STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madeira Healthcare Center	6940 Stiegler Lane Cincinnati, OH 45243

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, staff interview, and review of a facility policy, the facility failed to ensure residents were treated with dignity and respect during incontinence care by protecting a resident's private space. This affected one (#19) of three residents reviewed for dignity. The census was 87. Findings include: Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses of intracerebral hemorrhage, hemiplegia and hemiparesis, morbid (severe) obesity, encephalopathy, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was cognitively intact and was always incontinent of bowel and bladder. The resident required set up assistance for eating, was dependent for dressing, and required maximal assistance for oral and personal hygiene, toileting, bathing, bed mobility, and transfers. Observation on 01/22/25 from 11:20 A.M to 11:50 A.M. revealed Resident #19 was receiving incontinence care while in bed from Certified Nurse Aide (CNA) #575 with Licensed Practical Nurse (LPN) Unit Manager #405 providing stand-by assistance. Continued observation revealed Resident #19's body was partially exposed and CNA #575 was actively providing incontinence care when LPN #425 opened to door to Resident #19's room and entered without knocking or asking permission to enter the room. Resident #19 resided in a private room with no privacy curtain; therefore, the door to the resident's bedroom was the only privacy barrier. Interview on 01/22/25 at 3:04 P.M. with LPN Unit Manager #405 verified LPN #425 did not knock and ask permission before entering the room of Resident #19. Review of the undated policy titled, Resident Rights, revealed care for residents will be provided in a safe and respectful manner that includes care in a private setting, as appropriate. When providing care, staff will knock before entering the resident's room if the door was closed. If there was no answer, the staff member will knock a second time before entering and announce the entrance into the room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents an incidental finding discovered during the course of this complaint investigation.

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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** 49771 Based on medical record review, review of hospital documentation, staff interview, and policy review, the facility failed to timely implement pressure ulcer prevention interventions as ordered. This affected one (#002) of three residents reviewed for wounds. The facility census was 87. Findings include: Review of the medical record revealed Resident #002 was admitted to the facility on [DATE], after being hospitalized from 08/30/24 to 12/13/24, with diagnoses of traumatic brain injury (TBI), multiple sclerosis, Huntington's disease, chronic kidney disease stage III, acute kidney injury, lupus, cirrhosis, hypertension, anemia, and hyperlipidemia. The resident was discharged on [DATE]. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #002 had severe cognitive impairment, no range of motion impairments, and was always incontinent of bowel and bladder. The resident required total assistance with eating, oral and personal hygiene, toileting, bathing, dressing, bed mobility and transfers. The resident was identified with a stage I (non-blanchable erythema of intact skin) and a stage II (partial-thickness skin loss with exposed dermis) pressure ulcers on admission. Review of hospital discharge orders dated 12/13/24 revealed Resident #002 was ordered to have a low air loss mattress and heel lift boots. Review of the assessment to predict pressure ulcer development dated 12/13/24 revealed Resident #002 was at high risk for the development of pressure ulcers. Review of the admission nursing assessment dated [DATE] revealed Resident #002 had identified skin integrity impairments including moisture associated skin damage (MASD) to the groin, bruising to the chest and bilateral upper and lower extremities, redness on the buttocks, and scabs to the left upper extremity and right chest. Review of the December 2024 treatment administration record (TAR) revealed no documentation Resident #002 had a low loss air mattress from admission on 12/13/24 to discharge on 12/24/24 and no documentation of heel protector devices implemented until 12/17/24. Review of skin and wound notes dated 12/17/24 at 7:34 P.M., written by Wound Care Nurse Practitioner (WCNP) #900 revealed Resident #002 had a stage II pressure injury to the right heel measuring 7.0 centimeters (cm) long by 4.0 cm wide by 0.10 cm deep. The wound base was 100 percent (%) epithelial tissue with the peri-wound intact and no odors. Further review revealed recommendations were to cleanse the wound with wound cleanser, apply skin prep, and leave open to air, and ongoing pressure reduction and turning and repositioning precautions per protocol including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff and staff were to float the resident's heels while in bed with use of heel boots. (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 01/23/25 at 11:24 A.M. with (WCNP) #900 revealed she did not know Resident #002 had a right heel pressure wound prior to seeing her on 12/17/24. WCNP #900 stated Resident #002's right heel was identified as a facility acquired pressure ulcer. She described the wound to the right heel as being a fully intact blister, filled with a clear fluid that she categorized as a stage II pressure ulcer. WCNP #900 stated a wound such as that would occur in just one to two days, and had it initiated as a deep tissue injury the blister would have been filled with a blood-tinged fluid. WCNP #900 stated she did not recall seeing any skin recommendations from the hospital and could not recall if the resident had a low air loss mattress in place. WCNP #900 stated she was not aware of the discharge orders from the hospital on 12/13/24 and she made the recommendation for the resident to have heel protectors on 12/17/24. Interview on 01/23/25 at 3:20 P.M. with Regional Director of Clinical Operations #3030 verified there was no documentation that Resident #002 had a low air loss mattress in place from 12/13/24 to 12/24/24 and heel protectors were not documented as placed on the resident until 12/17/24. Review of the undated facility policy titled, Skin Care and Wound Management, revealed the facility strives to prevent skin impairment and to promote the healing of existing wounds. This deficiency represents non-compliance investigated under Complaint Number OH00161160.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, observation, and staff interview, the facility failed to maintain adequate infection control practices during incontinence care. This affected one (#19) of one residents observed for incontinence care. The facility census was 87. Findings include: Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses of intracerebral hemorrhage, hemiplegia and hemiparesis, morbid (severe) obesity, encephalopathy, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was cognitively intact and was always incontinent of bowel and bladder. The resident required set up assistance for eating, was dependent for dressing, and required maximal assistance for oral and personal hygiene, toileting, bathing, bed mobility, and transfers. Observation on 01/22/25 from 11:20 A.M to 11:50 A.M. revealed Resident #19 was receiving incontinence care while in bed from Certified Nurse Aide (CNA) #575 while Licensed Practical Nurse (LPN) Unit Manager #405 provided stand-by assistance. Resident #19 was noted to be incontinent of bowel and bladder. Continued observation revealed, after cleaning, rinsing, and drying Resident #19, CNA #575 did not change her soiled gloves and touched the resident's clean incontinence brief, clean linens, clean gown, head pillow, call light cord, and bed control cord. Interview on 01/22/25 at 2:55 P.M. with CNA #575 verified she did not change her gloves after completing incontinence care. Interview on 01/22/25 at 3:04 P.M. with LPN Unit Manager #405 verified CNA #575 should have changed her gloves after completing incontinence care on Resident #19 and before touching the resident's clean incontinence brief, gown, bed linens, pillow, call light cord, and bed control cord. This deficiency represents non-compliance investigated under Master Complaint Number OH00161670.