Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365560	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village of Dublin	6000 Riverside Dr Dublin, OH 43017

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to complete a preadmission screening and record review (PASRR) document in a timely manner. This affected one (Resident #29) of one reviewed for PASRR. The census was 40. Findings Include: Resident #29 was admitted to the facility on [DATE]. Her current diagnoses were nontraumatic intracranial hemorrhage, osteoporosis, dementia, morbid obesity, polyosteoarthritis, atrial fibrillation, congestive heart failure, anxiety disorder, hyperlipidemia, occlusion and stenosis of carotid artery, acute kidney failure, chronic kidney disease (stage III), post traumatic stress disorder, osteoarthritis, and major depressive disorder. Review of her minimum data set (MDS) assessment, dated 10/10/24, revealed she had a mild cognitive impairment. Review of Resident #29's progress notes, dated 09/12/24, revealed she was admitted to the facility from the hospital. Review of Resident #29's hospital documentation found the hospital completed a hospital exemption form for admission to the long term care/skilled care facility. This form allows the resident to remain in the facility for up to 30 days, without the facility having to complete a PASRR document. Review of Resident #29's PASRR document, dated 11/13/24, revealed this was the only PASRR document completed. The PASRR document should have been completed and submitted to the appropriate state agency by 10/12/24, which it was not. Interview with Social Worker (SW) #317 on 11/13/24 at 2:30 P.M. confirmed the hospital exemption form was completed on 09/12/24. She also confirmed a hospital exemption form was completed on 10/03/24 and thought that was acceptable for her to remain in the facility. She confirmed the only PASRR completed for Resident #29 was on 11/13/24. SW stated she didn't know she would have to complete a PASRR if they went into the hospital multiple times within the first 30 days.

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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NAME OF PROVIDER OR SUPPLIER Friendship Village of Dublin		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 Riverside Dr Dublin, OH 43017	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, staff interview, and record review the facility failed to ensure medications were administered according to the prescribing physician's orders. This affected two (#4 and #7) of four residents reviewed for medication administration. The census was 40. Findings include: 1. Resident #4 had an admitted [DATE] with diagnoses including: falls, depression, overactive bladder, hyperlipidemia, rosacea, abnormal gait/mobility, Parkinson's disease, and anxiety. Observation on 11/14/24 at 8:56 A.M. revealed Licensed Practical Nurse (LPN) #329 administered Carbidopa-Levodopa (used to treat symptoms of Parkinson's disease), extended release (ER), 25-100 mg, one tablet by mouth to Resident #4. Review of the electronic medication administration record (eMAR) on 11/14/24 at 8:57 A.M. revealed an order for Carbidopa-Levodopa ER, 25-100 mg, one tablet by mouth, give at 7:00 A.M. Review of the order summary report for Resident #4 on 11/14/24 at 10:00 A.M. revealed the following orders for Resident #4: Carbidopa-Levodopa ER, oral tablet 25-100 mg, give one tablet by mouth in the evening for Parkinson's disease, give at 8:00 P.M., dated 01/31/24. Carbidopa-Levodopa oral tablet, 25-100 mg, give two tablets by mouth three times a day for Parkinson's disease, dated 12/29/23. Interview with LPN #329 at 10:15 A.M. on 11/14/24 confirmed that the wrong dose of Carbidopa-Levodopa ER, was administered at the wrong time for Resident #4. 2. Resident #7 had an admitted [DATE] with diagnoses including: hypothyroidism, allergic rhinitis, anxiety, depression, dementia, Alzheimer's disease, hypertension, pain, and insomnia. Observation on 11/14/24 at 9:13 A.M. revealed LPN #329 administered Depakote Sprinkles (mood stabilizer anticonvulsant), Delayed Release (DR)125 mg, one capsule by mouth to Resident #7 at 9:15 A.M. Review of the eMar on 11/14/24 at 9:15 A.M. revealed an ordered administration time for Depakote Sprinkles DR, one capsule, of 7:30 A.M. Review of the order summary report for Resident #7 on 11/14/24 at 10:00 A.M. revealed the following orders for Resident #7: Depakote Sprinkles, oral capsule, DR, 125 mg, give one capsule by mouth two times a day for dementia with agitation. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Depakote Sprinkles, oral capsule, DR, 125 mg, give two capsules by mouth in the evening for agitation with dementia. Interview with LPN #329 at 10:15 A.M. on 11/14/24 confirmed that the administered dose of Depakote Sprinkles DR was given at the wrong time for Resident #7.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on medical record review, staff interview, and facility policy, the facility failed to ensure pressure injury interventions were implemented in a timely manner for one (Resident's #11) of two resident's reviewed for pressure ulcers. Additionally, the facility failed to complete skin measurements and monitoring in a timely manner for two (Residents #11 and #29) of two residents reviewed for pressure ulcers. The facility census was 40. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including fracture of left femur, disruption of wound, edema, type II diabetes, chronic diastolic heart failure, osteoarthritis, paroxysmal atrial fibrillation, rosacea, bilateral primary osteoarthritis of knee, anxiety, chronic pain, chronic kidney disease stage III, thrombophilia, gastro esophageal reflux disease, hypertension, hyperlipidemia, and irritable bowel syndrome. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview of mental status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #11 had impaired mobility, required the use of a walker or wheelchair for ambulation and required moderate to maximal assistance with acclivities of daily living. The resident was coded to have a stage three pressure ulcer present at the time of admission and a nutrition risk. Review of the skilled nursing assessments for Resident #11, from 10/04/24 to 11/12/24, revealed the facility did not document any measurements for the stage III pressure ulcer until 10/10/24 even though pressure ulcer was documented as present at time of admission. Review of the physician orders for Resident #11 revealed use of a Prevalon boot with a start date of 10/02/24. Review of the treatment administration record (TAR) reveaeld the resident had a treatment order for the left heel of change foam dressing to the left heel three times a week and as needed dated 10/07/24 and 10/08/24. No wound treatment intervention was implemented until 10/07/24. Review of the care plan for Resident #11 revealed the facility will administer treatments as ordered and monitor for effectiveness. Additionally, the facility was to assess, record, and monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician. Review of the progress notes for Resident #11 revealed on 10/11/24 at 4:13 P.M. Assistant Director of Nursing (ADON) placed call to the resident's daughter regarding current wound treatment for pressure injuries present on admission. Medication review complete and orders for labs to be drawn on Monday. All questions answered and verbalized understanding. Interview on 11/13/24 at 1:44 P.M. with ADON #345 confirmed pressure ulcers should be addressed promptly upon admission and confirmed that the interventions were not initiated until 10/07/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/24 at 2:16 P.M. with RN #347 verified a head to toe assessment is completed the day of admission and if a pressure ulcer or skin alteration is present they notify the Director of Nursing (DON) and Nurse practitioner (NP). RN #347 stated the Nurse Practitioner will examine the pressure ulcer the same day. RN #347 also stated the staff, including the NP, ADON, or nursing staff, will measure the wound the same day as admission and the wound nurse will measure again on Thursday when they are at the facility. 37100 2. Resident #29 was admitted to the facility on [DATE]. Her current diagnoses were nontraumatic intracranial hemorrhage, osteoporosis, dementia, morbid obesity, polyosteoarthritis, atrial fibrillation, congestive heart failure, anxiety disorder, hyperlipidemia, occlusion and stenosis of carotid artery, acute kidney failure, chronic kidney disease (stage III), post traumatic stress disorder, osteoarthritis, and major depressive disorder. Review of her minimum data set (MDS) assessment, dated 10/10/24, revealed she had a mild cognitive impairment. Review of Resident #29 progress notes, dated 11/01/24, revealed she was readmitted back to the facility after an acute hospital stay. Review of Resident #29 skin observation tool, dated 11/01/24, revealed staff documented that she had Moisture Associated Skin Damage (MASD) on her right and left buttocks. There were no measurements or description documented for this skin alteration. Review of Resident #29 Skin Provider Consultation report, dated 11/05/24, revealed the nurse practitioner assessed the wound and determined it to be a stage III pressure ulcer to her buttocks with the measurements of 3.0 centimeters (cm) by 3.5 cm by 0.1 cm. The report also documented this wound was present upon admission. Interview with Assistant Director of Nursing (ADON) #345 on 11/13/24 at 1:44 P.M. and 11/14/24 at 9:05 A. M. confirmed Resident #29 skin injury/pressure ulcer was not officially measured and monitoring was not started until 11/05/24, which was four days after she was readmitted to the facility from the hospital. She confirmed the skin injury was not present when she left for the hospital, so it was only present upon readmission. She confirmed they have started new procedures of having each new skin injury assessed and measured upon admission, instead of waiting until the wound nurse arrives to the facility on ce a week. Review of the Pressure Ulcers/Skin Breakdown - Clinical Protocol revealed, the staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions and the physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. Additionally, the clinical protocol indicated treatments such as pressure-reducing surfaces and appropriate wound care measures should be initiated immediately.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on medical record review, interviews, and review of facility policy, the facility failed to ensure resident weights were obtained as per dietician recommendations. This had the potential to affect two (#36 and #37) out of four reviewed for nutrition. The census was 40. Findings Include: 1. Review of the medical record for Resident #37 revealed an admitted [DATE] diagnoses include severe fracture of the left femur, history of falling, dementia, severe cognitive deficits, and anemia. Resident required one person assist with activities of daily living. Review of Resident #37's plan of care revealed the resident will maintain adequate nutrition support as evidenced with no significant weight changes. Review of Resident #37's Nutrition/Dietary Note dated 09/18/24 revealed Resident #37 weighed 140.2 pounds triggering him for significant weight loss of 5.7% weight loss in one month. This was related to his decreased intakes and appetite. Medications to increase appetite have been ordered. Dietician will continue to monitor Resident #37's weight trends via weekly weights to review effectiveness of interventions . Review of Resident #37's physician orders for 09/22/24 to 11/14/24 did not indicate resident was to be weighed weekly. Review of Resident #37's documented weights revealed a weight was obtained on 9/22/24 of 141.8 pounds and on 10/23/24 137.6 pounds. No additional weights were obtained. Interview with Dietician #380 on 11/14/24 at 10:50 A.M. revealed she did see the resident on 9/18/24 and recorded in his progress notes to monitor the resident's weight trends and indicated the resident was to be weighed weekly. She notified Resident #37's doctor to order the weekly weights. 2. Resident #36 was admitted to the facility on [DATE], diagnoses include collapsed vertebra, history of falling , pacemaker, severe cognitive deficits, and unspecified dementia with agitation. Review of Resident #36's plan of care revealed Resident #36 will maintain adequate nutrition support as evidenced by no significant weight changes. Weigh resident as ordered and in similar manner for accuracy. Review of Resident #36's Quarterly Nutrition Review note on 10/04/24 at 10:16 A.M. Resident #36 weighed 115.2 pounds indicating she has had a decline in the last three months. Dietician to order weekly weights for close monitoring for four weeks. Review of Resident #36's physician orders for 10/04/24 to 11/14/24 did not indicate resident was to be weighed weekly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's documented weights revealed on 09/01/24 she weighed 115.2 pounds and on 10/30/24 she weighed 111.4 lbs. Resident #36 had no other documented weights. Interview with Dietician #380 on 11/14/24 at 11:30 A.M. revealed she did see the resident on 10/04/24 and stated in progress notes to monitor the residents weight trends and indicated the resident was to be weighed weekly. She notified Resident #36's doctor to order the weekly weights. Review of facility policy titled Interventions for Unintended Weight Loss , dated 03/01/2019, revealed Unintended weight loss or gradual weight loss will be monitored so that appropriate and individualized intervention can be implemented. Residents will be weighed upon admission or readmission , weekly for the first four weeks after admission, and at least monthly thereafter to help identify and document weight trends. Weekly weights may be ordered due to significant change in condition or altered nutritional status.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on medical record review, staff interview, policy review and review of medication information from Medscape, the facility failed to ensure a resident was free from unnecessary psychotropic medications by ensuring there was an adequate indicate for use for the use of an antipsychotic medication. This affected one (#7) of five residents reviewed for unnecessary medications. Additionally, the facility failed to adequately monitor behaviors for residents that were prescribed psychotropic medications. This affected two (Residents #7 and #29) of five reviewed for unnecessary medications. The facility census was 40. Findings include: 1. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Her diagnoses were Alzheimer's disease, insomnia, dementia, hypothyroidism, allergic rhinitis, depression, hypertension, intervertebral disc degeneration lumbar region, gastro-esophageal reflux disease without esophagitis, pain, pure hypercholesterolemia, and postnasal drip. Review of the Minimum Data Set (MDS) assessment, dated 05/08/24, revealed a brief interview of mental status (BIMS) score of 02 indicating significant cognitive impairment. Resident #7 was not coded as having any psychotic disorder. Review of the physician orders for antipsychotic medications used in Resident #7's care from 10/08/24 to present revealed the following orders: Seroquel (antipsychotic) oral tablet 25 milligrams (mg) one tablet by mouth every 24 hours as needed for Alzheimer's dementia with psychosis for 14 days with a start date of 11/12/24 and an end date of 11/26/24. Seroquel oral tablet 25 mg one tablet by mouth two times a day for agitation for seven days with a start date of 11/4/24. Seroquel oral tablet 25 mg by mouth one time a day for agitation for seven days with a start date of 10/27/24 and an end date of 10/29/24. Seroquel oral tablet 25 mg by mouth in the evening for agitation for seven days with a start date of 10/18/24 and an end date of 10/25/24. Seroquel oral tablet 50 mg by mouth one time a day for agitation for seven days with a start date of 10/19/24 and an end date of 10/26/24. Seroquel oral tablet 50 mg by mouth one time a day for dementia with psychosis and give 50 mg by mouth one time a day and give 50 mg by mouth at bedtime for dementia with psychosis with a start date of 10/8/24 and an end date of 10/18/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seroquel oral tablet 25 mg by mouth one time a day for dementia with psychosis give at noon with a start date of 10/8/24 and an end date of 10/18/24. Review of the progress notes revealed on 11/06/24 at 11:18 A.M., medication review team which included the Certified Nurse Practitioner (CNP), Medical Director, Pharmacy, Director of Nursing (DON), Assistant Director of Nursing (ADON) but did not indicate clear evidence or outcomes of the review that supported ongoing use of Seroquel for Resident #7. The note does not specify whether behavioral management strategies other than pharmacological interventions were considered and there was insufficient evidence in the record that other non-pharmacologic interventions were attempted or that the family was involved in discussions about the medication changes. There was no clear documentation present in the record of the need for continued use of psychotropic medications and justification for such use. The use of Seroquel was not sufficiently documented as being aligned with the goals of treatment. There was no evidence of specific documentation regarding the resident's response to Seroquel or any assessments regarding the risks and benefits of its use. Interview on 11/13/24 at 8:51 A.M. with ADON #345 and DON confirmed the diagnoses for ordering Seroquel were not appropriate for the medications use. Documentation provided no clear rationale for the ongoing use of the medication and its effectiveness in managing the Resident's symptoms. Interview on 11/14/24 at 9:24 A.M. the Nurse Practitioner verified Seroquel was initially prescribed to address agitation related to Alzheimer's disease, but the plan to taper off Seroquel was discussed. Review of medication information from Medscape at: https://reference.medscape.com/drug/seroquel-xr-quetiapine-342984?_gl=1*5jj9fp*_gcl_au*MTU0MDAzODMxNC4xNzI2NTk1Nzgz revealed Seroquel is an antipsychotic medication used for schizophrenia, bipolar and major depressive disorder. Seroquel is not approved for dementia-related psychosis; elderly patients with dementia-related psychosis who are treated with antipsychotic drugs are at increased risk of death, as shown in short-term controlled trials; deaths in these trials appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (eg, pneumonia) in nature. 2. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Her diagnoses were Alzheimer's disease, insomnia, dementia, hypothyroidism, allergic rhinitis, depression, hypertension, intervertebral disc degeneration lumbar region, gastro-esophageal reflux disease without esophagitis, pain, pure hypercholesterolemia, and postnasal drip. Review of the Minimum Data Set (MDS) assessment, dated 05/08/24, revealed a brief interview of mental status (BIMS) score of 02 indicating significant cognitive impairment. Additionally, Resident #7 was not coded as having a psychotic disorder. Review of Resident #7's current orders revealed the resident had the current psychotropic medications used in her care: Seroquel (antipsychotic) oral tablet 25 milligrams (mg) one tablet by mouth every 24 hours as needed for Alzheimer's dementia with psychosis for 14 days with a start date of 11/12/24 and an end date of 11/26/24. Rexulti (Serotonin-Dopamine Activity Modulator used for schizophrenia, depression, and agitation associated with Alzheimer's dementia) oral tablet three mg one tablet by mouth one time a day for Alzheimer's dementia with agitation with a start date of 11/19/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Depakote sprinkles (mood stabilizer anticonvulsant) oral capsule delayed release sprinkle 125 mg, two capsules by mouth in the evening for agitation with dementia start date 10/30/24. Review of the care plan for Resident #7 revealed that the nursing staff was responsible for monitoring and documenting any behavioral symptoms that occur while the resident is receiving psychotropic medications. This includes tracking any changes in behavior (e.g., increased agitation, aggression, confusion) and evaluating whether the antipsychotic medications are effective or if dosage adjustments are necessary. There was no evidence behavioral symptoms (such as agitation, aggression, or confusion) were systematically monitored or documented on a shift-by-shift basis as required by the care plan. Review of the progress notes revealed no evidence that behavioral symptoms (such as agitation, aggression, or confusion) were systematically monitored or documented on a shift-by-shift basis as documented in the care plan. Despite changes in medication orders there was no clear documentation of the effectiveness of these medications in managing the resident's behavioral symptoms over time. Interview on 11/13/24 at 12:12 P.M. with the Administrator, verified behavior documentation for the facility would be in the skilled notes. Interview on 11/14/24 at 9:43 A.M. with the DON confirmed the facility documents by exception and would document behaviors in the progress notes if they occur and then discuss the behaviors at their daily/weekly meetings with the nurse practitioner and staff. 37100 3. Resident #29 was admitted to the facility on [DATE]. Her current diagnoses were nontraumatic intracranial hemorrhage, osteoporosis, dementia, morbid obesity, polyosteoarthritis, atrial fibrillation, congestive heart failure, anxiety disorder, hyperlipidemia, occlusion and stenosis of carotid artery, acute kidney failure, chronic kidney disease (stage III), post traumatic stress disorder, osteoarthritis, and major depressive disorder. Review of her minimum data set (MDS) assessment, dated 10/10/24, revealed she had a mild cognitive impairment. Review of Resident #29's current physician orders revealed she was ordered Duloxetine (anti-depressant) 40 milligrams (mg) for depression. Review of Resident #29 current care plan revealed she was prescribed Duloxetine for depression and anxiety. An intervention for this care plan stated the facility was to, monitor/document/report as needed adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in activities of daily living (ADL) ability, continence, no voiding, constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes. Review of Resident #29 progress notes and behavior tracking documentation, dated 09/12/24 to 11/14/24, revealed no behaviors documented. Also, there was no documentation to support behaviors were being tracked in general. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Administrator on 11/13/24 at 12:12 P.M., via email revealed the behavior documentation for residents are completed in progress notes as each behavior occurs. They do not keep logs for specific behaviors for each resident. Interview with DON on 11/14/24 at 9:43 A.M. stated they document by exception for behaviors. She confirmed the staff would document behaviors in the progress notes if they occur, and then discuss the behaviors at their daily/weekly meetings with the facility nurse practitioner if changes to their medication regimen needs to occur. Review of the behavioral assessment, intervention and monitoring policy revealed if the resident is being treated for altered behavior or mood, the interdisciplinary team (IDT) will seek and document any improvements or worsening in the individuals behavior, mood, and functioning. Additionally, the IDT will monitor the progress of individuals with impaired cognition and behavior until stable with new or emergent symptoms being documented and reported. Finally, interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment.

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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. 36648 Based on observations, staff interviews and policy review the facility failed to prepare, distribute and serve food in a safe, sanitary manner. This had the potential to affect all residents. The census was 40. Findings Include: Observation on 11/13/24 at 11:30 A.M. of the lunch meal preparation revealed [NAME] #501 and Dietary Aid #502 preparing food for the meal and neither worker were observed to have beard covers on, to cover their cheeks, upper lip, and chin hair while working in the kitchen . This observation was verified by Director of Dietary Quality Assurance #700. Interview on 11/13/24 at 11:45 A.M. with [NAME] #501 confirmed he should have had a beard cover on while cooking the food. Review of facility policy titled Employee Sanitary Practices, dated 04/04/19 and 03/01/19, revealed employees will wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365560	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Friendship Village of Dublin		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 Riverside Dr Dublin, OH 43017	

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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 - Many	Provide and implement an infection prevention and control program. 50536 Based on record review, staff interviews, review of the facility's water management program, review of facility policy and review of the Centers for Disease Control and Prevention's (CDC) guidance, the facility failed to ensure adequate monitoring of the water management program to control the spread of waterborne pathogens. This had the potential to affect all 40 residents. The census was 40. Findings include: Interview on 11/14/24 at 9:01 A.M. with the Facilities Director #450 confirmed the facility had performed a Legionella (bacteria that can cause a severe type of pneumonia) risk assessment in April of 2024. Review of the facility's binder titled Water Management, no date, on 11/14/24 at 9:01 A.M. revealed a list of team members and their responsibilities in the water management program, and a map to describe the water filtration system. There was no documented evidence provided to show the facility monitored physical controls, documented water temperatures, monitored disinfectant level controls, completed visual inspections, or environmental testing for waterborne pathogens in the calendar years of 2023 or 2024. Interview on 11/14/24 at 10:20 A.M. with the Facilities Safety Specialist #455 it was confirmed there was no documented evidence of Legionella monitoring from 2023 to present. Interview on 11/14/24 at 10:34 A.M. with the Facilities Director #450 he stated he was hired in December of 2023, and had no documented evidence of Legionella monitoring from 2023 to present. Review of the facility's policy and procedures document on 11/14/24 at 11:30 A.M. titled Water Mitigation Program dated November of 2023, revealed the facility's policy was to contract with a water mitigation system provider to ensure adequate facilitation of the water management program to control the spread of waterborne pathogens. The procedures were listed as follows:. Water will be tested in accordance with the facility's contracted water mitigation and management program. The Facilities Director is the responsible party for overseeing the facility's water mitigation and management program Regular testing of the water mitigation and management program is reported and reviewed through the monthly quality assurance and performance improvement committee, including Legionella surveillance and compliance. Review of the CDC guidance titled Overview of Water Management Programs, dated 03/15/24, revealed water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Further review revealed the seven key elements of a Legionella water management program included: establish a water management program team, describe the building water systems, identify areas where Legionella could grow and spread, decide where control measures should be applied and how to monitor them, establish ways to intervene when control limits are not met, ensure the program runs as designed and is effective, and document and communicate all the activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365560	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
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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 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** 50536 Based on record review, staff interview, and policy review the facility failed to ensure residents had an appropriate indication for the use of antibiotics. This affected one resident (#26) of five residents reviewed for antibiotic stewardship. The census was 40. Findings include: Review of medical record for Resident #26 revealed the resident was admitted on [DATE], diagnoses included: vitamin D deficiency, myocardial infarction, hypertension, osteoporosis, obstructive sleep apnea, heart disease, and abnormal weight loss with a body mass index (BMI) of 19.9 or less, (normal healthy weight rage is BMI 18.5-24.9). Review of Resident #26's physician orders for January of 2024 revealed an order for Macrobid (antibiotic) oral capsule, 100 milligrams (mg), give one capsule by mouth, two times a day, for urinary tract infection (UTI), for five days. The order start date was 01/04/24, with a stop date of 01/09/24. The order was listed as completed. Review of Resident #26's Infection Report Form based on The McGeer Criteria (set of surveillance tools used to identify health care-associated infections), dated 01/04/24 on 11/14/24 at 1:30 P.M. revealed Resident #26 was hallucinating with increased incontinence. Documentation on the form stated Resident #26 was not experiencing fever, pain, hematuria, urgency, frequency, dysuria, or tenderness, and no urinalysis or urine culture was completed. No subcriteria, nor microbiologic criteria were met to support the use of an antibiotic for a urinary tract infection. Resident #26 was prescribed Macrobid, 100 mg, twice a day, for five days, with an ordered start date of 01/04/24 and a stop date of 01/09/24 for a urinary tract infection. Interview with the Assistant Director of Nursing (ADON) #345 on 11/14/24 at 2:09 P.M. confirmed Resident #26 completed a course of antibiotics for a urinary tract infection that did not meet The McGeer Criteria for a UTI from 01/04/24 - 01/09/24. Review of the policy titled Antibiotic Stewardship dated 2001 revised 12/2016 revealed: Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents.