 and #30 were observed on the locked Alzheimer's unit. Resident #14 and #18 were observed ambulating in and out of rooms including the bathrooms and Resident #28 was in an unoccupied room, laying on a bed. On 06/17/24 at 10:59 A.M., interview with MD #89 verified the long term unit (200 hall) and the Alzheimer's locked unit (300 hall) hot water temperatures were above 120 degrees (F) and the water for those units came from the hot water tank set to 140 degrees (F). MD #89 stated he tests two rooms per unit per week and normally tested the water temperatures in the afternoon without any concerns. MD #89 verified the water temperatures exceeded 120 degrees (F) and should not be above 115 degrees (F) according to the facility's guidelines. On 06/17/24 at 11:09 A.M., interview with Registered Nurse (RN) #143 verified the water temperatures exceeded 120 degrees (F) and posed a burn risk. RN #143 stated there had been no reports of residents receiving a burn from the elevated water temperatures. Review of the Incidents by Incident Type report dated 04/17/24 to 06/17/24 revealed no resident burns. Review of the procedure: Resident Hot Water Temperature Log revealed all hot water for resident rooms and areas were supplied through a single closed loop system. Choose one patient room on the 2nd and 3rd floors to measure the water temperature. Each week rotate between all three wings. Take a thermometer and test the hot water in each restroom. It must be between 105 degrees (F) and 115 degrees (F). Water temperatures out of range must be corrected immediately. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00154268.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 28704 Based on observation, policy review and interview, the facility failed to prepare and serve food in a sanitary manner. This had the potential to affect 54 of 55 residents residing in the facility. The facility identified Resident #55 not receiving nutrition by mouth. The facility census was 55. Findings include: On 06/17/24 between 9:45 A.M. and 10:01 A.M. observations of the kitchen revealed Dietary Director #69 and Dietary [NAME] #73 were observed to have beards and a mustache. Upon entrance to the kitchen, Dietary [NAME] #73 had his beard net below his chin and when the surveyor approached the dishwashing station, Dietary [NAME] #73 raised the beard net to cover his beard; however, his mustache remained uncovered. Dietary [NAME] #73 was washing dishes and removing clean dishes from the low temperature dishwasher at the time of the observation. Dietary Director #69 and Dietary [NAME] #73 were both observed with facial hair approximately one inch in length, uncovered at the time of the observation. On 06/17/24 between 11:56 A.M. and 12:08 P.M., observation of the lunch meal tray line service revealed Dietary [NAME] #73 was positioned over the kitchen steam tables and serving individual resident meals and placed them on a cafeteria-style serving tray to be distributed to residents. Dietary [NAME] #73 was observed to have a beard net covering only a portion of his beard and his mustache was uncovered. Dietary Director #69 was standing next to the surveyor and did not have his beard net covering his mustache during the lunch meal observation. Dietary Director #69 verified Dietary [NAME] #73's beard was only partially covered and his mustache was uncovered during the meal service. On 06/17/24 between 12:01 P.M. and 12:07 P.M., observation revealed Dietary [NAME] #100 washed his hands and donned gloves. Dietary [NAME] #100 then grabbed a package of hamburger buns placed them on the prep table, was handed a cafeteria-style tray from Dietary [NAME] #73 and placed it on the prep area to put the buns on. Dietary [NAME] #100 used a utensil to open the top of the bun package and then reached into the bag of buns and opened the buns with his gloved hands and put them on the cafeteria-style tray. Dietary [NAME] #100 repeated the above with a second bag of hamburger buns and Dietary [NAME] #73 was observed using the buns to serve a BBQ rib sandwich for the lunch meal service. Dietary [NAME] #100 did not change his gloves during the above observation. On 06/17/24 at 12:08 P.M., the above observation was verified by Dietary Director #69. Review of the undated policy: What to Wear revealed a hair covering was to be worn in prep areas, while prepping food, working in areas used to clean utensils and equipment and food handlers with facial hair should also wear a beard restraint. This deficiency represents non-compliance investigated under Complaint Number OH00154268.