STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365393	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Jackson	8668 State Route 93 Jackson, OH 45640

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, resident interview, and staff interview, the facility failed to ensure residents were treated with dignity when indwelling urinary catheter collection bags were not covered when the residents were in bed and left visible from the hallway. This affected two (Resident #40 and #66) of three residents reviewed for indwelling urinary catheters. The census was 68. Findings include: 1. Review of Resident #40's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included neuromuscular dysfunction of the bladder. Review of Resident #40's quarterly Minimum Data Set (MDS) assessment revealed the resident did not have any communication issues and was cognitively intact. The resident was identified as having the use of an indwelling urinary catheter. Review of Resident #40's care plans revealed she had a care plan in place for the use of an indwelling urinary catheter due to a neurogenic bladder. The interventions included the need to provide a dignity cover over the drainage bag when out of the room. Review of Resident #40's physician's orders revealed she had the use of an indwelling urinary catheter due to urinary retention related to neurogenic bladder. The order had been in place since 02/22/24. On 05/06/24 at 10:07 A.M., an observation of Resident #40 noted her to be lying in bed. She was noted to have an indwelling urinary catheter with the collection bag secured to the left side of the bed that was facing the door. Her catheter bag was visible from the hall, as it was not concealed in a cover bag, and was noted to have amber colored urine in it. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/24 at 10:22 A.M., an interview with State tested Nursing Assistant #9 revealed she had worked at the facility for about a month now. She was assigned as an aide for Resident #40's hall. She was asked what responsibilities the aides had in regards to the care of a resident's catheter. She stated the aides were responsible for doing catheter care and emptying of the catheter at the end of every shift. She was asked about any specific requirements in regards to the catheter bag/ tubing. She then reported catheter bags should be kept inside a cover bag. She was asked to go to the resident's room to see if her catheter's collection bag was concealed in a cover bag. She confirmed the catheter's collection bag was not in a cover bag and was visible from the hall. She found a cover bag in the room near the sink, but stated the strap had broke off and it could not be secured to the bed. She stated she would have to get the resident a new one. On 05/07/24 at 10:26 A.M., an interview with Resident #40 revealed she did have concerns with the care of her indwelling urinary catheter. She indicated yesterday the staff were running around saying they had to get a cover bag for her catheter due to State being there. They usually did not have a cover bag on her catheter's collection bag and she had even went out of the facility for appointments without a cover bag in place. She felt it was embarrassing to not have it covered when in public. 2. Review of Resident #66's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included adult onset diabetes mellitus and urinary retention. Review of Resident #66's physician's orders revealed he had an order for the use of an indwelling urinary catheter due to urinary retention secondary to diabetes mellitus and hospice care. The order had been in place since 03/15/24. Review of Resident #66's care plans revealed he had a care plan in place for the use of an indwelling urinary catheter. The care plan was initiated on 03/15/24. The interventions included the need to ensure the resident's indwelling urinary catheter's collection bag was placed on the side of the bed that was not visible from the hall. On 05/06/24 at 10:05 A.M., an observation of Resident #66 noted the resident to be lying in bed receiving a breathing treatment. He was noted to have an indwelling urinary catheter that was on the right side of the bed between the bed and the window, but was still visible from the hall due to its placement at the foot of the bed and resting directly on the floor. The collection bag was not in a cover bag and had amber colored urine in it that was visible from the hall. On 05/06/24 at 10:25 A.M., a follow up observation of Resident #66 noted him to remain in bed. His indwelling urinary catheter's collection bag had been moved and secured to the left side of the bed instead of being on the floor on the right side of the bed as was previously noted. It was then properly concealed in a cover bag and secured off the floor. On 05/06/24 at 10:35 A.M., an interview with Licensed Practical Nurse (LPN) #21 revealed she was Resident #66's nurse that day. She confirmed the resident's indwelling urinary catheter bag had been resting on the floor and not placed in a cover bag, while being visible from the hall. She stated she had been in the resident's room, after the initial observation had been made, and moved the indwelling urinary catheter's collection bag to the other side of his bed. She had noted it was resting on the floor as the hook was broke. She got a cover bag and placed the collection bag inside of it so she could secure it to the bed. She confirmed urinary collection bags should be stored in a cover bag for privacy/ dignity reasons and should not be visible from the hall. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00153058.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, review of Centers for Medicare and Medicaid (CMS) Quality, Safety, and Oversight (QSO) Memo 24-08-NH, staff interview, and policy review, the facility failed to ensure a resident's indwelling urinary catheter's collection bag was properly secured so it was not in direct contact with the floor. They also failed to ensure residents with chronic wounds and those with indwelling medical devices were placed in enhanced barrier precautions as required. This affected one (Resident #66) of three residents reviewed for indwelling urinary catheters and affected nine residents (5, #10, #32, #36, #40, #50, #63, #66, and #67) who the facility identified as having chronic wounds or indwelling medical devices. The facility census was 68. Findings include: 1. Review of Resident #66's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included adult onset diabetes mellitus and urinary retention. Review of Resident #66's physician's orders revealed he had an order for the use of an indwelling urinary catheter due to urinary retention secondary to diabetes mellitus and hospice care. The order had been in place since 03/15/24. Review of Resident #66's care plans revealed he had a care plan in place for the use of an indwelling urinary catheter. The care plan was initiated on 03/15/24. The interventions included maintaining the indwelling urinary catheter. The interventions also included the need to check the tubing for kinks as needed. There was nothing in the care plan specific to how to secure the indwelling urinary catheter's collection bag while in bed. On 05/06/24 at 10:05 A.M., an observation of Resident #66 noted the resident was lying in bed, He was noted to have an indwelling urinary catheter that was on the right side of the bed between the bed and the window. The indwelling urinary catheter's bag was noted to not be properly secured to the bed and was resting directly on the floor. On 05/06/24 at 10:25 A.M., a follow up observation of Resident #66 noted him to remain in bed. His indwelling urinary catheter's collection bag had been moved and secured to the left side of the bed, instead of resting on the floor as was previously noted. On 05/06/24 at 10:35 A.M., an interview with Licensed Practical Nurse (LPN) #21 revealed she was Resident #66's nurse that day. She confirmed his indwelling urinary catheter bag had been found resting on the floor at the end of his bed. She went in his room to take him off his breathing treatment and noted it was on the floor. She stated she had noted the clip on the bag had broke off and that was why it was on the floor. She obtained a cover bag and placed the collection bag inside of that and secured it to the left side of his bed. She confirmed indwelling urinary catheter bags were to be maintained off the floor for infection control purposes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 05/06/24 from 9:57 A.M. to 10:09 A.M., observations during tour of the facility revealed there were no residents in enhanced barrier precautions. There were several residents throughout the facility that had indwelling urinary catheters that were not in enhanced barrier precautions as required. Ongoing observations throughout the course of the complaint investigation completed on 05/07/24 at 12:42 P. M. revealed no evidence of enhanced barrier precautions being used for any residents. They had one resident that was in contact isolation precautions for a reported Clostridium Difficile infection. Findings were verified by Infection Preventionist (IP) #38. On 05/07/24 at 11:23 A.M., an interview with IP #38 revealed they did not have any residents in enhanced barrier precautions. She stated they did not have anyone that required that then. She confirmed they had residents with indwelling urinary catheters, enteral feeding tubes, and chronic wounds. She stated the staff just followed standard precautions for those. She stated she thought that they needed to have more than just one to require enhanced barrier precautions. On 05/07/24 at 12:11 P.M., a follow up interview with IP #38 revealed she was wrong with her previous information she provided regarding the enhanced barrier precautions. She reviewed QSO-24-08-NH and confirmed all residents with chronic wounds or indwelling medical devices should be placed in enhanced barrier precautions. She acknowledged that requirement was effective 04/01/24. She stated they would place them under enhanced barrier precautions immediately. Review of CMS's QSO-24-08-NH dated 03/20/24 pertaining to Enhanced Barrier Precautions in Nursing Homes revealed CMS was issuing new guidance for State survey agencies and long term care facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now included use of EBP's for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multi-drug resistant organism status. The new guidance related to EBP's was being incorporated into F880 Infection Prevention and Control. Guidance under F880 indicated EBP's referred to an infection control intervention designed to reduce transmission of multi-drug resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. EBP's were to be used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. Review of the facility's policy on Enhanced Barrier Precautions (EBP) dated 04/01/24 revealed it included the same information provided in CMS QSO-24-08-NH. The procedures included placing EBP signage on the resident's room door and to have PPE (gowns and gloves) available. Gown and gloves would be required for high-contact resident care activities. EBP was indicated for residents with MDRO infections or colonizations when contact precautions did not apply. They were also to be used with wounds, indwelling medical devices such as central lines, urinary catheters, feeding tubes etc. They were to be employed when performing the following high-contact resident care activities: dressing, bathing/ showering, transferring, personal hygiene, changing linens, housekeeping services, changing briefs or assisting with toileting, wound care, and device use/ care. This deficiency represents non-compliance investigated under Complaint Number OH00153058.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of the facility's infection control logs, review of McGeer's criteria for infection surveillance checklist, staff interview, and policy review, the facility failed to ensure a resident was not given antibiotics unless they met criteria for the treatment of a urinary tract infection (UTI). This affected one (Resident #40) of three residents reviewed for indwelling urinary catheter's/ UTI's. The census was 68. Findings include: Review of Resident #40's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included neuromuscular dysfunction of the bladder and flaccid neuropathic bladder not elsewhere classified. Review of Resident #40's physician's orders revealed she had the use of an indwelling urinary catheter due to urinary retention related to neurogenic bladder. The order had been in place since 02/22/24. Review of Resident #40's progress notes revealed she had been sent out to the hospital several times for concerns of a UTI. Most of her visits was to the emergency room with one of her transfers to the hospital resulting in an admission for the treatment of a UTI. She had been ordered multiple antibiotics in the past six months for the treatment of a UTI. On 05/07/24 at 11:23 A.M., an interview with Infection Preventionist #38 confirmed Resident #40 had been treated multiple times for a UTI while in the facility since August 2023. She reported the facility used McGeer's criteria to determine if a resident met criteria for the treatment of a UTI. The facility's infection control log for the past six months was reviewed with the IP to review the multiple UTI's the resident had been treated for during that time. Review of the facility's infection control log for January 2024 revealed Resident #40 was identified as having had a UTI on 01/18/24. A urine culture was indicated to have been obtained and showed a colony count of 30,000 of Enterococcus species. The infection control log indicated the resident was given Ciprofloxacin (an antibiotic) between 01/18/24 and 01/25/24. Additional comments on the log revealed the emergency room (ER) had started the antibiotic. A review of the urinalysis that had been collected on 01/16/24 revealed Resident #40's urine was tested and showed between 26,000 and 30,000 CFU/ml of Enterococcus species. A review of the McGeer's criteria sheet for a date of infection of 01/21/24 revealed Resident #40 was only indicated to have had a acute change in mental status or acute functional decline with no alternate diagnosis and leukocytosis. She was not identified as having had a urinary catheter specimen culture with >100,000 CFU/Ml of any organism. Based on that, she did not meet criteria for treatment as the McGeer's criteria sheet indicated the resident must have fulfilled both of the above criteria when having an indwelling urinary catheter to meet criteria for treatment. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IP #38 was asked about Resident #40's treatment of a UTI on 01/18/24 and indicated the resident came back from the ER with the antibiotic ordered and believed the hospital did their own U/A. She stated the urinalysis (U/A) that was dated 01/16/24 was one that they collected at the facility, prior to the resident going to the ER. She denied that she received a copy of any U/A done at the hospital to ensure the resident met criteria for treatment. She stated the doctor they had at the time just went along with whatever the ER physician's wanted to do and would not discontinue an antibiotic, even if the resident did not meet criteria. The infection control log for January 2024 also showed Resident #40 was identified as having a UTI again on 01/23/24. As with the 01/18/24 infection, the resident was indicated to have Enterococcus species at a colony count as 30,000. The antibiotic ordered was Nitrofurantoin and it was given between 01/23/24 and 01/31/24. IP #38 was asked about Resident #40's antibiotic treatment for her reported UTI on 01/23/24 and indicated the antibiotic was ordered as a result of a ER visit. She denied that they did a U/A at the facility. She was told a U/A had been done at the hospital, but did not obtain those results. She denied that she contacted the hospital in an effort to obtain those results. She claimed the nurse that had gotten report asked for the lab to be sent but they did not get it. Review of the facility's infection control log for February 2024 revealed Resident #40 was treated twice for UTI's during that month. On 02/10/24 and again on 02/22/24, she was indicated to have been put on Nitrofurantoin (an antibiotic) for the treatment of a UTI. The first round of the antibiotic was given between 02/10/24 and 02/15/24 and the second round was given between 02/22/24 and 02/29/24. There was no evidence on the infection control log of a U/A being obtained to verify whether the SR had a UTI or not. IP #38 was asked about Resident #40 being treated with antibiotics for a UTI on 02/10/24 and again on 02/22/24. She reported those antibiotics were ordered as a result of a ER visit. She indicated the ER diagnosed her with a UTI, but she did not have any labs to support it. Review of the McGeer's criteria sheet for her UTI surveillance dated 02/10/24 revealed it did not indicate Resident #40 met criteria for treatment for a UTI, as the only criteria marked was a change in mental status or acute functional decline with no alternate diagnosis and leukocytosis. She was not indicated to have a colony count of >100,000 that would have been needed for her to meet criteria for treatment, Review of the McGeer's criteria sheet for her UTI surveillance dated 02/22/24 revealed Resident #40 was indicated to have met criteria despite her not meeting both areas needed for criteria to be met. The IP documented on the forms the ER diagnosis of a UTI on both forms. Review of the facility's infection control log for March 2024 revealed Resident #40 was treated for a UTI on 03/30/24. She was indicated to have been placed on Nitrofurantoin starting on 03/31/24 and continued it through 04/05/24 despite no U/A and culture being done. IP #38 reported Resident #40 came back from the hospital (after an inpatient stay) on that antibiotic and she did not have the labs from the hospital to support treating that infection. She indicated she looked for the lab but it had not been uploaded. She called the lab and was told they would send it, but they did not. She got busy with something else and did not follow up on that any further. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's infection control log for April 2024 revealed Resident #40 was treated for a UTI once that month on 04/09/24. A urine sample was indicated to have been collected, but did not identify what the culture results showed. Resident #40 was given Rocephin (an antibiotic given intramuscularly) on 04/09/24. The additional comments on the log revealed a one time IM dose of Rocephin was given while waiting on culture results. IP #38 reported Resident #40 was given IM Rocephin to treat symptoms. The resident insisted she was given an antibiotic, so that was what they gave her. She further claimed they must have received the culture as the resident was not put on any other antibiotics. She provided a copy of the U/A results that indicated microbiology testing was to follow. She denied the facility received those results and she did not call to follow up to get them. On 05/07/24 at 12:25 P.M., an interview with the Director of Nursing (DON) revealed the facility's physician's were fairly cooperative with following the antibiotic stewardship program. She reported Resident #40 was always complaining about symptoms and felt she had a UTI. She would often request to go to the ER and they did not know what to do with her, so they would just put her on an antibiotic and send her back. She acknowledged the facility's IP should be monitoring antibiotic use and ensure they were only being used when appropriate. She further acknowledged when an antibiotic was ordered (as a result of an ER visit or a hospital stay) the IP should review and obtain any labs completed at the hospital to verify the resident met criteria for the treatment of a UTI. If those labs were not supportive, then the IP should follow up with the physician to see if the antibiotic was to be continued. Review of the facility's Antibiotic Stewardship policy revised August 2023 revealed antibiotics would be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of the program was to monitor the use of antibiotics in their residents. When a resident was admitted from an emergency department, acute care facility, or other care facility, the admitting nurse would review discharge and transfer paperwork for current antibiotic orders. When a culture and sensitivity was ordered lab results and the current clinical situation would be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.