STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365530	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delhi Post-Acute	5999 Bender Road Cincinnati, OH 45233

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28196 Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to ensure medications were ordered and available for administration as ordered by the physician. This affected one (Resident #40) of 19 sampled residents. The facility census was 95 residents. Findings include: Review of the medical record for Resident #40 revealed an admitted [DATE] with a diagnosis of anxiety disorder. Review of the care plan for Resident #40 initiated on 06/08/22 and revised on 01/30/24 revealed the resident received psychotropic medications that included antianxiety medications. Interventions included staff were to give medications as ordered. Review of the medication review report for Resident #40 revealed a physician's order dated 06/30/23 for Ativan (an antianxiety medication) one milligram (mg) by mouth every six hours for anxiety disorder. Review of the annual Minimum Data Set (MDS) assessment for Resident #40 dated 04/19/24 revealed the resident was cognitively intact and had received antianxiety medication during the last seven days of the assessment period. Review of the order audit for Resident #40 revealed the pharmacy dispensed Ativan on 04/28/24. Review of the controlled drug record for Resident #40 revealed the facility received 60 Ativan tablets on 04/29/24. According to the prescription label on the form, the next Ativan refill required a new prescription. Further review of the drug record revealed the last dose of Ativan for Resident #40 was signed out on 05/19/24 at 6:00 A.M. Review of a medication error report dated 05/20/24 timed at 1:00 P.M. for Resident #40 revealed the resident's Ativan supply was exhausted on 05/19/24, which caused the resident to miss four doses between 05/19/24 and 05/20/24. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/20/24 at 12:50 P.M. with Resident #40 confirmed the facility ran out of the resident's Ativan on 05/19/24 at 6:00 A.M. Interview on 05/22/24 at 10:43 A.M. with Registered Nurse (RN) #03 confirmed she did not administer Resident #40's 12:00 A.M. or 6:00 A.M. dose of Ativan on 05/20/24 because she did not have access to the facility's emergency medication kit. Interview on 05/22/24 at 6:42 A.M. with Licensed Practical Nurse (LPN) #05 confirmed there had been times when the facility did not have Resident #40's Ativan medication. LPN #05 stated when that happened, she called the pharmacy to make sure it was on the way. LPN #05 stated medications should be reordered at least two days prior to the last dose available to ensure the medication was available to administer as ordered. Interview on 05/22/24 at 2:01 P.M. with LPN #06 confirmed the normal process for reordering medications was to first check to see if the resident had an active prescription. If the resident had an active prescription, the staff could reorder the medication via the resident's electronic health record two to three days prior to the last available dose of the medication to ensure the medication would be available when needed. LPN #06 further confirmed she did not notice Resident #40 was low on Ativan, but if she had, she would have reordered the medication. Interview on 05/22/24 at 1:31 P.M. with the Regional Nurse Consultant (RNC) confirmed that typically the facility should reorder narcotics at least two days prior to the last available dose of medication or when there were 10 doses left to give. The RNC stated the staff should have re-ordered Resident #40's Ativan by 05/17/24, but they had not done so, and Resident #40 missed four doses of Ativan on 05/19/24 and 05/20/24. Interview on 05/23/24 at 11:07 A.M. with the Director of Nursing (DON) confirmed nurses should reorder controlled substances according to the sticker on the medication pack provided by the pharmacy. The DON confirmed nurses should administer medications as ordered and to report to her as soon as possible of any missed doses or difficulty accessing the emergency medication box. Review of the facility policy titled Pharmacy Services Overview revised in April 2019, revealed the facility staff should ensure residents had a sufficient supply of their prescribed medications and that residents received medications (routine, emergency or as needed) in a timely manner. Nursing staff should communicate prescriber orders to the pharmacy and were responsible for contacting the pharmacy if a resident's medication was not available for administration.

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	365530	A. Building B. Wing	05/23/2024

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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 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** 28196 Based on medical record review, staff interview and facility document and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected one (Resident #40) of 19 sampled residents. The facility census was 95 residents. Findings include: Review of the medical record for Resident #40 revealed an admitted [DATE] with a diagnosis of anxiety disorder. Review of the care plan for Resident #40 initiated on 06/08/22 and revised on 01/30/24 revealed the resident received psychotropic medications that included antianxiety medications. Interventions included staff were to give medications as ordered. Review of the medication review report for Resident #40 revealed a physician's order dated 06/30/23 for Ativan (an antianxiety medication) one milligram (mg) by mouth every six hours for anxiety disorder. Review of the annual Minimum Data Set (MDS) assessment for Resident #40 dated 04/19/24 revealed the resident was cognitively intact and had received antianxiety medication during the last seven days of the assessment period. Review of the order audit for Resident #40 revealed the pharmacy dispensed Ativan on 04/28/24. Review of the controlled drug record for Resident #40 revealed the facility received 60 Ativan tablets on 04/29/24. According to the prescription label on the form, the next Ativan refill required a new prescription. Further review of the drug record revealed the last dose of Ativan for Resident #40 was signed out on 05/19/24 at 6:00 A.M. Review of a medication error report dated 05/20/24 timed at 1:00 P.M. for Resident #40 revealed the resident's Ativan supply was exhausted on 05/19/24, which caused the resident to miss four doses between 05/19/24 and 05/20/24. Interview on 05/20/24 at 12:50 P.M. with Resident #40 confirmed the facility ran out of the resident's Ativan on 05/19/24 at 6:00 A.M. Interview on 05/22/24 at 10:43 A.M. with Registered Nurse (RN) #03 confirmed she did not administer Resident #40's 12:00 A.M. or 6:00 A.M. dose of Ativan on 05/20/24 because she did not have access to the facility's emergency medication kit. Interview on 05/22/24 at 6:42 A.M. with Licensed Practical Nurse (LPN) #05 confirmed there had been times when the facility did not have Resident #40's Ativan medication. LPN #05 stated when that happened, she called the pharmacy to make sure it was on the way. LPN #05 stated medications should be reordered at least two days prior to the last dose available to ensure the medication was available to administer as ordered. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/22/24 at 2:01 P.M. with LPN #06 confirmed the normal process for reordering medications was to first check to see if the resident had an active prescription. If the resident had an active prescription, the staff could reorder the medication via the resident's electronic health record two to three days prior to the last available dose of the medication to ensure the medication would be available when needed. LPN #06 further confirmed she did not notice Resident #40 was low on Ativan, but if she had, she would have reordered the medication. Interview on 05/22/24 at 1:31 P.M. with the Regional Nurse Consultant (RNC) confirmed that typically the facility should reorder narcotics at least two days prior to the last available dose of medication or when there were 10 doses left to give. The RNC stated the staff should have re-ordered Resident #40's Ativan by 05/17/24, but they had not done so, and Resident #40 missed four doses of Ativan on 05/19/24 and 05/20/24. Interview on 05/23/24 at 11:07 A.M. with the Director of Nursing (DON) confirmed nurses should reorder controlled substances according to the sticker on the medication pack provided by the pharmacy. The DON confirmed nurses should administer medications as ordered and to report to her as soon as possible of any missed doses or difficulty accessing the emergency medication box. The DON confirmed the facility made a significant medication error for Resident #40 because the resident missed four doses of ordered medication. Review of the facility policy titled Pharmacy Services Overview revised in April 2019, revealed the facility staff should ensure residents had a sufficient supply of their prescribed medications and that residents received medications (routine, emergency or as needed) in a timely manner. Nursing staff should communicate prescriber orders to the pharmacy and were responsible for contacting the pharmacy if a resident's medication was not available for administration.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45849 Based on staff interview and facility document review, the facility failed to ensure that the designated director of food and nutrition services met the requirements for a dietary supervisor of a facility kitchen. This had the potential to affect 94 of 95 residents who received meals from the kitchen. Findings include: Interview on 05/20/24 at 9:01 A.M. with the Dietary Director (DD) confirmed she had been in the position since January 2024, and she was in the process of completing her certified dietary manager course. Interview on 05/23/24 at 9:02 A.M. with the Administrator confirmed the DD did not have a food service manager certification. The Administrator stated the DD had only been in the position since January 2024 and was obtaining the certification but had not yet scheduled the exam. Interview on 05/23/24 at 9:08 A.M. with the facility's Registered Dietitian (RD) confirmed that the DD was working on her food service manager certification. The RD stated the DD should have the certification, because she was running a kitchen. Interview on 05/23/24 at 10:15 A.M. with the Administrator confirmed the DD did not meet the qualifications for their position. The Administrator confirmed the DD should have certification as a food service manager. Review of the job description titled Dietary Supervisor signed by the DD on 01/21/24 revealed the job required the employee to be a graduate of an approved dietary manager's course that met the state and federal care regulations.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45849 Based on review of the facility menu, observation, staff interview, facility document review, and facility policy review, the facility failed to follow the planned menu as approved by the dietitian. This had the potential to affect 94 of 95 residents who received meals from the kitchen. Findings include: Review of the facility menu dated 05/21/24 revealed the planned lunch menu included Polish sausage on bun, sauerkraut, garlic mashed potatoes, green beans, and Jello rainbow cake. Observation on 05/21/24 at 11:22 A.M. revealed the lunch trays included a Polish sausage on a bun, mashed potatoes, and sauerkraut. Further observation also revealed lunch trays included an orange (for residents with a regular diet order), canned fruit (for residents with a mechanical soft diet order) and apple slices (for residents with a renal diet order). There was no cake or green beans on the lunch trays. Interview on 05/21/24 at 2:29 P.M. with the Dietary Director (DD) confirmed the lunch trays did not include green beans or cake as outlined on the menu. The DD further confirmed an orange was not an equivalent substitute for cake, and that the cake was not served because they did not have staff available to bake a cake. Interview on 05/22/24 at 12:43 P.M. with the Registered Dietitian (RD) confirmed the current menus were already in use when she started at the facility. The RD stated she had not reviewed the menus because they had been reviewed and approved by the previous RD. The RD stated her expectation was that the facility should follow the menus and an orange was not an appropriate substitute for cake. Interviews on 05/22/24 at 4:32 P.M. with the Director of Nursing (DON) confirmed the kitchen staff should follow the menus, policy, and RD recommendations. Interview on 05/23/24 at 10:49 A.M. with the Administrator confirmed the kitchen should follow the menus or get approval from the RD to change them. Review of the facility policy titled Menus revised October 2008 revealed menus shall meet the nutritional needs of residents, should be prepared in advance, and should be followed. The Dietitian should review and approve all menus.

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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. 45849 Based on observation, staff interview, review of facility documents and policies, and review of the United States Food and Drug Administration (USFDA) Code, the facility to ensure kitchen equipment used in resident food preparation was kept clean and free of dust and debris. This had the potential to affect 94 of 95 residents who received meals from the kitchen. Findings include: Observation on 05/20/24 at 9:09 A.M. revealed there was a black and pink substance on the interior ice shield of the ice machine in the kitchen. Observation on 05/21/24 at 10:25 A.M. revealed the black and pink substance remained on the interior shield of the ice machine in the facility kitchen. Observation on 05/21/24 at 10:33 A.M. revealed there was a fan running in the dish room that had dust and dirt buildup on the fan cover. Dust was hanging off the cover and blowing in the wind produced by the fan. The fan was blowing toward the clean dishes in the dish room. Observation on 05/21/24 at 10:52 A.M. revealed there was a metal dish rack being used to store clean water pitchers stored upside down. The rack had dust buildup with small pieces of dust hanging from the metal racks. Interview on 05/22/24 at 10:39 A.M. with the Administrator confirmed the fan and the ice machine were dirty and should be cleaned by the Maintenance Director (MD). The Administrator confirmed the metal dish rack was dirty and should be cleaned as needed by the kitchen staff. Interview on 05/22/24 at 10:56 A.M. with the MD confirmed there was no cleaning log for the fans in the kitchen, and the ice machine was scheduled for cleaning every six months. The MD stated they might need to change the ice machine to a quarterly cleaning schedule. Interview on 05/22/24 at 12:43 P.M. with the Registered Dietitian (RD) stated the kitchen staff should keep kitchen equipment clean to prevent dirt from falling in the food. The RD stated she had told the kitchen staff about the dust hanging off the fan and that it could blow onto the clean dishes. The RD stated she was not aware of the dirty ice machine but had noted some general cleaning needs on a previous visit to the kitchen. Interview on 05/22/24 at 4:32 P.M. with the Director of Nursing (DON) confirmed the kitchen staff should follow the policies for cleaning because it was important for infection control. Review of the facility document titled Daily Kitchen Cleaning Schedule, undated, revealed there were no guidelines for cleaning the ice machine, the kitchen fan, or metal dish racks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility document titled Ice Machine Cleaning Schedule, undated, revealed the ice machine should be cleaned every six months and was due to be cleaned next in July 2024. The cleaning schedule indicated staff should check the filters, clean the coils, sanitize the interior, and delime the machine, as necessary. Review of an undated manufacturer's instruction manual for cleaning the ice machine revealed the manufacturer generally recommended two annual cleanings, but some businesses required four major cleanings every year. Further review revealed in between the more thorough cleans, the machine should be wiped down as needed due to spillage or any noticeable internal or external dirtiness. Review of the facility policy titled Sanitization revised November 2022 revealed the food service area should be maintained in a clean and sanitary manner. All kitchens, kitchen areas and dining areas should be kept clean, free from garbage and debris, and protected from rodents and insects. Ice machines and ice storage containers should be drained, cleaned, and sanitized per the manufacturer's instructions. Review of the USFDA Code dated 2022 Chapter 4, Section 4-601.11, revealed nonfood contact surfaces or equipment should be kept free of an accumulation of dust, dirt, food residue, and other debris.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28196 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure staff accurately documented medication administration. This affected one (Resident #40) of 19 sampled residents. The facility census was 95 residents. Findings include: Review of the medical record for Resident #40 revealed an admitted [DATE] with a diagnosis of anxiety disorder. Review of the care plan for Resident #40 initiated on 06/08/22 and revised on 01/30/24 revealed the resident received psychotropic medications that included antianxiety medications. Interventions included staff to give medications as ordered. Review of the medication review report for Resident #40 revealed a physician's order dated 06/30/23 for Ativan (an antianxiety medication) one milligram (mg) by mouth every six hours for anxiety disorder. Review of the annual Minimum Data Set (MDS) assessment for Resident #40 dated 04/19/24 revealed the resident was cognitively intact and received antianxiety medications during the assessment period. Review of the Medication Administration Record (MAR) for Resident #40 dated May 2024 revealed Registered Nurse (RN) #03 documented administration of Ativan one mg to the resident on 05/20/24 at 12:00 A.M. and 6:00 A.M. Review of the facility medication error report dated 05/20/24 timed at 1:00 P.M., revealed Resident #40's Ativan supply was exhausted on 05/19/24, which caused the resident to miss four doses of medication between 05/19/24 and 05/20/24. Interview on 05/22/24 at 10:43 A.M. with RN #03 confirmed she did not administer Resident #40's routine doses of Ativan on 05/20/24 at 12:00 A.M. and 6:00 A.M. because she could not access the emergency box. RN #03 stated she documented administration of those doses in error. Interview on 05/23/24 at 11:07 A.M. with the Director of Nursing confirmed nurses should not document administration of a medication unless the medication had actually been administered. Review of the facility policy titled Administering Medications revised April 2019 revealed the individual administering the medication should initial the resident's MAR on the appropriate line after giving each medication and before administering the next one.