STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365399	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westerwood Rehabilitation	5757 Ponderosa Drive Columbus, OH 43231

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, review of bed hold notices, review of the facility census, review of discharge communications, staff interview, and facility policy review, the facility failed to allow a resident was permitted to return to the facility from the hospital in a timely manner. This affected one (Resident #4) out of two residents reviewed for hospitalization s. The facility census was 62. Findings include: Review of Resident #4's medical record revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #4's diagnoses included Alzheimer's disease, Parkinson's disease without dyskinesia (uncontrolled, involuntary muscle movement), acquired absences of right and left legs above the knee, severe protein-calorie malnutrition, unstageable pressure ulcer of sacral region, adult failure to thrive, hypertensive chronic kidney disease, mood affective disorder, and type two diabetes mellitus. Review of the quarterly Minimum Data Set 3.0 assessment, dated 03/21/24, revealed Resident #4 had severely impaired cognition and was unable to complete the Brief Interview for Mental Status assessment. Resident #4 required total dependence on staff to complete all activities of daily living. Review of Resident #4's census revealed the resident was hospitalized from 03/22/24 to 04/02/24. Review of Resident #52's census revealed the resident had a private pay payer source, resided in a private room, and was hospitalized from 03/21/24 until 04/01/24. Review of the Bed Hold Notification, dated 03/21/24, revealed Resident #52 was marked as having a Medicare/Managed Care payer source. The notice stated these payers do not pay for a bed when it is unoccupied. Therefore, the Health Center will reserve a bed during your hospitalization or therapeutic leave only if you choose to pay the above private pay rates for your applicable room. The large private room rate was noted as 463 dollars and was circled. The notice was signed by the facility representative on 03/27/24 and sent via certified mail to Resident #52's representative on 03/29/24. There was no indication Resident #52 or Resident #52's representative agreed to pay the private room rate during his hospitalization . (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Bed Hold Notification, dated 03/22/24, revealed Resident #4 had a Medicaid payer source. The notice stated, on 01/01/24, you had a total of 30 bed hold days. This notice is to inform you that as of 03/06/24 you have used eight out of 30 bed hold days and had 22 bed hold days remaining. The notice was signed by the facility representative on 03/22/24 and sent to Resident #4's representative via certified mail on 03/22/24. Review of the written discharge planning communications between the facility and the hospital social worker, dated 03/27/24 at 9:14 A.M., revealed Resident #4 was ready to discharge from the hospital and return to the facility. The facility representative responded to the hospital social worker on 03/27/24 at 9:18 A.M. indicating the facility did not have an isolation room available and the facility would update the social worker if a room became available. Review of the facility census, dated 03/27/24, revealed there were 67 residents in the facility. Resident #4 and Resident #52 were in the hospital. Interview on 04/04/24 at 10:13 A.M. with the Administrator confirmed Resident #52 was in a private room when he was sent to the hospital from the facility on 03/21/24 (one day prior to Resident #4). The Administrator confirmed Resident #52 had a private pay payer source and did not have any bed hold days to reserve the private room during his hospitalization . The Administrator confirmed Resident #52 had not agreed to pay the daily private pay room rate in order to reserve his private room at the facility. The Administrator confirmed Resident #52 had not been charged the daily private room rate during his hospitalization from [DATE] to 04/01/24. The Administrator confirmed there was no facility policy which indicated any resident's room, regardless of payer source, would be held for a certain number of days without being charged any fees. The Administrator confirmed the hospital social worker indicated Resident #4 was ready to be discharged on [DATE] but Resident #4 was not accepted back to the facility until 04/02/24. The Administrator confirmed Resident #4 was not accepted back to the facility on [DATE] because there was no private room available, however, Resident #52's private room was available due to Resident #52 being in the hospital with no confirmed discharge date . Review of the facility policy titled Resident Discharge, revised 04/2019, revealed the policy stated, It is the facility's policy to comply with federal regulations by permitting each resident to remain in the community. Emergency Transfers/Discharges: for medical reasons, or for the immediate safety and welfare of a resident, initiated by the facility; Admissions Coordinator or designee coordinate with the hospital regarding resident's current clinical status and anticipated return. This deficiency represents non-compliance investigated under Master Complaint Number OH00152690, Complaint Number OH00152551 and Complaint Number OH00152366.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on medical record review, resident and staff interview, and observation, the facility failed to ensure residents were provided with activities to meet their needs. This affected one resident (Resident #32) of four residents reviewed for activities. The facility census was 62. Findings include: Review of medical record for Resident #32 revealed an admitted [DATE] with diagnoses which included nuerolyptic parkinsonism, dementia, depression, bipolar II disorder, anxiety disorder, benign prostatic hyperplasia, cognitive communication deficit, drug induced movement disorder, and dorsalgia (back pain). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/18/24, revealed Resident #32 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status assessment. Resident #32 required a varied amount of assistance which ranged from minimal to total dependence on staff to complete Activities of Daily Living. Review of Resident #32's Activities Assessment, dated 02/09/24, revealed the resident enjoys watching the news, watching Cleveland Browns football on television, spending time with family, spending time outside hiking, ham radio, reading, and listening to music. Resident #32 liked to do research and activity staff have been giving him a tablet to work on. Resident #32 was to receive one-to-one visits. Review of Resident #32's Activities Log from 02/01/24 to 03/31/24 revealed the activities that were documented as having been completed for Resident #32 included reading on 20 out of 60 days, watching television on 45 out of 60 days, This Day in History & Puzzles on 40 out of 60 days, catholic communion and other religious activities on 02/06/24, 02/13/24, 02/20/24, 03/03/24, 03/05/24, 03/10/24, 03/12/24 and 03/19/24, family or friends visits on 02/06/24, 02/14/24, 02/26/24, and 03/01/24 and electronics use (Kindle which is a mobile reading device) on 13 out of 60 days. The activities log documented one to one visits occurred on 02/07/24, 02/20/24, 02/23/24, 02/25/24, 02/26/24, 03/04/24, 03/07/24, 03/11/24, 03/13/24, 03/18/24, 03/22/24, 03/24/24, and 03/27/24 with documentation which indicated the one on one visits consisted of dropping off a Kindle to Resident #32. Review of Resident #32's Care Plan, completed on 03/26/24, revealed Resident #32 needed to maintain social interaction and stimulation, and his interests included watching the news, watching Cleveland Browns football on television, spending time with family, spending time outside hiking, ham radio, reading, and listening to music. Interventions for Resident #32 included assessing Resident #32 for response to activities and adjusting the plan, assisting the resident to the activity area per his choice, introducing Resident #32 to peers, and providing an activity calendar. Interview on 04/01/24 at 11:03 A.M. with Resident #32 revealed he does not like to participate in group activities. Resident #32 stated he has a hard time speaking and was tired all the time. Resident #32 stated he does not really watch television and would like more things to do. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/24 at 3:25 P.M. with Resident #32 revealed he does not watch television and wished he had his computer but it was a desktop computer and he had nowhere to put it. Resident #32 stated he liked listening to music too but did not have a radio. Observations on 04/01/24 at 3:09 P.M., on 04/02/24 at 3:25 P.M. and on 04/03/24 at 10:42 A.M., revealed Resident #32 was sitting up in his chair with no reading materials, no music, and the television was off. Resident #32 was not actively engaged in any activities. Interview on 04/04/24 at 11:42 A.M. with State tested Nurse Aide (STNA) #217 revealed Resident #32 liked to stay in his room and read, visit with family or listen to music. STNA #217 confirmed there was no radio or reading materials in Resident #32's room. Interview on 04/04/24 at 1:47 P.M. with Community Life Coordinator (CLC) #192 confirmed CLC #192 was aware of Resident #32's preferred activities which included reading and listening to music. CLC #192 confirmed Resident #32 did not have a radio or reading device in his room and stated Resident #32 would be provided a radio or Kindle, but it was expected that he ask for it. CLC #192 indicated Resident #32 used to have a radio however it broke and the facility did not have enough radios available to give each resident their own radio. CLC #192 stated staff are supposed to check in every morning to ask if residents want anything but do not document requests or refusals. CLC #192 indicated the actitivity titled This Day in History & Puzzles on the activity log meant staff dropped off a packet to the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, observation, and staff interview, the facility failed to obtain a physician order for a right arm sling prior to use. This affected one (Resident #116) out of two residents reviewed for limited mobility. The facility census was 62. Findings include: Review of the medical record for Resident #116 revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #116's medical diagnoses included fracture of shaft of right humerus, laceration of part of head, difficulty in walking, lack of coordination, cognitive communication deficit, and history of falling. Review of the Admission Minimum Data Set 3.0 assessment, dated 03/26/24, revealed Resident #116 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #116 had an impairment on one side of her upper extremity (shoulder, elbow, wrist, hand). Resident #116 required setup or clean-up assistance with eating and hygiene, and required partial to substantial assistance from staff to complete all other activities of daily living. Resident #116's active diagnoses included fractures and other multiple trauma. Review of Resident #116's physician orders dated April 2024 revealed there was no order for a right arm sling. Observation on 04/01/24 at 3:00 P.M. revealed Resident #116 was in her room, laying in bed, wearing a sling on her right arm. Interview on 04/02/24 at 2:45 P.M. with the Assistant Director of Nursing (ADON) #229 confirmed there was no a physician order in place for Resident #116's right arm sling and stated there should be an order for it. ADON #229 stated Resident #116 fractured her right humerus bone and was wearing the sling while the bone healed.

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, resident and staff interviews, and facility policy review, the facility failed to ensure residents were provided with timely dental services. This affected one (Resident #116) out of one resident reviewed for dental services. The facility census was 62. Findings include: Review of the medical record for Resident #116 revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #116's medical diagnoses included fracture of shaft of right humerus, laceration of part of head, difficulty in walking, lack of coordination, cognitive communication deficit, and history of falling. Review of a progress note, dated 03/06/24 at 8:00 A.M., revealed Resident #116 had a Medicare payer source. Review of the Admission Evaluation, dated 03/19/24, revealed Resident #116 had broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose). Review of Resident #116's plan of care, dated 03/20/24, revealed there were no dental or denture concerns addressed in the resident's care plan. Review of the Admission Minimum Data Set 3.0 assessment, dated 03/26/24, revealed Resident #116 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status assessment. The assessment did not note any dental issues. Review of Resident #116's physician orders, dated April 2024, revealed Resident #116 had an order for a regular, mechanical soft diet per the resident's request. The order was dated 03/28/24 at 2:24 P.M. Review of a dietary progress note, dated 03/28/24 at 2:26 P.M., by Dietitian #327 revealed an oral exam showed Resident #116 had broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable, or loose). The note stated, dentures do not fit. Furthermore, Resident #116 reported the dentures have caused a sore and that it is effecting her ability to eat with dentures in. Resident #116 agreed to downgrade her diet to mechanical soft until the sore healed. The diet change would allow Resident #116 to eat without dentures in at meal time and allow the gums to heal. Review of the list of residents seen by the dentist, dated 03/28/24, revealed Resident #116 had not been seen by the dentist. Review of a progress note, dated 03/29/24 at 6:57 A.M., by Assistant Director of Nursing (ADON) #229 revealed a new order was implemented for a mechanical soft diet per Resident #116's request related to a sore from Resident #116's dentures. The start date of the new diet was 03/28/24. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 04/02/23 at 11:18 A.M. and on 04/03/24 at 4:40 P.M. with Resident #116 revealed the resident reported her dentures did not fit and she had sore gums. Resident #116 stated she had a canker sore on her right upper gum. The resident attempted to raise her upper lip to show the sore to this surveyor but stated, I don't think you can see it. Resident #116 placed her finger on the outside of her upper lip just under her right nostril and stated, it's right there. Resident #116 stated when she had to bite into harder foods her upper denture rubbed against the canker sore and caused pain so she had been leaving her dentures out during meals. This surveyor observed both her upper and lower dentures to be sitting on the bed side table next to the resident's bed. Resident #116 stated she had an appointment with an outside dentist scheduled in June 2024 but would like to be seen by a dentist sooner. Resident #116 stated she had not been informed of an in-facility dentist or any dental services offered by the facility. Interview on 04/03/24 at 6:08 P.M. with Ancillary Specialist (AS) #141 revealed the facility did offer dental services to residents. The services were offered to both Medicare and Medicaid residents. AS #141 stated when a resident was admitted to the facility, ancillary services were part of the admission packet that was reviewed with the resident. A consent form was reviewed with the resident and the resident signed the form indicating whether the resident wanted to accept or decline ancillary services. AS #141 reviewed the admission packets and notified providers of the residents who wished to receive services. AS #141 confirmed the dentist visited the facility on 03/28/24 and Resident #116 was not seen at that time. AS #141 reviewed Resident #116's admission packet and ancillary services consent form and confirmed neither had been completed. AS #141 stated Dietitian #327 informed her of Resident #116's ill-fitting dentures after the dentist's visit to the facility. AS #141 stated she had not been told Resident #116 was experiencing any pain. Interview on 04/03/24 at 6:27 P.M. with Admissions Coordinator (AC) #319 revealed he reviewed admission packets and ancillary services consent forms with new admissions to the facility. AC #319 stated the admission packet and consent forms should be completed within 72 hours of admission. AC #319 confirmed the admissions packet or ancillary services consent form for Resident #116 had not been completed yet. AC #319 stated he had not been able to connect with the resident yet in order to complete the paperwork. Review of the facility policy titled Dental Services, undated, revealed the policy stated, it was the policy of the facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. The dental needs of each resident are identified through the physical assessment and MDS assessment processes, and are addressed in each resident's plan of care. Referrals to dietitian, speech therapist, physician, or dental provider shall be made as appropriate. In the case of an acute dental condition, the facility will take measures to ensure residents are still able to eat and drink while awaiting dental services including: notifying physician of pain or other needs, modifying diet consistency, referring to dietitian for food preferences during the interim, and referral to speech therapist for chewing or swallowing problems.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, review of a lunch tray ticket, observation, and staff interview, the facility failed to ensure was provided meals as preferred. This affected one resident (#4) of five residents reviewed for nutrition. The facility census was 62. Findings include: Review of the medical record for Resident #4 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, Parkinson's disease, severe protein-calorie malnutrition, vascular dementia, acquired absence of right and left leg above knee, type two diabetes mellitus, unspecified mood disorder, dysphagia, adult failure to thrive, and constipation. Review of Resident #4's Plan of Care, dated 02/07/24, revealed Resident #4 had the potential for nutrition or hydration issues related to her diagnoses, need for mechanically altered diet, dysphagia, pocketing food, severe protein calorie malnutrition, being underweight, and increased nutrient needs related to her wound. Interventions included a consistent carbohydrate and pureed diet, offering alternates if intake is poor, assisting with meals, providing supplements as ordered, encouraging intake of meals and fluids, and per the resident's preference and daughters request the resident was to be given a bite of food with or dipped in frozen nutritional treat. Review of Resident #4's quarterly Minimum Data Set (MDS) assessment, dated 03/21/24, revealed Resident #4 had severely impaired cognition. Resident #4 weighed 72 pounds, had no significant weight changes, and was on a mechanically altered and therapeutic diet. Review of Resident #4's physician order, dated 04/02/24, revealed Resident #4 was to receive a frozen nutritional treat with meals. Review of the lunch tray ticket, dated 04/04/24, revealed Resident #4 was to receive pureed cornflake chicken breast, pureed squash, carrots, and green beans, and a vanilla frozen nutritional treat. Observation on 04/04/24 from 1:00 P.M. to 1:15 P.M. revealed STNA #77 was assisting Resident #4 with her meal. There was a plate which included two pureed foods and no supplements on Resident #4's bedside table. STNA #77 was observed feeding Resident #4 bites of pureed food and the bites of pureed food were not mixed with or dipped in frozen nutritional treat as indicated on Resident #4's care plan. The observation further revealed there was a refrigerator in Resident #4's room which contained one frozen nutritional treat and two house shakes. STNA #77 indicated he would call the kitchen to find out if Resident #4 was supposed to receive a nutritional supplement. STNA #77 verified with the kitchen that Resident #4 was supposed to receive a frozen nutritional treat with the lunch meal and the kitchen staff agreed to deliver a nutritional treat to the residents room. STNA #77 did not mix any bites of pureed food with a nutritional treat or dip the bites in a nutritional treat at any point prior to the kitchen staff bringing the nutritional treat to Resident #4's room. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/04/24 from 1:00 P.M. to 1:15 P.M. with STNA #77 verified there was no nutritional treat on Resident #4's bedside table or with Resident #4's meal tray. He additionally reported Resident #4 had not eaten a nutritional treat or supplement prior to the beginning of the observation and he was unsure what supplements Resident #4 was supposed to be receiving as she had just returned to the facility. STNA #77 verified the tray ticket indicated Resident #4 was to receive a frozen nutritional treat and he called the kitchen to ensure one was sent to the room. STNA #77 reported the facility staff was not supposed to take things from the refrigerator in the residents room. This deficiency represents non-compliance investigated under Master Complaint Number OH00152690 and Complaint Number OH00152366.

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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** 41266 Based on medical record review, review of hospital records, observation, staff interview, facility policy review, and review of Centers for Disease Control and Prevention guidance, the facility failed to staff practiced proper infection control practices while assisting residents with meals. This affected one (Resident #4) out of three residents reviewed for transmission based precautions. The facility census was 62. Findings include: Review of Resident #4's medical record revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #4's diagnoses included but were not limited to Alzheimer's disease, Parkinson's disease without dyskinesia (uncontrolled, involuntary muscle movement), severe protein-calorie malnutrition, adult failure to thrive, type two diabetes mellitus, and colonized clostridium difficile (C. Diff) colitis. Review of the quarterly Minimum Data Set 3.0 assessment, dated 03/21/24, revealed Resident #4 had severely impaired cognition and was unable to complete the Brief Interview for Mental Status assessment. Resident #4 required total dependence on staff to complete all activities of daily living. Review of Resident #4's census revealed the resident was hospitalized from 03/22/24 to 04/02/24. Review of hospital records, dated 04/02/24, revealed Resident #4 tested positive for Clostridium difficile (C. Diff) at the hospital on 03/23/24. However, the hospital records indicated the second step of the test was negative which was indicative of a colonized infection and not an active infection. Resident #4 was noted to have watery stool on 03/28/24 and was placed under contact transmission-based precautions (TBP) during her hospitalization . Review of a progress note dated 04/02/24 at 9:36 A.M., revealed Resident #4 ' s daughter was contacted to inform her Resident #4 ' s discharge date and time had been confirmed as today at 2:00 P.M. Resident #4's daughter was informed that Resident #4 would be readmitted to a private room due to isolation needs. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/04/24 from 12:45 P.M. to 1:12 P.M. of Resident #4 during lunch meal service with State-tested Nurse Aide (STNA) #77 revealed Resident #4 was in a private room and was under contact TBP. STNA #77 was observed in the room wearing an isolation gown and gloves. Resident #4's meal tray was observed on the bedside table on the right side of the resident's bed. The resident's meal ticket was observed laying on the floor next to the bedside table. There was no nutritional supplement observed on Resident #4's meal tray and STNA #77 stated he would call the kitchen to find out if Resident #4 was supposed to receive a nutritional supplement because prior to the resident's hospitalization , she did receive a frozen nutritional treat with meals. STNA #77 walked over to corded phone in room that was sitting on the floor and picked it up with gloves on and called the kitchen. STNA #77 verified with the kitchen Resident #4 was supposed to receive a frozen nutritional treat with the resident's lunch meal and agreed to deliver one to the resident's room. STNA #77 hung up the phone and placed it back onto the floor. STNA #77 walked back over to Resident #4's bedside table where Resident #4's meal tray was sitting, picked up the spoon (with the same gloves on) and began attempting to feed the resident again. STNA #77 put the spoon up to Resident #4's lips and encouraged the resident to open her mouth. Resident #4 opened her mouth slightly and took a very small amount of food into her mouth before shutting it again. STNA #77 looked down at the floor and noticed the resident's meal ticket was laying on the floor. STNA #77 picked up the resident's meal ticket from the floor with the same gloves on and handed it to this surveyor. STNA #77 did not change gloves or complete any hand hygiene. STNA #77 walked back over to Resident #4 and lifted the resident's covers to reveal the resident's abdominal binder with his gloved hands. STNA #77 replaced the resident's covers with the same gloves on. Kitchen staff arrived at Resident #4's room with a frozen nutritional treat. STNA #77 answered the knock at the door with the same gloves on and accepted the nutritional treat from the kitchen staff. STNA #77 did not change gloves or complete any hand hygiene. STNA #77 returned to the resident's bed side table and opened the frozen nutritional treat with the same gloves in place, picked up the resident's spoon again and began mixing the nutritional treat with the resident's pureed foods. STNA #77 again put the spoon to Resident #4's lips and encouraged her to open her mouth. Resident #4 opened her mouth and accepted bites of food. STNA #77 continued feeding Resident #4 without changing his gloves or completing any hand hygiene during the observation. Interview on 04/04/24 at 2:05 P.M. with STNA #77 confirmed the above observations. STNA #77 confirmed he had not changed his gloves or completed any hand hygiene after picking up items from the floor or answering the resident's door with gloves on and continued feeding Resident #4. STNA #77 stated Resident #4 ate approximately 25 percent of her meal at lunch and drank approximately 120 milliliters (mL) of fluids. STNA #77 stated he was not told why Resident #4 was under contact TBP and he did not ask anyone. STNA #77 stated he was not aware Resident #4 had colonized C. Diff with possible symptoms (water stools) of an active C. Diff infection. Review of the facility policy titled Handwashing/Hand Hygiene Policy, undated, revealed the facility policy stated, it was the policy of the facility that hand washing/hand hygiene be regarded as the single most important means of preventative measures in the spread of infectious disease. When to wash hands: before serving food, before and after the use of gloves, gowns, and masks, before and after caring for a resident in an isolation area, after contact with work surfaces potentially contaminated with a resident's blood, excretions, or secretions, and when in doubt, wash. The use of gloves does not replace hand washing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365399	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westerwood Rehabilitation	5757 Ponderosa Drive Columbus, OH 43231

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers for Disease Control and Prevention guidance titled Your Risk of C. diff, last reviewed 06/27/22, revealed the guidance under the section, What is Colonization? stated, someone who is colonized has no signs or symptoms. If you are colonized with C. diff, you can spread the infection to others. Once your body is colonized with C. diff, you can remain colonized for several months. It is more common to become infected with C. diff in healthcare settings, such as hospitals and nursing homes. In a healthcare setting, while caring for you and other patients with C. diff, healthcare professionals will use certain precautions, such as wearing a gown and gloves, to prevent the spread of C. diff to themselves and to other patients. In addition to Standard Precautions, use Transmission-Based Precautions for patients with documented or suspected infection or colonization with highly transmissible or epidemiologically-important pathogens for which additional precautions are needed to prevent transmission. This deficiency represents non-compliance investigated under Complaint Number OH00152366.