

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure residents were treated in a dignified manner related to an indwelling urinary catheter collection bag. This affected one (Resident #89) of one resident reviewed for indwelling urinary catheter usage. The census was 94.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #89 revealed an initial admitted [DATE] with the latest readmission of 01/11/25 with the diagnoses including but not limited to cerebral infarction, intervertebral disc degeneration of lumbosacral region, visual loss, acute kidney failure, encephalopathy, slow transit constipation, subdural hemorrhage, history of traumatic brain injury, dementia, anemia, osteoarthritis, obstructive and reflux uropathy, hypertension, hydronephrosis, anxiety disorder, hearing loss, chronic pain, hyperlipidemia, malignant neoplasm of overlapping sites of right female breast.</p> <p>Review of the admit complete admission review dated 07/25/24 revealed the resident was admitted to the facility with an 18 FR indwelling urinary catheter.</p> <p>Review of the plan of care dated 08/01/24 revealed the resident had the potential for urinary tract infection (UTI), altered urinary pattern related indwelling urinary catheter, urinary retention and obstructive uropathy. Interventions included assess for UTI, note characteristics of urine, monitor lab results, administer medications as ordered, observe for side effects and effectiveness, observe voiding patterns, may straight catheterize for urinalysis, catheter care per facility policy, follow up with urology per orders and peri-care when incontinent.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had an indwelling urinary catheter and was always continent of bowel.</p> <p>Review of the resident's monthly physician orders for January 2025 identified orders dated 07/25/24 catheter care every shift, dignity cover over collection bag every shift, intake and output every shift and 12/16/24 change indwelling urinary 16 FR catheter with 10 milliliter (ml) balloon as needed for indwelling urinary catheter care.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/27/25 at 11:21 A.M., observation of the resident revealed her indwelling urinary catheter collection bag was hanging on her bed with no privacy bag and/or cover in place. Further observation revealed clear yellow urine was visible from the hallway.</p> <p>On 01/27/25 at 4:29 P.M., observation of the resident revealed her indwelling urinary catheter was hanging on the resident's wheelchair with no privacy bag and/or cover in place. Further observation revealed clear yellow urine was visible from the hallway.</p> <p>On 01/29/25 at 10:24 A.M., observation of the resident revealed her indwelling urinary catheter was hanging on the bed with no privacy bag and/or cover in place. Further observation revealed clear yellow urine was visible from the hallway.</p> <p>On 01/29/25 at 10:29 A.M., interview with Registered Nurse (RN) #235 confirmed the resident's indwelling urinary catheter collection bag did not have a cover and/or privacy bag and the resident's urine was visible from the hallway.</p> <p>Review of the facility policy titled, Dignity, not dated revealed each resident shall be care for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Residents are treated with respect and dignity at all times. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example, helping the resident keep urinary catheter bags covered.</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>07316</p> <p>Based on resident interview, staff interview, and policy review, the facility failed to ensure residents had ready and reasonable access to their personal funds handled by the facility in the evening and on weekends. This could affect 50 of 50 residents whose funds were handled by the facility (Residents #73, #32, #3, #55, #48, #90, #51, #9, #78, #65, #24, #85, #76, #23, #72, #70, #347, #10, #19, #12, #5, #7, #61, #86, #2, #50, #62, #54, #64, #63, #82, #44, #15, #38, #13, #36, #69, #81, #49, #14, #52, #8, #28, #21, #11, #147, #71, #68, #31, and #17). The facility census was 94.</p> <p>Findings include:</p> <p>Interview with Resident #70 on 01/27/25 at 4:49 P.M. revealed he had no access to his money handled by the facility on weekends. He stated he would like to be able to access some of his personal funds on the weekend.</p> <p>Interview with Business Office Manager #266 on 01/30/25 at 9:35 A.M. revealed resident funds handled by the facility are available from her from 9:00 A.M. to 4:00 P.M. Monday through Friday. She further stated funds are available to residents at the 2 East nurses station on weekends.</p> <p>Interview with Registered Nurse #257 on 01/30/25 at 9:37 A.M. revealed she was the nurse working on 2 East. She stated there were no funds available for residents in the evening or on weekends.</p> <p>Interview with Licensed Practical Nurse #319 on 01/30/25 at 9:25 A.M. revealed she was the nurse working on 1 East. She stated there were no funds available for residents in the evening or on weekends.</p> <p>Review of the facility policy titled Management of Residents' Personal Funds dated 2001 and revised March 2021 revealed it did not address the availability of resident personal funds to the residents.</p> <p>Interview with the Administrator on 01/30/25 at 2:50 P.M. confirmed the facility policy did not address when residents had access to their personal funds handled by the facility or that they would have access on evenings or weekends. The Administrator stated that Business Office Manager #266 places money in a locked box at the receptionist desk on first floor when leaving for the day. However, Business Office Manager #266, in her interview on 01/30/25 at 9:35 A.M. stated the funds were available at the 2 East nurses station. The Administrator stated that it could not be confirmed that money was available at the receptionist desk at this time as the receptionist and business office manager were still there for the day.</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>07316</p> <p>Based on review of personal fund records and staff interview, the facility failed to notify a resident/responsible party when the amount in the resident's account reached \$200 less than the resource limit for one person and that, if the amount in the account reached the resource limit for one person, the resident may lose eligibility for Medicaid or Social Security. This affected one (Resident #2) of 50 residents whose funds were handled by the facility. The facility census was 94.</p> <p>Findings include:</p> <p>Review of the facilities record revealed Resident #2's personal funds were handled by the facility. Review of a quarterly statement of Resident #2's account revealed on 09/30/24 the balance was \$1778.78. The balance had not been at or above \$1800.00 between 07/01/24 and 9/30/24. (The resident was on Medicaid).</p> <p>Interview with Business Officer Manager #266 on 01/30/25 at 10:15 A.M. revealed that she had sent a notification letter to the resident's responsible party 09/30/24 indicating the balance was \$1778.78 and that the facility shall provide written notice when the balance is within \$200.00 less than the resource limit.</p> <p>Review of a quarterly statement of Resident #2's account revealed on 10/01/24 the resident's balance went to \$1828.78. The balance remained above \$1800.00 through 01/30/25 with a current balance of \$1889.13. There was no evidence the resident/responsible party had been notified between 10/01/24 and 01/30/25 that the balance in the account had reached \$200.00 less than the resource limit and that the resident could lose eligibility for Medicaid/Social Security if the amount reached the resource limit.</p> <p>Interview with Business Office Manager #266 on 01/30/25 at 10:15 A.M. confirmed she had not provided notification of the balance reaching \$1800.00 and that the balance had been above \$1800.00 since 10/01/24. She stated the facility had handled the resident's funds since 2005.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure one resident's physician was notified of blood sugars outside of the physician ordered parameters. This affected one (Resident #70) of five residents reviewed for unnecessary medications. The census was 94.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #70 revealed an initial admitted [DATE] with the latest readmission of 08/28/24 with the diagnoses including but not limited to Rhabdomyolysis, diabetes mellitus, chronic obstructive pulmonary disease (COPD), benign prostatic hyperplasia, hyperlipidemia, pain, dementia, peripheral vascular disease, intellectual disabilities, major depressive disorder, nicotine dependence, legal blindness, schizoaffective disorder, hypertension, acquired absence of left foot, insomnia, major depressive disorder and anxiety disorder.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident received hypoglycemic medications.</p> <p>Review of the January 2025 monthly physician orders revealed orders dated 12/10/24 Humalog injection solution 100 units/milliliter (ml) inject 10 units subcutaneously with meals for diabetes hold if less than 70, notify physician if less than 70 or greater than 400, 03/20/24 Humalog injection solution 100 units/ml finger sticks blood sugar as per sliding scale coverage subcutaneously before meals 200 to 249 give 2 units, 250 to 299 give 4 units, 300 to 349 give 6 units, 350 to 399 give 8 units, 400 to 449 give 10 units, 09/13/24 FreeStyle Libre 2 Reader Device (continuous blood glucose system receiver) inject one unit subcutaneously as needed, 07/23/24 Metformin 1000 milligrams (mg) by mouth twice daily, Lantus insulin subcutaneous solution pen injector 100 units/ml inject 60 units subcutaneously twice daily, and 01/15/25 Trulicity Subcutaneous Solution Auto-injector 3 mg/0.5 ml Inject 3 mg subcutaneously in the morning every Friday for Hyperglycemia.</p> <p>Review of the resident's blood sugar revealed on 08/02/24 at 4:30 P.M. the resident's blood sugar was not obtained, on 08/18/24 at 11:30 A.M. the resident blood sugar was 405, on 10/16/24 at 11:30 A.M. the resident's blood sugar was 61, on 11/04/24 at 4:30 P.M. the resident's blood sugar was 64 and on 01/05/25 at 4:30 P.M. the resident's blood sugar was 69.</p> <p>Review of the medical record revealed no documented evidence the resident's physician was notified of the resident's blood sugars below 70, greater than 400 or not being obtained as physician ordered.</p> <p>On 01/30/25 at 3:06 P.M. interview with Cooperate Nurse #325 verified the resident's physician was not notified of the blood sugars below 70, above 400 and the blood sugar not obtained.</p> <p>(continued on next page)</p>		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Change in a Resident's Condition or Status, last revised 02/21 revealed the facility promptly notifies the resident his or her attending physician and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there was a specific instruction to notify the physician of changes in the resident's condition.		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on observation, record review, staff interview, and policy review, the facility failed to maintain personal privacy for a resident during a dressing change. This affected one (Resident #74) of two residents reviewed for wounds. The facility census was 94.</p> <p>Findings include:</p> <p>Record review of Resident #74 revealed an admitted [DATE] with pertinent diagnoses of: sepsis due to streptococcus, type two diabetes mellitus, chronic respiratory failure with hypoxia, encephalopathy, moderate intellectual disabilities, hypertension, heart failure, morbid obesity due to excess calories, type two diabetes mellitus with diabetic neuropathy, acute respiratory failure with hypoxia, benign prostatic hyperplasia, hyperlipidemia, venous insufficiency chronic peripheral, lymphedema, type two diabetes mellitus with foot ulcer, cardiomyopathy, iron deficiency anemia, solitary pulmonary nodule, and unspecified hydronephrosis.</p> <p>Review of the 12/23/24 admission Minimum Data Set (MDS) revealed the resident is moderately cognitively impaired and uses a walker and wheelchair to aid in mobility. The resident is coded as having a venous or arterial ulcer.</p> <p>Review of an active Physician Order dated 01/15/25 revealed right heel diabetic ulcer: Cleanse with wound cleanser or normal saline. Apply calcium alginate to wound and cover with foam dressing. Change daily and as needed. Every day shift for wound care and as needed.</p> <p>Review of the Wound Provider Consultation document dated 01/22/25 revealed Resident #74 had diabetic wound to the right foot heel.</p> <p>Observation on 01/30/25 at 12:54 P.M. revealed Registered Nurse (RN) #257 gathered supplies including wound cleanser, calcium alginate, and border gauze. Resident #74 was in the bed beside the door and RN #257 did not close the door to provide privacy or draw the curtains while performing the dressing change. RN #257 put on gloves and removed the soiled dressing. RN #257 removed gloves and put on clean gloves the nurse did not sanitize or wash hands. RN #257 used wound cleanser on the wound and cleaned the wound area, and tried to open border gauze, took off gloves but did not wash hands and put on clean gloves. RN #257 applied calcium alginate to the wound bed and border gauze. RN #257 took off gloves gathered supplies and left the room at 1:04 P.M.</p> <p>Interview with RN #257 on 01/30/25 at 1:06 P.M. verified she did not shut the door or pull the curtain for Resident #74 to provide privacy during the dressing change.</p> <p>Review of the undated facility Dignity policy revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well being, level of satisfaction with life, and feelings of self worth and self esteem. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on observations, staff and resident interviews and record review, the facility failed to ensure comfortable water temperatures. This affected 31 Residents (#2, #4, #10, #11, #13, #14, #17, #19, #21, #23, #32, #33, #44, #46, #51, #54, #55 #59, #64, #67, #78, #79, #80, #82, #86, #87, #88, #90, #91, #92, and #146.) Facility census was 94.</p> <p>Findings include</p> <p>1. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included dementia, fibromyalgia, cerebral attack, altered mental status, spinal stenosis, diabetes, and emphysema.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was cognitively intact.</p> <p>Observation and interview on 01/27/25 at 12:08 P.M. with Resident #19 revealed her private bathroom sink had no warm water. She revealed the water was freezing cold and had been cold since she moved into her room several months ago. During resident interview water was left running and was confirmed to be cold to touch with no warm or hot water flowing.</p> <p>Observation and interview on 01/27/25 at 12:50 P.M. with Certified Nurse Aide (CNA) #269 confirmed temperature of resident water after running over three minutes was at highest 52 degrees. CNA confirmed water temperatures in resident rooms on the whole unit have been a problem since at least November.</p> <p>Interview on 01/27/25 at 1:00 P.M. with Licensed Practical Nurse (LPN) #279 revealed staff will write up work orders and place in binders for maintenance to review and follow up on. She revealed staff have placed maintenance requests several times and confirmed it had been ongoing for several months.</p> <p>Review of the work order binders revealed the most recent request found was 07/2024 with a response from maintenance to wait for tank to warm up.</p> <p>07316</p> <p>2. During a tour of 2 [NAME] (a secured dementia unit with 12 resident rooms where 14 residents resided) on 01/27/25 between 11:36 A.M. and 11:52 A.M. the following hot water temperatures were obtained:</p> <p>room [ROOM NUMBER] (Resident #54)- hot water in bathroom sink was 52 degrees Fahrenheit (F) after letting the water run for three minutes. (Comfortable hot water temperatures are generally between 100-110 degrees F).</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] (Resident #11)- hot water in bathroom sink was 54 degrees F after letting the water run for three minutes.</p> <p>room [ROOM NUMBER] (Resident #146)- hot water in bathroom sink was 60 degrees F after letting the water run for four minutes.</p> <p>room [ROOM NUMBER] (Resident #147)- hot water in bathroom sink was 50 degrees F after letting the water run for three minutes.</p> <p>Interview with Licensed Practical Nurse (LPN) #279 on 01/27/25 at 11:36 A.M. revealed there had been an issue with not having hot water in resident room sinks on 2 [NAME] for a few weeks. She stated she had put in a maintenance request but was told by maintenance to just let the hot water run longer. She confirmed this did not work and there was still not hot water for resident use.</p> <p>Interview with Nursing Assistant #299 on 01/27/25 at 11:36 A.M. confirmed there had been a problem with no hot water in the sinks on 2 West. She was not sure how long the problem existed but stated it had been longer than a week.</p> <p>Interview with LPN #308 on 01/28/25 at 7:30 A.M. confirmed there had been a problem with no hot water in the sinks on 2 [NAME] for the past month.</p> <p>Review of a maintenance request form dated 07/14/24 revealed on 2 [NAME] the hot water in none of the sinks was getting warm. On the form on 07/15/24 under the work completed section, it was documented that water just needed to heat back up. There was no further description of the problem or the repair.</p> <p>Interview with Maintenance Assistant #247 on 01/27/25 at 11:45 A.M. revealed the facility monitors water temperatures weekly. He stated he was aware of an issue with no hot water in the room sinks on 2 West. He stated the issue was noted on 01/24/25 and that a contractor had been contacted for repair sometime this current week.</p> <p>Review of weekly hot water temperature logs for 2 [NAME] between 06/28/24 and 01/22/25 did not reveal any hot water temperature below 100 degrees F. On 01/22/25 (the most recent hot water temperature documented for 2 West) the hot water was noted to be 112 degrees F. in room [ROOM NUMBER]. (one room on each unit checked weekly).</p> <p>Interview with Maintenance Director #228 on 01/27/25 at 2:30 P.M. revealed there had been an issue with the hot water not getting hot in the sinks on 2 [NAME] on and off for several months. He confirmed there was currently no hot water in any of the sinks on 2 West. He stated they work on it and it gets better then it goes out again. He stated there was no documentation to verify when the hot water was not working correctly and there was no documentation to verify any repairs that had been done.</p> <p>Hot water temperatures in the sinks on 2 [NAME] were checked again on 01/30/25 between 2:30 P.M. and 2:35 P.M. and were noted as follows:</p> <p>room [ROOM NUMBER] (Resident #54) 58 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] (Resident #146) 56 degrees F.</p> <p>room [ROOM NUMBER] (Resident #147) 58 degrees F.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review and interview, the facility failed to ensure one resident's (#89) comprehensive assessment was accurate. This affected one resident (#89) of one resident reviewed for dental .The facility census was 94.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #89 revealed an initial admitted [DATE] with the latest readmission of 01/11/25 with the diagnoses including but not limited to cerebral infarction, intervertebral disc degeneration of lumbosacral region, visual loss, acute kidney failure, encephalopathy, slow transit constipation, subdural hemorrhage, history of traumatic brain injury, dementia, anemia, osteoarthritis, obstructive and reflux uropathy, hypertension, hydronephrosis, anxiety disorder, hearing loss, chronic pain, hyperlipidemia, malignant neoplasm of overlapping sites of right female breast.</p> <p>Review of the admit complete admission review dated 07/25/24 revealed the had her own teeth but the question of broken or carious teeth was not answered. The resident's activities of daily living (ADL) was not assessed on admission to determine the assistance she required with personal hygiene.</p> <p>Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no obvious or likely cavity or broken natural teeth. The assessment indicated the resident required set-up or clean-up assistance with personal hygiene.</p> <p>Review of the readmit complete admission review dated 01/11/25 revealed the resident required extensive assistance with personal hygiene. The assessment indicated the resident had her own teeth but the question of broken or carious teeth was not answered.</p> <p>Review of the resident's oral assessment dated [DATE] revealed the resident needed reminders daily to clean her teeth and had intermittent confusion. The assessment indicated the resident had impaired hand dexterity, functional limitation in upper extremity range of motion and decreased mobility.</p> <p>On 01/27/25 at 4:29 P.M., observation of the resident's teeth revealed she had missing natural teeth and obvious carried teeth.</p> <p>On 01/29/25 at 11:49 A.M., interview with the Minimum Data Set (MDS) Coordinator #289 verified the assessments of the resident's teeth were not accurate reflecting her missing teeth and carried teeth.</p> <p>On 01/29/25 at 11:49 A.M., interview with MDS Coordinator #289 verified assessments were not accurate reflecting the resident's missing and obvious carried teeth.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316</p> <p>Based on observations, record review, and staff interview, the facility failed to ensure assessments were accurate in the areas of safe smoking, dental status, and mental health diagnoses. This affected three (Residents #6, #70, and #89) of 24 residents reviewed for comprehensive assessments. The facility census was 94.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #6 revealed an admitted [DATE]. He had diagnoses including chronic obstructive pulmonary disease, nicotine dependence, peripheral vascular disease, and bilateral above the knee amputations.</p> <p>Review of a Minimum Data Set (MDS) assessment completed 12/28/24 revealed a brief interview for mental status score of 13 out of 15, indicating intact cognition. The resident used a wheelchair for mobility.</p> <p>Review of a Smoking Safety Evaluation completed 09/23/24 revealed the resident had poor vision, balance problems, and followed the facility's policy on location and time of smoking.</p> <p>Review of a Smoking Safety Evaluation started on 12/23/24 but completed on 01/28/25 also revealed the resident followed the facility policy on location and time of smoking. The assessment was completed by MDS Nurse #259.</p> <p>The facility provided a list of residents who smoke that included Resident #6 as a supervised smoker. (supervised by staff while smoking).</p> <p>Review of the plan of care for Resident #6 dated 01/28/25 revealed the resident was non compliant with the smoking policy. Another care plan dated 01/27/25 revealed Resident #6 would smoke safely with supervision.</p> <p>Review of a nursing progress note on 01/20/25 at 1:30 P.M. revealed Resident #6 was now a supervised smoker due to non-compliance with the smoking policy.</p> <p>On 01/28/25 at 8:00 A.M. Resident #6 was observed smoking by the facility front door in a non-designated smoking area. There were no ash trays or cigarette butt containers nearby to safely dispose of ashes and cigarette butts.</p> <p>Interview with Resident #6 on 01/29/25 at 10:50 A.M. confirmed he was aware of the smoking policy. He stated he was an independent smoker and keeps his cigarettes and lighter with him at all times. He was observed to have his lighter at that time (outside) and was not under the supervision of staff. He stated he will keep two or three cigarette butts in his pocket and then take them to the red metal can to dispose of them.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Receptionist #267 on 01/29/25 at 11:04 A.M. revealed Resident #6 was a supervised smoker and should not still have cigarettes or a lighter at that time because the supervised smoking session was over.</p> <p>Interview with MDS Nurse #259 on 01/29/25 at 11:15 A.M. confirmed that she signed the smoking assessment that was started on 12/23/24 but completed on 01/28/25. She stated that although her electronic signature was on it, she did not remember signing it on 01/28/25. She confirmed the assessment was not accurate as Resident #6 did not follow the facility policy on smoking and the assessment said he did.</p> <p>32654</p> <p>2. Review of the medical record for Resident #89 revealed an initial admitted [DATE] with the latest readmission of 01/11/25 with the diagnoses including but not limited to cerebral infarction, intervertebral disc degeneration of lumbosacral region, visual loss, acute kidney failure, encephalopathy, slow transit constipation, subdural hemorrhage, history of traumatic brain injury, dementia, anemia, osteoarthritis, obstructive and reflux uropathy, hypertension, hydronephrosis, anxiety disorder, hearing loss, chronic pain, hyperlipidemia, malignant neoplasm of overlapping sites of right female breast.</p> <p>Review of the admit complete admission review dated 07/25/24 revealed the had her own teeth but the question of broken or carious teeth was not answered. The resident's activities of daily living (ADL) was not assessed on admission to determine the assistance she required with personal hygiene.</p> <p>Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no obvious or likely cavity or broken natural teeth. The assessment indicated the resident required set-up or clean-up assistance with personal hygiene.</p> <p>Review of the readmit complete admission review dated 01/11/25 revealed the resident required extensive assistance with personal hygiene. The assessment indicated the resident had her own teeth but the question of broken or carious teeth was not answered.</p> <p>Review of the resident's oral assessment dated [DATE] revealed the resident needed reminders daily to clean her teeth and had intermittent confusion. The assessment indicated the resident had impaired hand dexterity, functional limitation in upper extremity range of motion and decreased mobility.</p> <p>On 01/27/25 at 4:29 P.M., observation of the resident's teeth revealed she had missing natural teeth and obvious carried teeth.</p> <p>On 01/29/25 at 11:49 A.M., interview with the Minimum Data Set (MDS) Coordinator #289 verified the MDS was not accurately coded to reflect the resident's missing natural teeth and obvious carried teeth.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the medical record for Resident #70 revealed an initial admitted [DATE] with the latest readmission of 08/28/24 with the diagnoses including but not limited to Rhabdomyolysis, diabetes mellitus, chronic obstructive pulmonary disease (COPD), benign prostatic hyperplasia, hyperlipidemia, pain, dementia, peripheral vascular disease, intellectual disabilities, major depressive disorder, nicotine dependence, legal blindness, schizoaffective disorder, hypertension, acquired absence of left foot, insomnia, major depressive disorder and anxiety disorder.</p> <p>Review of the plan of care dated 03/15/24 revealed the resident takes psychotropic medications r/t depression, anxiety, schizoaffective disorder. Interventions included administer medications as ordered, monitor/document for side effects and effectiveness, consult with pharmacy, Medical Doctor (MD) to consider dosage reduction when clinically appropriate, discuss with MD, family re ongoing need for use of medication, educate about risks, benefits and the side effects and/or toxic symptoms, monitor/record occurrence of for target behavior symptoms and document per facility protocol and monitor/record/report to MD as needed side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors. The assessment indicated dementia, anxiety disorder, depression, were active diagnoses. The MDS indicated schizoaffective disorder was not an active diagnoses. The assessment indicated the resident received antipsychotic, antianxiety, antibiotic, diuretic, antiplatelet, hypoglycemic medications. The resident received antipsychotic medications on a routine basis, a gradual dosage reduction (GDR) was not attempted and the GDR was not documented as clinically contraindicated.</p> <p>Review of the psychiatry progress note dated 01/23/25 revealed the resident was being seen for chronic psychiatric medications and medication change follow up. The assessment and plan indicated the resident's current mood and behavior suggested an exacerbation of his schizoaffective disorder, depressive type. His increased aggression and irritability, particularly surrounding his smoke breaks, are indicative of this. The recent increase in Seroquel dosage does not appear to be effective in managing these symptoms, as reported by the patient. Plan: Will reassess the efficacy of Seroquel in two weeks. If the patient continues to report no improvement, alternative psychotropic medications will be considered.</p> <p>On 01/30/25 at 11:21 A.M., interview with Corporate Nurse #325 confirmed the resident's 11/21/24 MDS was not coded to reflect the resident's schizoaffective diagnoses.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on staff interview, and record review the facility failed to ensure the accuracy of Pre-Admission Screening and Resident Review (PASARR) assessments for Residents #7, #32 and #81 for mental health diagnosis. This affected three (Resident #7, #32 and #81) of five residents reviewed for PASARR. The facility census was 94.</p> <p>Findings include:</p> <p>1. Record review of Resident #7 revealed an admitted [DATE] with pertinent diagnoses of: chronic obstructive pulmonary disease, cerebral infarction, delusional disorders, restlessness and agitation, insomnia due to other mental disorder, sexual dysfunction, schizoaffective disorder bipolar type, major depressive disorder with psychotic symptoms, mild cognitive impairment of uncertain etiology, hypothyroidism, atrial fibrillation, dysphagia following cerebral infarction, type two diabetes mellitus, acute and chronic respiratory failure with hypoxia, aphasia, cardiomyopathy, atherosclerotic heart disease, congestive heart failure, major depressive disorder, hyperlipidemia, hypertension, weakness, repeated falls, and personal history of covid-19.</p> <p>Record review of the 11/08/24 quarterly Minimum Data Set (MDS) assessment revealed the resident is moderately cognitively impaired and uses a walker to aid in mobility.</p> <p>Review of the medical record revealed on 02/07/24 the resident was given a diagnosis of schizoaffective disorder bipolar type.</p> <p>Review of the medical record on 01/27/25 revealed there was no updated PASARR in the medical record.</p> <p>Interview with the Social Services #244 on 01/29/25 at 10:09 A.M. verified no one updated the PASARR with Resident #7's new schizophrenia diagnosis until 01/28/25.</p> <p>2. Record review of Resident #81 revealed an admitted [DATE] with pertinent diagnoses of: dementia with psychotic disturbance, malignant neoplasm of prostate, deficiency of B group vitamins, hyperlipidemia, hypertension, gastro-esophageal reflux disease, edema, anxiety disorder, and psychotic disorders with delusions.</p> <p>Review of the 11/22/24 modification of quarterly Minimum Data Set (MDS) revealed the resident is rarely or never understood.</p> <p>Review of the 11/08/23 PASARR revealed the resident did not have any mental disorders listed.</p> <p>Review of Resident #81's medical record on 01/27/25 revealed an anxiety disorder diagnosis on 08/13/24 and a psychotic disorder with delusions on 08/13/24.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Social Services #244 on 01/29/25 at 10:09 A.M. verified no one updated the PASARR with Resident #81's anxiety disorder diagnosis or psychotic disorder with delusions diagnosis until 01/28/25.</p> <p>44070</p> <p>3. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included dysarthria, restlessness and agitation, anxiety disorder, schizoaffective disorder bipolar type, schizophrenia, bipolar disorder, depression and dysphasia.</p> <p>Review of Resident #32's preadmission screening and resident review (PASRR) dated 09/12/19 revealed only mood disorder and bipolar disorder was documented and schizophrenia was not included in the PASRR document.</p> <p>Review of facility policy titled, PASRR, dated 04/01/23 revealed facility shall follow regulations set forth from department of Medicaid guidelines.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Review of the medical record, interview, and facility policy review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) within 30 days following admission for one resident. This affected one (Resident #18) of five residents reviewed for PASARR. The facility census was 94.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #18 revealed an initial admitted [DATE] with the diagnoses including but not limited to wedge compression fracture of thoracic 11 and thoracic 12 vertebra, neuropathy, severe morbid obesity, vitamin D deficiency, obstructive sleep apnea, dorsalgia, dipolar disorder, insomnia, overactive bladder, major depressive disorder, anxiety disorder, spinal stenosis, hypertension, hyperlipidemia, diabetes mellitus and restless leg syndrome.</p> <p>Review of the plan of care dated 09/11/24 revealed the resident's discharge plans were undetermined, new/recent admission to facility with possible long term care placement. Interventions include encourage follow up with Primary Care Physician upon discharge, if Long Term Care Placement (LTC) is deemed appropriate, provide support and reassurance and assist resident with adjustment and transition to LTC placement, offer support, point out strengths and weaknesses. Obtain discharge order when appropriate and one-on-one visits as needed to assess progress towards discharge plans.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] the resident had no cognitive deficit. The assessment indicated the resident did not want to return to the community and did not want to be asked quarterly.</p> <p>Review of the Preadmission screening and resident review (PASARR) result application dated 09/06/24 revealed the preadmission screen was completed at the acute care hospital.</p> <p>Review of the resident's medical record revealed no resident review PASARR completed within the first 30 days of the resident's admission.</p> <p>On 01/29/25 at 1:31 P.M., interview with Licensed Social Worker (LSW) #244 confirmed a PASARR was not completed within the first 30 days of the resident's stay.</p> <p>Review of the facility policy titled, PASARR, note dated revealed the facility shall follow regulations set forth by the Ohio Department of Medicaid (ODM) guidelines for PASARR. The facility will use ODM guidelines for PASARR for all new admissions and continued stays at the facility.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to develop and implement a comprehensive plan of care in the area of smoking, activities of daily living (ADL) and dental. This affected three residents (#6, #75, #89) of 19 sampled residents. The facility census was 94.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #89 revealed an initial admitted [DATE] with the latest readmission of 01/11/25 with the diagnoses including but not limited to cerebral infarction, intervertebral disc degeneration of lumbosacral region, visual loss, acute kidney failure, encephalopathy, slow transit constipation, subdural hemorrhage, history of traumatic brain injury, dementia, anemia, osteoarthritis, obstructive and reflux uropathy, hypertension, hydronephrosis, anxiety disorder, hearing loss, chronic pain, hyperlipidemia, malignant neoplasm of overlapping sites of right female breast.</p> <p>Review of the admit complete admission review dated 07/25/24 revealed the resident had her own teeth but the question of broken or carious teeth was not answered. The resident's activities of daily living (ADL) was not assessed on admission.</p> <p>Review of the plan of care dated 08/01/24 revealed the resident had a self-care deficit related to confusion, impaired balance, visual impairment, history of stroke and dementia. Interventions included transfers and toileting the resident required limited assistance, bed mobility the resident required supervision and eating the resident required supervision. The plan of care contained no other information on how to care for the resident.</p> <p>Review of the resident's plan of cares revealed no care plan addressing the resident's dental status of missing teeth and obvious carried teeth.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had an indwelling urinary catheter and was always continent of bowel.</p> <p>Review of the resident's oral assessment dated [DATE] revealed the resident needs reminders daily to clean her teeth and had intermittent confusion. The assessment indicated the resident had impaired hand dexterity, functional limitation in upper extremity range of motion and decreased mobility.</p> <p>On 01/27/25 at 4:29 P.M., observation of the resident's teeth revealed she had missing natural teeth and obvious carried teeth.</p> <p>On 01/29/25 at 11:49 A.M., interview with MDS Coordinator #289 verified the facility had not developed a comprehensive care plan addressing the resident's ADL deficit and dental status.</p> <p>07316</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #6 revealed an admitted [DATE]. He had diagnoses including chronic obstructive pulmonary disease, nicotine dependence, peripheral vascular disease, and bilateral above the knee amputations.</p> <p>Review of a Minimum Data Set (MDS) assessment completed 12/28/24 revealed a brief interview for mental status score of 13 out of 15, indicating intact cognition. The resident used a wheelchair for mobility.</p> <p>Review of a Smoking Safety Evaluation completed 09/23/24 revealed the resident had poor vision, balance problems, and followed the facility's policy on location and time of smoking.</p> <p>Review of a Smoking Safety Evaluation started on 12/23/24 but completed on 01/28/25 also revealed the resident followed the facility policy on location and time of smoking. The assessment was completed by MDS Nurse #259.</p> <p>The facility provided a list of residents who smoke that included Resident #6 as a supervised smoker. (supervised by staff while smoking).</p> <p>Review of nursing progress notes revealed the following:</p> <p>11/07/24 7:01 A.M. Resident actively smoking in front of facility entrance at this time. (non-designated area). Resident was advised prior to exiting facility to smoke in designated smoking area.</p> <p>01/20/25 1:30 P.M. Resident #6 now a supervised smoker due to non-compliance with the smoking policy.</p> <p>01/22/25 9:09 A.M. Resident observed smoking in front of facility in a non smoking area. Unit Manager instructed resident smoking is only allowed in designated areas.</p> <p>Observations by the surveyor on 01/28/25 at 8:00 A.M. revealed Resident #6 was smoking by the facility front door in a non-designated smoking area. There were no ash trays or cigarette butt containers nearby to safely dispose of ashes and cigarette butts.</p> <p>Interview with Resident #6 on 01/29/25 at 10:50 A.M. confirmed he was aware of the smoking policy. He stated he was an independent smoker and keeps his cigarettes and lighter with him at all times. He was observed to have his lighter at that time (outside) and was not under the supervision of staff. He stated he will keep two or three cigarette butts in his pocket and then take them to the red metal can to dispose of them.</p> <p>Interview with Receptionist #267 on 01/29/25 at 11:04 A.M. revealed Resident #6 was a supervised smoker and should not still have cigarettes or a lighter at that time because the supervised smoking session was over.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care for Resident #6 dated 01/28/25 revealed the resident was non compliant with the smoking policy. It stated the resident would accept compliance. Another care plan dated 01/27/25 revealed Resident #6 had the potential for injury related to smoking (smokes cigarettes). It stated the resident would safely smoke with supervision. Interventions included advise resident to wear smoking apron while smoking, if indicated. Assist to smoking area as needed. Complete smoking assessment quarterly and with significant change. Provide supervision during smoking. Secure cigarettes and lighter at nurses station.</p> <p>Interview with MDS Nurse #259 on 01/29/25 at 11:15 A.M. confirmed Resident #6's care plan for smoking was dated 01/27/25 and 01/28/25 with no evidence of previous care plans for smoking, even though the resident was non-compliant with smoking.</p> <p>3. Review of the medical record for Resident #75 revealed an admitted [DATE] and diagnoses of diabetes, below the knee amputation on one side, and chronic obstructive pulmonary disease.</p> <p>Review of a Minimum Data Set (MDS) assessment completed 12/09/24 revealed the resident was cognitively intact (Brief Interview for Mental Status score of 15 out of 15). The resident used a wheelchair for mobility.</p> <p>The facility provided a list of smokers that included Resident #75 as an independent smoker.</p> <p>Review of the medical record for Resident #75 did not reveal any assessment completed related to safety with smoking.</p> <p>Review of nursing progress notes revealed the following:</p> <p>11/30/24 5:16 P.M. Has been in/out smoking all day.</p> <p>12/01/24 1:11 P.M. Resident states at this time he is going to smoke despite being educated and he will be back in when they get here to transport (issue with IV and going to hospital).</p> <p>12/02/24 9:35 A.M. Manager informed this writer that resident was actively smoking in his room. Walked toward resident room, smelled smoke, and resident exited room. Advised resident of smoking policy. Resident ignored nurse and said he does not have time for this and he is not a child. Advised resident that he needs to give receptionist his cigarettes after smoking outside. Resident went outside, came back inside and refused to give receptionist his cigarettes and lighter. Notified unit manager.</p> <p>01/07/25 10:57 A.M. Resident educated on smoking policy.</p> <p>01/11/25 6:14 A.M. Resident at nurses's station yelling at staff to let him out (outside). Explained that staff were in the middle of report and will let out once completed. When let out, resident proceeded to smoke in non-designated smoking area and when writer explained where resident was designated to smoke, he began screaming at writer. Refusing to go to designated area and began smoking. Resident also did not ask staff for cigarettes and lighter and when asked he stated I have my own shit. Advised resident he is at risk of losing smoking privileges by not following rules and he said f. that, I don't care.</p> <p>(continued on next page)</p>

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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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>01/20/25 9:15 A.M. Resident noted to be directly outside front door smoking. (not designated smoking area). Education provided on smoking policy. Did not ask receptionist for cigarettes when went out to smoke.</p> <p>01/22/25 9:09 A.M. Resident observed smoking in front of facility in a non smoking area. Unit Manager informed. Unit Manager instructed resident smoking is only allowed in designated areas.</p> <p>Observations by the surveyor on 01/28/25 at 8:00 A.M. revealed Resident #75 was smoking by the facility front door in an non-designated smoking area. There were no ash trays or cigarette butt containers nearby to safely dispose of ashes and cigarette butts.</p> <p>Interview with Resident #75 on 01/29/25 at 10:43 A.M. revealed he was aware of the smoking policy upon admission. He stated he keeps his own cigarettes and lighter. He just has to sign out at the front desk that he is going out to smoke. Observed with lighter in jacket. He confirmed he did smoke in his room about a month ago but has not done it since. He confirmed he smokes in front of the facility in non-designated area at times.</p> <p>Review of the plan of care revealed it was dated 01/27/25 and stated the resident had a potential for injury related to smoking cigarettes. It stated the resident would safely smoke. It included: advise to wear smoking apron while smoking if indicated, secure cigarettes/lighters at nurses station. There was no evidence of a plan of care related to smoking prior to 01/27/25.</p> <p>Interview with Social Service Director #244 on 01/29/25 at 11:44 A.M. confirmed Resident #75 had smoked since admitted and did not follow the smoking policy. She further confirmed the plan of care was dated 01/27/25.</p> <p>Review of the facility policy titled, Comprehensive Person-Centered Care Plans, last revised 03/22 revealed a comprehensive person center care plan that includes measurable objectives and timetables to meet the resident's to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive person center care plan included measurable objectives and times frames and describes the services that are to be furnished to attain and maintain the resident's highest practical physical, mental and psychosocial well being.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on staff interview, record review, and policy review, the facility failed to ensure care plan interventions were updated. This affected two residents (#13 and #67) who were involved in a resident to resident altercation and a third resident (#17) after a fall out of 25 resident careplans reviewed. Facility census was 94.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes, dysphasia, muscle weakness, schizophrenia and kidney disease.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively impaired with a brief interview for mental status (BIMS) of 0 (rarely/never understood) out of 15.</p> <p>Review of the plan of care dated 01/28/25 revealed resident had potential for altered mood pattern related to schizophrenia with interventions for one to one visits as needed, give comfort measures with calm approach, and try different approaches including walk away and reapproach. Resident had potential for altered behavioral patterns including disruptive verbally and resistive to care with intervention to consult with psych services as needed, encourage family support, explain procedures and what to expect, keep environment calm and obtain help if resident becomes abusive/resistive.</p> <p>Review of physician orders for 01/29/25 revealed an order for a stop sign to be placed on residents door.</p> <p>2. Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included encephalopathy, chronic obstructive pulmonary disease, respiratory failure, dementia, epilepsy, schizophrenia, muscle weakness and cognitive communication deficit, dysphasia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively impaired with a BIMS of 0 (rarely/never understood) out of 15.</p> <p>Review of the plan of care dated 01/27/25 revealed resident had potential for altered mood pattern and behaviors with interventions to provide calm approach and comfort measures, intervention when appropriate and monitor for behaviors. Resident wanders into other resident rooms and gets easily agitated with interventions to administer prescribed medications, allow resident to pace where she can be observed and to keep environment calmed.</p> <p>Review of Self Reported Incident investigation dated 01/19/25 revealed a resident to resident altercation occurred on 01/18/25 between Resident #13 and #67. The investigation reported Resident #67 was wandering into Resident #13's room when Resident #13 struck Resident #67 several times. Resident #67 had injuries of bruising on her neck as well as a laceration on her neck and a superior abrasion to her chin. The investigation documents revealed the intervention included a stop sign to be placed on Resident #13's door.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/29/25 at 1:20 P.M. with Certified Nursing Aide (CNA) #269 and Licensed Practical Nurse (LPN) #306 confirmed the stop signs were taken down after the initial incident and put back up on 01/29/25 late morning. She confirmed no stop signs were hanging during survey 01/27/25 and 01/28/25.</p> <p>Interviews on 01/30/25 at 4:00 P.M. to 5:30 P.M. with Administrator revealed the intervention of stop signs were implemented after the resident to resident altercation. She revealed she was unaware they were not left up and had been taken down prior to the start of the survey. Administrator then revealed they were not meant to be put up immediately but had to be ordered and were just delivered 01/29/25. When asked for the order form and delivery information Administrator then stated they did not order the stop signs and had them in stock to put up. Administrator was unable to provide explanation why they were not consistently used since the incident on 01/18/25.</p> <p>3. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included Fibromyalgia, Alzheimer's, hemorrhage of anus and rectum, chronic obstructive pulmonary disease, dementia, and anxiety.</p> <p>Review of fall investigation dated 11/07/24 revealed Resident #17 had dementia and forgets to ask for assistance and was found on the floor of her room. The intervention planned was for non-skid socks to be initiated.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively impaired with a BIMS of 0 (rarely/never understood) out of 15.</p> <p>Review of the plan of care dated 12/17/24 revealed Resident #17 was at risk of falls with intervention for non skid socks which was initiated on the care plan 01/19/25 (12 days post fall with injury).</p> <p>Interview on 01/28/25 at 4:47 P.M. with Director of Nursing (DON) confirmed the intervention for non-skid socks was added after the fall with injury that occurred on 11/07/24. DON also confirmed the careplans was not updated until 11/19/25.</p> <p>Review of facility policy titled, Falls and Fall Risk Managing, dated 03/2018 revealed staff shall identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p> <p>Review of facility policy titled, Care plan, comprehensive person centered, dated 03/2022 revealed the care plan was to include services and objectives to attain or maintain highest practicable well-being including services to be furnished. Care plan interventions were chosen only after data gathering, events, and careful consideration of the relationship between the resident's problem areas and their causes. The interdisciplinary team shall review and update the care plans after a significant change, when desired outcome had not been met and at least quarterly.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to provide meal assistance for one resident (#9) and provide nail care for one resident (#89), who was dependent on staff. This affected two (Resident #9 and #89) of four residents reviewed for activities of daily living (ADL). The facility census was 94.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #9 revealed an initial admitted [DATE] with the diagnoses including but not limited to cerebrovascular accident with right sided hemiplegia, anorexia, hyperlipidemia, palliative care, age related physical debility, osteoporosis, hypertension, psychotic disorder with delusions and hallucinations.</p> <p>Review of the plan of care dated 12/27/21 revealed the resident had an activities of daily living (ADL) self care performance deficit related dementia, impaired balance, limited mobility, need for assist/support may fluctuate based on fatigue, time of day and motivation. Interventions included assess to determine status and adjust support/assist to accommodate immediate need, the resident requires set-up to limited assistance with eating, extensive assistance with bathing, bed mobility, dressing transfers and ambulation, converse with resident while providing care, keep fingernails short/clean and staff to monitor for decline in range of motion, notify nurse of any abnormal findings.</p> <p>Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive impairment.</p> <p>Review of the resident's January 2025 physician orders identified orders dated 09/29/23 regular diet, regular texture with thin consistency liquids and 06/27/23 staff to provide additional ADL assistance due to hemiplegia, refer to ADL care plan.</p> <p>On 01/27/25 at 11:35 A.M., observation of the resident revealed she was served her lunch meal and immediately picked up the beverage of tea from the tray. The resident took a drink and said she did not like the drink and requested another beverage.</p> <p>On 01/27/25 at 12:03 P.M., observation of the resident revealed her bedside table was pushed away from her and the head of her bed was laid down. Further observation revealed no assistance or cues was provided by the staff.</p> <p>On 01/27/25 at 12:30 P.M., interview with Certified Nursing Assistant (CNA) #225 verified the resident had not received assistance or cues with her meal.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #89 revealed an initial admitted [DATE] with the latest readmission of 01/11/25 with the diagnoses including but not limited to cerebral infarction, intervertebral disc degeneration of lumbosacral region, visual loss, acute kidney failure, encephalopathy, slow transit constipation, subdural hemorrhage, history of traumatic brain injury, dementia, anemia, osteoarthritis, obstructive and reflux uropathy, hypertension, hydronephrosis, anxiety disorder, hearing loss, chronic pain, hyperlipidemia, malignant neoplasm of overlapping sites of right female breast.</p> <p>Review of the admit complete admission review dated 07/25/24 revealed the resident's activities of daily living (ADL) was not assessed on admission.</p> <p>Review of the plan of care dated 08/14/24 revealed the resident had little or no activity involvement related to anxiety, pain and poor vision. The resident likes to visit with staff and roommate, getting nails done and some arts and crafts. Interventions included provide resident with appropriate one on one activities, provide resident with monthly activity calendar, remind resident they are invited to attend group activities, remind the resident that the resident may leave activities at any time and not required to stay for entire activity and the resident needs assistance/escort activity functions.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit.</p> <p>Review of the readmit complete admission review dated 01/11/25 revealed the resident required extensive assistance with personal hygiene.</p> <p>On 01/27/25 at 4:27 P.M., observation of the resident revealed her nails were long and jagged. The resident reported she did not prefer long nails and needed them trimmed.</p> <p>On 01/27/25 at 4:55 P.M., interview with Certified Nursing Assistant (CNA) #272 confirmed the resident's fingernails were long, jagged and in need of care.</p> <p>Review of the facility policy titled, Care of Fingernails/Toenails, last revised 02/18 revealed the purpose of the procedure was to clean the nail bed, to keep the nails trimmed and to prevent infection. nail care includes daily cleaning and regular trimming.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on record review, family and staff interviews, the facility failed to maintain hospice records. This affected one Resident (#67) of one reviewed for hospice. Facility census was 94.</p> <p>Findings include</p> <p>Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included encephalopathy, chronic obstructive pulmonary disease, respiratory failure, dementia, epilepsy, schizophrenia, muscle weakness and cognitive communication deficit, dysphasia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively impaired.</p> <p>Review of the plan of care dated 01/27/25 revealed resident was receiving hospice services.</p> <p>Review of the medical record on 01/30/25 found no evidence of hospice notes being uploaded directly to the residents medical record.</p> <p>Review of the hospice binder maintained by the facility, resident was admitted to hospice 06/2024 and only three visit notes were documented.</p> <p>Interview on 01/28/25 at 9:13 A.M. with resident family revealed concerns whether hospice was actually coming to facility and providing the promised services.</p> <p>Interview on 01/30/25 at 9:50 A.M. with Administrator revealed facility did not keep hospice records but emailed for communication. She confirmed facility had binders maintained at the unit nurses stations.</p> <p>Interview on 01/30/25 at 10:15 A.M. with Registered Nurse (RN) #281 confirmed facility had a binder for Resident #67 hospice services. The binder was reviewed with RN and found only one page of notes including three dates since hospice services were initiated. The notes were dated 01/13/25, 01/17/25, and 01/27/25.</p> <p>Review of facility policy titled, Hospice Program, dated 07/2017 revealed it was the responsibility of the facility to maintain documentation of hospice communication.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure safe smoking for two residents (#6, #75). Additionally the facility failed to ensure safe hot water temperatures for three residents (#9, #79, #89). This affected two (Resident #6 and #75) of three resident reviewed for smoking and three (Resident #9, #79, and #89) of 19 sampled residents for water temperatures. The facility census was 94.</p> <p>Findings Include:</p> <p>1. On 01/27/25 at 12:38 P.M., observation of Resident #9's room water temperature revealed a temperature of 131.2 degrees.</p> <p>On 01/27/25 at 12:45 P.M., interview with Maintenance Director (MD) #228 verified the water temperature was above the maximum 120 degree limit.</p> <p>2. On 01/27/25 at 12:23 P.M., observation of Resident #89's water temperature in the bathroom revealed a temperature of 125.7 degrees.</p> <p>On 01/27/25 at 12:45 P.M., interview with Maintenance Director (MD) #228 verified the water temperature was above the maximum 120 degree limit.</p> <p>3. On 01/27/25 at 12:34 P.M., observation of Resident #79's room water temperature revealed a temperature of 138.8 degrees.</p> <p>On 01/27/25 at 12:45 P.M., interview with Maintenance Director (MD) #228 verified the water temperature was above the maximum 120 degree limit.</p> <p>07316</p> <p>4. Review of the medical record for Resident #6 revealed an admitted [DATE]. He had diagnoses including chronic obstructive pulmonary disease, nicotine dependence, peripheral vascular disease, and bilateral above the knee amputations.</p> <p>Review of a Minimum Data Set (MDS) assessment completed 12/28/24 revealed a brief interview for mental status score of 13 out of 15, indicating intact cognition. The resident used a wheelchair for mobility.</p> <p>Review of a Smoking Safety Evaluation completed 09/23/24 revealed the resident had poor vision, balance problems, and followed the facility's policy on location and time of smoking.</p> <p>Review of a Smoking Safety Evaluation started on 12/23/24 but completed on 01/28/25 also revealed the resident followed the facility policy on location and time of smoking. The assessment was completed by MDS Nurse #259.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care for Resident #6 dated 01/28/25 revealed the resident was non compliant with the smoking policy. It stated the resident would accept compliance. Another care plan dated 01/27/25 revealed Resident #6 had the potential for injury related to smoking (smokes cigarettes). It stated the resident would safely smoke with supervision. Interventions included advise resident to wear smoking apron while smoking, if indicated. Assist to smoking area as needed. Complete smoking assessment quarterly and with significant change. Provide supervision during smoking. Secure cigarettes and lighter at nurses station.</p> <p>Review of a physician progress note dated 01/28/25 at 8:00 A.M. revealed it stated Resident #6 was blatantly noncompliant with the smoking policy.</p> <p>The facility provided a list of residents who smoke that included Resident #6 as a supervised smoker. (supervised by staff while smoking).</p> <p>Review of nursing progress notes revealed the following:</p> <p>11/07/24 7:01 A.M. Resident actively smoking in front of facility entrance at this time. (non-designated area). Resident was advised prior to exiting facility to smoke in designated smoking area.</p> <p>01/20/25 1:30 P.M. Resident #6 now a supervised smoker due to non-compliance with the smoking policy.</p> <p>01/22/25 9:09 A.M. Resident observed smoking in front of facility in a non smoking area. Unit Manager instructed resident smoking is only allowed in designated areas.</p> <p>Observations by the surveyor on 01/28/25 at 8:00 A.M. revealed Resident #6 was smoking by the facility front door in an non-designated smoking area. There were no ash trays or cigarette butt containers nearby to safely dispose of ashes and cigarette butts. There were signs posted that stated positively no smoking. There were multiple cigarette butts on the ground in leaves. The cigarette butts were approximately five feet from the the facility.</p> <p>Interview with Housekeeper #262 on 01/28/25 (supervises smoking) at 12:55 P.M. revealed Resident #6 smokes in front of the building in undesignated area. She stated the resident had been told by many staff members that he needs to smoke in the designated area, but he does not listen.</p> <p>Interview with Registered Nurse (RN) #327 on 01/29/25 at 10:15 A.M. revealed Resident #6 is a smoker. She stated he is allowed to sign himself out to smoke. She stated residents are allowed to keep their cigarettes but get lighter from the front desk. She stated he goes out quite frequently. She confirmed residents are not to smoke by the front door. She stated she was not aware of Resident #6 having any issues following the smoking policy.</p> <p>Interview with RN #235 on 01/29/25 at 10:20 A.M. revealed she was not sure if residents are allowed to keep their cigarettes or not.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #6 on 01/29/25 at 10:50 A.M. confirmed he was aware of the smoking policy. He stated he was an independent smoker and keeps his cigarettes and lighter with him at all times. He was observed to have his lighter at that time (outside) and was not under the supervision of staff. He stated he will keep two or three cigarette butts in his pocket and then take them to the red metal can to dispose of them.</p> <p>Interview with Receptionist #267 on 01/29/25 at 11:04 A.M. revealed cigarette and lighters are stored in a box that is taken outside by staff at the times for supervised smoking. Independent smokers have cigarettes and lighters kept at desk and are provided when residents signs themselves out to go smoke. She confirmed Resident #6 smokes in front of the facility in non designated area. She stated staff had reported it to administrator multiple times. She stated Resident #6 was a supervised smoker and should not still have cigarettes or a lighter at that time because the supervised smoking session was over.</p> <p>Interview with MDS Nurse #259 on 01/29/25 at 11:15 A.M. confirmed that she signed the smoking assessment that was started on 12/23/24 but completed on 01/28/25. She stated that although her electronic signature was on it, she did not remember signing it on 01/28/25. She confirmed the assessment was not accurate as Resident #6 did not follow the facility policy on smoking and the assessment said he did. She stated he is one of the residents they catch smoking out front. She further confirmed Resident #6's care plan for smoking was dated 01/27/25 and 01/28/25 with no evidence of previous care plans for smoking, even though the resident was non-compliant with smoking.</p> <p>Interview with Social Service Director #244 on 01/29/25 at 11:26 A.M. revealed Resident #6 does not follow the smoking policy. She confirmed he smokes in the front of the facility in non designated area. She stated the resident's sign the smoking policy on admission and then if they are non compliant with smoking, the facility does a care conference and then if still non compliant, they issue a 30 day discharge notice. She stated they had a care conference with him 01/17/25 and had him re-sign the smoking policy. She confirmed no action had been taken since 01/17/25 related to non-compliance with smoking.</p> <p>5. Review of the medical record for Resident #75 revealed an admitted [DATE] and diagnoses of diabetes, below the knee amputation on one side, and chronic obstructive pulmonary disease.</p> <p>Review of a Minimum Data Set (MDS) assessment completed 12/09/24 revealed the resident was cognitively intact (Brief Interview for Mental Status score of 15 out of 15). The resident used a wheelchair for mobility.</p> <p>The facility provided a list of smokers that included Resident #75 as an independent smoker.</p> <p>Review of the medical record for Resident #75 did not reveal any assessment completed related to safety with smoking.</p> <p>Review of nursing progress notes revealed the following:</p> <p>11/30/24 5:16 P.M. Has been in/out smoking all day.</p> <p>12/01/24 1:11 P.M. Resident states at this time he is going to smoke despite being educated and he will be back in when they get here to transport (issue with IV and going to hospital).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/02/24 9:35 A.M. Manager informed this writer that resident was actively smoking in his room. Walked toward resident room, smelled smoke, and resident exited room. Advised resident of smoking policy. Resident ignored nurse and said he does not have time for this and he is not a child. Advised resident that he needs to give receptionist his cigarettes after smoking outside. Resident went outside, came back inside and refused to give receptionist his cigarettes and lighter. Notified unit manager.</p> <p>01/07/25 10:57 A.M. Resident educated on smoking policy.</p> <p>01/11/25 6:14 A.M. Resident at nurses's station yelling at staff to let him out (outside). Explained that staff were in the middle of report and will let out once completed. When let out, resident proceeded to smoke in non-designated smoking area and when writer explained where resident was designated to smoke, he began screaming at writer. Refusing to go to designated area and began smoking. Resident also did not ask staff for cigarettes and lighter and when asked he stated I have my own shit. Advised resident he is at risk of losing smoking privileges by not following rules and he said f. that, I don't care.</p> <p>01/14/25 8:59 A.M. Social Worker and Director of Nursing met with resident to sign smoking policy. Social Worker explained what would happen if he would not abide by the smoking policy. Resident is agreeance and signed policy.</p> <p>01/20/25 9:15 A.M. Resident noted to be directly outside front door smoking. (not designated smoking area). Education provided on smoking policy. Did not ask receptionist for cigarettes when went out to smoke.</p> <p>01/22/25 9:09 A.M. Resident observed smoking in front of facility in a non smoking area. Unit Manager informed. Unit Manager instructed resident smoking is only allowed in designated areas.</p> <p>Review of the plan of care revealed it was dated 01/27/25 and stated the resident had a potential for injury related to smoking cigarettes. It stated the resident would safely smoke. It included: advise to wear smoking apron while smoking if indicated, secure cigarettes/lighters at nurses station. There was no evidence of a plan of care related to smoking prior to 01/27/25.</p> <p>Observations by the surveyor on 01/28/25 at 8:00 A.M. revealed Resident #75 was smoking by the facility front door in an non-designated smoking area. There were no ash trays or cigarette butt containers nearby to safely dispose of ashes and cigarette butts. There were signs posted that stated positively no smoking. There were multiple cigarette butts on the ground in leaves. The cigarette butts were approximately five feet from the the facility.</p> <p>Interview with Licensed Practical Nurse #319 on 01/29/25 at 10:28 A.M. revealed Resident #75 was an independent smoker. She stated he will go out before the receptionist gets there in the morning and staff do not know where he gets his cigarettes from as he is not supposed to have them. She stated he does smoke in non designated areas.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #75 on 01/29/25 at 10:43 A.M. revealed he was aware of the smoking policy upon admission. He stated he keeps his own cigarettes and lighter. He just has to sign out at the front desk that he is going out to smoke. Observed with lighter in jacket. He confirmed he did smoke in his room about a month ago but has not done it since. He confirmed he smokes in front of the facility in non-designated area at times.</p> <p>Interview with Social Service Director #244 on 01/29/25 at 11:44 A.M. confirmed Resident #75 had smoked since admitted and did not follow the smoking policy. She confirmed a smoking assessment had not been completed for Resident #75. She further confirmed the plan of care was dated 01/27/25. She stated the resident keeps his own cigarettes and lighter and does not turn them in even though that does not follow the smoking policy. She confirmed he signed the smoking policy again on 01/14/25 after being non compliant. She stated no further interventions had been taken to ensure safe smoking.</p> <p>Review of the undated facility policy titled Resident Smoking revealed the facility shall establish and maintain safe resident smoking/use of electronic cigarette practices. Prior to or upon admission, residents will be informed about any limitations on smoking. This included designated smoking areas. Residents will be required to sign a document acknowledging the smoking policy and ramifications if policy is not followed. No smoking signs shall be prominently displayed throughout the facility where smoking is prohibited. Smoking restrictions shall be strictly enforced in all non smoking areas. No resident shall hold on their person or in their room: cigarettes, cigars, tobacco, lighters, matches, or electronic cigarettes. Ashtrays shall only be emptied into designated receptacles (red cans). The staff shall consult with the physician and director of nursing to determine any restrictions on a resident's smoking based on observation and completion of smoking assessments. Any smoking restrictions or concerns shall be noted on the care plan. All personnel caring for the resident shall be alerted to any potential issues. The facility may impose smoking restrictions on a resident if it is determined the resident cannot smoke safely with the available levels of support and supervision. Residents may not use matches or lighters. It is the responsibility of staff to light tobacco items for residents. Failure to abide by these policies and procedures shall result in the following: Re-signing of the smoking policy; care conference with resident and/or family; 30 day notice if the smoking policy and procedure is not followed.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to ensure residents had access to fluids and bedside. Additionally, the facility failed to ensure one resident received beverages with meals. This affected three (#8, #9, and #89) of four residents reviewed for hydration. The facility census was 94.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #8 revealed an initial admitted [DATE] with the diagnoses including but not limited to fibromyalgia, chronic respiratory failure, chronic pulmonary edema, cerebrovascular accident (CVA) with hemiplegia, dorsalgia, congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease (COPD), spinal stenosis, obstructive sleep apnea, restless leg syndrome, hypertension, chronic kidney disease, peripheral vascular disease, irritable bowel syndrome with constipation, spondylosis, dementia, osteoarthritis, hyperlipidemia, anxiety disorder, gout, hypothyroidism, osteoporosis and depressive episodes.</p> <p>Review of the plan of care dated 11/15/23 revealed the resident was at risk for malnutrition related to fibromyalgia, COPD, CVA with hemiplegia, congestive heart failure, diabetes mellitus, hypertension, chronic kidney disease, peripheral vascular disease, irritable bowel syndrome, dementia, anxiety, depression, reports weight loss prior to admission, history of diuretic use, significant weight gain, reports eating more at the facility than at home, had snacks in room and admit to hospice. Interventions included diet as order, nutrition related medications as order, monitor and record meal intake, honor food preferences, monitor weights per order/policy, monitor labs as needed and coordinate care with hospice to promote dignity and comfort.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit.</p> <p>Review of the monthly physician orders for January 2025 identified orders dated 11/13/23 regular diet, regular texture with thin consistency liquids.</p> <p>On 01/27/25 at 11:00 A.M., interview with Resident #8 revealed she only receives fresh ice water when she requests. She revealed the facility does not pass fresh ice water routinely. Observation of the resident's water pitcher at bedside revealed the pitcher contained warm water.</p> <p>On 01/29/25 at 12:30 P.M., observation of the resident's water pitcher revealed the pitcher contained warm water.</p> <p>On 01/29/25 at 3:00 P.M., observation of the resident's water pitcher revealed the pitcher contained warm water. Interview with the resident at the time of the observation revealed the facility had not passed ice fresh ice water on this date.</p> <p>On 01/29/25 at 3:04 P.M., interview with Certified Nursing Assistant (CNA) #231 revealed the facility does not pass fresh ice water routinely but upon request. CNA #231 revealed the resident are also able to obtain ice from the ice chest in the dining room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/29/25 at 3:12 P.M., interview with Registered Nurse (RN) #235 and RN #325 revealed ice should be passed at the beginning of each shift and as needed.</p> <p>2. Review of the medical record for Resident #9 revealed an initial admitted [DATE] with the diagnoses including but not limited to cerebrovascular accident with right sided hemiplegia, anorexia, hyperlipidemia, palliative care, age related physical debility, osteoporosis, hypertension, psychotic disorder with delusions and hallucinations.</p> <p>Review of the plan of care dated 12/24/21 revealed the resident had potential risk for altered hydration/nutrition and potential risk for malnutrition related to anorexia, CVA with right sided hemiplegia, cognitive communication deficit, hyperlipidemia, heart disease, hypertension, palliative care, advanced age, history of underweight, need for supplement, history of weight loss and history of weight gain. Interventions included provide diet as ordered and monitor meal intakes, honor food preferences and offer substitutes as needed, provide assistance and encouragement with eating and drinking as needed, monitor for signs/symptoms of chewing or swallowing difficulties, obtain weight at a minimum of monthly and report significant weight changes to physician</p> <p>Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive impairment.</p> <p>Review of the resident's January 2025 physician orders identified orders dated 09/29/23 regular diet, regular texture with thin consistency liquids, 06/27/23 staff to provide additional ADL assistance due to hemiplegia, refer to ADL care plan and 01/12/25 house supplement ready care 2.0 120 milliliters (ml) twice daily.</p> <p>On 01/27/25 at 11:35 A.M., observation of the resident revealed she was served her lunch meal and immediately picked up the beverage of tea from the tray. The resident took a drink and said she did not like the drink and requested another beverage.</p> <p>On 01/27/25 at 11:50 A.M., observation of the resident revealed she continued to have no drink other than the unsweet tea she was served with her meal and refused to drink. The resident continued to have no fresh ice water at bedside.</p> <p>On 01/27/25 at 12:30 P.M., interview with CNA #225 verified the resident had not received another beverage as requested with her meal.</p> <p>01/29/25 at 10:31 A.M., observation of the resident revealed she continued to have no access to fresh water at bedside. Interview with RN #235 at the time of the observation verified the resident had no fresh water at bedside.</p> <p>3. Review of the medical record for Resident #89 revealed an initial admitted [DATE] with the latest readmission of 01/11/25 with the diagnoses including but not limited to cerebral infarction, intervertebral disc degeneration of lumbosacral region, visual loss, acute kidney failure, encephalopathy, slow transit constipation, subdural hemorrhage, history of traumatic brain injury, dementia, anemia, osteoarthritis, obstructive and reflux uropathy, hypertension, hydronephrosis, anxiety disorder, hearing loss, chronic pain, hyperlipidemia, malignant neoplasm of overlapping sites of right female breast.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit.</p> <p>On 01/27/25 at 11:21 A.M., observation of the resident she had not fresh water at bedside.</p> <p>On 01/27/25 at 4:32 P.M., interview with the resident revealed the staff bring ice water when she ask for it. Observation of the resident at the time of the interview revealed her lips and mouth were dry. The resident continued to have no access to fresh water at bedside.</p> <p>On 01/29/25 at 10:24 A.M., observation of the resident revealed she continued to have no access to fresh ice water at bedside.</p> <p>On 01/29/25 at 10:29 A.M. interview with RN #235 confirmed the resident had no access to fresh ice water at bedside.</p> <p>Review of the facility policy titled, Hydration Guidelines, not dated revealed dietary was to provide water on each resident meal tray/order unless resident refuses. Nursing passes ice water to all residents per diet order unless nothing by mouth on each shift.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on record review and interview, the facility failed to monitor one resident's blood pressure prior to the administration of the medication Hydralazine (a medication used to lower blood pressure). This affected one (Resident #70) out of five residents reviewed for unnecessary medications. The facility census was 94.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #70 revealed an initial admitted [DATE] with the latest readmission of 08/28/24 with the diagnoses including but not limited to Rhabdomyolysis, diabetes mellitus, chronic obstructive pulmonary disease (COPD), benign prostatic hyperplasia, hyperlipidemia, pain, dementia, peripheral vascular disease, intellectual disabilities, major depressive disorder, nicotine dependence, legal blindness, schizoaffective disorder, hypertension, acquired absence of left foot, insomnia, major depressive disorder and anxiety disorder.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit.</p> <p>Review of the January 2025 monthly physician orders revealed orders dated 06/27/24 Hydralazine 10 milligrams (mg) by mouth three times daily and 06/27/24 Hydralazine 10 mg by mouth every 12 hours as needed for systolic blood pressure greater than 175 and/or diastolic blood pressure greater than 90.</p> <p>Review of the medical record revealed the resident's blood pressure (BP) was not being monitored prior to the administration of the medication Hydralazine 10 mg by mouth three times daily.</p> <p>On 01/30/25 at 3:06 P.M., interview with Cooperate Nurse #325 verified the lack of blood pressure monitoring prior to the administration of the medication Hydralazine.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on staff interview, record review, and policy review, the facility failed to obtain Physician ordered labs for residents. This affected two (Resident #70, and #81) of five residents reviewed for medications. The facility census was 94.</p> <p>Findings include:</p> <p>1. Record review of Resident #81 revealed an admitted [DATE] with pertinent diagnoses of: dementia with psychotic disturbance, malignant neoplasm of prostate, deficiency of B group vitamins, hyperlipidemia, hypertension, gastro-esophageal reflux disease, edema, anxiety disorder, and psychotic disorders with delusions.</p> <p>Review of the 11/22/24 modification of quarterly Minimum Data Set (MDS) revealed the resident is rarely or never understood.</p> <p>Review of a Physicians Order dated 08/13/24 revealed complete blood count (CBC, a lab to check blood cells) and basic metabolic panel (BMP, a lab to check chemical balance and metabolism) laboratory values one time only for new admit.</p> <p>Review of a Physicians Order dated 08/23/24 revealed complete blood count and basic metabolic panel laboratory values one time only for admission labs until 08/26/24.</p> <p>Review of the electronic and paper medical record on 01/30/25 revealed no documented lab value for either CBC or BMP on those dates.</p> <p>Interview with Regional Director Clinical Operations #325 on 01/30/25 at 4:44 P.M. verified there was no CBC or BMP labs per the orders on 08/13/24 or 08/23/24.</p> <p>32654</p> <p>2. Review of the medical record for Resident #70 revealed an initial admitted [DATE] with the latest readmission of 08/28/24 with the diagnoses including but not limited to Rhabdomyolysis, diabetes mellitus, chronic obstructive pulmonary disease (COPD), benign prostatic hyperplasia, hyperlipidemia, pain, dementia, peripheral vascular disease, intellectual disabilities, major depressive disorder, nicotine dependence, legal blindness, schizoaffective disorder, hypertension, acquired absence of left foot, insomnia, major depressive disorder and anxiety disorder.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident received hypoglycemic medications.</p> <p>Review of the January 2025 monthly physician orders revealed orders dated 07/23/24 resident needs new A1c in three months from today 07/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record revealed no results for the HemoglobinA1c (HgbA1c) as physician ordered.</p> <p>On 01/30/25 at 3:06 P.M., interview with Cooperate Nurse #325 verified HgbA1c was due on 10/23/24 and was not obtained as physician ordered.</p> <p>Review of the facility policy titled, Lab and Diagnostic Test Results, last revised 11/18 revealed the physician will identify and order diagnostic lab testing based on the resident's diagnostic monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider or other testing source will report test results to the facility.</p>

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to ensure one resident received dental services. This affected one resident (#89) of two residents reviewed for dental. The facility census was 94.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #89 revealed an initial admitted [DATE] with the latest readmission of 01/11/25 with the diagnoses including but not limited to cerebral infarction, intervertebral disc degeneration of lumbosacral region, visual loss, acute kidney failure, encephalopathy, slow transit constipation, subdural hemorrhage, history of traumatic brain injury, dementia, anemia, osteoarthritis, obstructive and reflux uropathy, hypertension, hydronephrosis, anxiety disorder, hearing loss, chronic pain, hyperlipidemia, malignant neoplasm of overlapping sites of right female breast.</p> <p>Review of the admit complete admission review dated 07/25/24 revealed the resident had her own teeth but the question of broken or carious teeth was not answered. The resident's activities of daily living (ADL) was not assessed on admission.</p> <p>Review of the plan of care dated 08/01/24 revealed the resident had a self-care deficit related to confusion, impaired balance, visual impairment, history of stroke and dementia. Interventions included transfers and toileting the resident required limited assistance, bed mobility the resident required supervision and eating the resident required supervision. The plan of care contained no other information on how to care for the resident.</p> <p>Review of the resident's plan of cares revealed no care plan addressing the resident's dental status of missing teeth and obvious carried teeth.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit.</p> <p>Review of the resident's oral assessment dated [DATE] revealed the resident needs reminders daily to clean her teeth and had intermittent confusion. The assessment indicated the resident had impaired hand dexterity, functional limitation in upper extremity range of motion and decreased mobility.</p> <p>Review of the resident's monthly physician orders for January 2025 identified orders dated 07/25/24 may consult podiatrist, audiologist, ophthalmology, dentist, Certified Nurse Practitioner (CNP) from Northeast surgical, and CNP from psych 360, and counseling source as needed.</p> <p>On 01/27/25 at 4:29 P.M., observation of the resident's teeth revealed she had missing natural teeth and obvious carried teeth.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>01/29/25 at 11:40 A.M., interview with Licensed Social Worker (LSW) #244 revealed the resident refused 360 services and had no documented evidence the resident refused the new facility contracted dental service implemented in 12/2024. LSW #244 revealed the resident had not been seen by a dentist since her admission to the facility.</p> <p>Review of the facility policy titled, Dental Services, last revised 09/20/24 revealed it is the policy of the facility to assist residents in obtaining routine and emergency dental care.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>44070</p> <p>Based on observations, staff interview and record review, the facility failed to maintain the substitution log. This had potential to affect all facility residents. Facility census was 94.</p> <p>Findings include</p> <p>Review of the menu revealed chilled pears were to be served for the lunch meal on 01/29/25.</p> <p>Interview on 01/29/25 at 11:31 A.M. with Kitchen staff #287 revealed they ran out of pears so they switched to pineapple for regular texture and applesauce of puree texture for the lunch meal.</p> <p>Interview on 01/29/25 at 11:35 A.M. with Kitchen Manager (KM) #286 revealed the substitution logs should be completed at the beginning of the day or prior to the meal service.</p> <p>Through surveyor interventions KM #286 and Dietician #327 were informed and revealed they were both unaware of the switch in food products.</p> <p>Review of the substitution log revealed no entries were made related to a change for the lunch meal on 01/29/25.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on observations, staff interviews and record review, the facility failed to maintain a safe and sanitary food storage, ensure food holding temperatures were maintained in a safe range and ensure kitchen staff was trained on proper use of the dishwasher. This had potential to affect all facility residents. Facility census was 94.</p> <p>Findings include</p> <p>1. Observation and interview [DATE] at 10:45 A.M. with Kitchen Manager (KM) #286 revealed in the freezers were crumble (for pies) dated [DATE] to [DATE]. KM revealed [DATE] was likely the use by date. Two bags of black olives were dated ,d+[DATE] to an unknown date due to smudging. They appeared to be frostbitten and KM acknowledged they should be thrown out due to finding them frostbitten. In the refrigerator a large bag of ham was undated, five fruit cups were expired from [DATE] and a gallon of milk was expired [DATE], blueberries had a use by date of [DATE], salad dressing had a date of ,d+[DATE], [NAME] sauce had a date of ,d+[DATE]. Broccoli leftovers had no date, vegetable soup leftovers had no date, baked chicken leftovers had a use by date of [DATE], gravy had use by date of [DATE], and an unknown food item (KM also could not say what the food was) had a use by date of [DATE]. Kitchen manager verified food should be eaten by that use by or sell by date and any leftovers should be discarded after that date. Dry storage found brownie mix was open and undated, dry noodles were open and undated, and a cart with five racks of sweet potato pie were left uncovered. KM also revealed all items should be covered and dated but was unsure the requirements of when to date and how to date.</p> <p>Interview on [DATE] at 11:05 A.M. with Dietician #327 revealed facility had been doing monthly (if not more frequent training) due to issues found during the dietician and diet tech audits. Dietician revealed ongoing concerns related to food storage had not improved.</p> <p>Review of facility policy titled, Food Receiving and Storage, dated ,d+[DATE] revealed foods shall be stored in a manner that complies with safe food handling practices. Dry foods shall be labeled with a use by date. All foods in refrigerated and frozen storage shall be covered, labeled and dated with a use by date.</p> <p>2. Interview on [DATE] at 11:38 A.M. with Kitchen staff #239 informed a resident ordered a hamburger for lunch. Facility staff did not get a temperature of the food prior to placing on the tray and in the meal cart.</p> <p>After surveyor intervention, observation of a temperature was taken by Kitchen staff #239 and found the burger holding temperature was 110 degrees. Two additional burgers sitting in the warming box where the initial burger was retrieved from, had temperatures taken and were 110 and 112 degrees.</p> <p>Interview with Dietician #327 confirmed the burger was going to be served at a temperature outside a safe range.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with Kitchen Manager #286 confirmed he was unsure why the food was not staying hot enough in the warming box.</p> <p>Review of facility policy titled, General Food Preparation and Handling, dated ,d+[DATE] revealed hot foods shall be held at 135 or greater.</p> <p>3. Observations and interviews on [DATE] at 11:40 A.M. when checking the working status of the dishwasher with Kitchen Manager (KM) #286 revealed a lack of knowledge of the dish machine. Kitchen manager was unable to inform surveyor where the temperature gauges were and was unable to explain the temperature requirement. KM stated it is a chemical dishwasher with no temperature requirements. KM grabbed a chemical testing strip and as soon as the dishwasher wash cycle began placed the strip in the water for a chemical reading and held it in the water for about 15 to 20 seconds.</p> <p>Observation and interview on [DATE] at 11:41 A.M. with Dietician #327 confirmed the dish machine was a low temp chemical machine and verified it should be at at least 120 degrees and informed kitchen manager he grabbed chlorine strips and not sanitation strips to test.</p> <p>Observation and interview on [DATE] at 11:42 A.M. with Kitchen Manager #286 and Dietician #327 revealed KM found the correct strips and when asked what measurement he was looking for KM stated 200 ppm to which Dietician corrected him to 50ppm. They confirmed Dietician was at facility once monthly and revealed kitchen manager was in charge and worked full time.</p> <p>Review of facility policy titled, General Food Preparation and Handling, dated ,d+[DATE] revealed kitchen equipment shall be cleaned and sanitized after each use.</p>		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on observation, record review, policy review ,and staff interview, the facility failed to maintain an infection prevention and control program to help prevent the transmission of infections when they failed to use proper hand hygiene during a dressing change, and failed to follow enhanced barrier precautions. This affected one (Resident #74) of two residents reviewed for wounds. The facility census was 94.</p> <p>Findings include:</p> <p>Record review of Resident #74 revealed an admitted [DATE] with pertinent diagnoses of: sepsis due to streptococcus, type two diabetes mellitus, chronic respiratory failure with hypoxia, encephalopathy, moderate intellectual disabilities, hypertension, heart failure, morbid obesity due to excess calories, type two diabetes mellitus with diabetic neuropathy, acute respiratory failure with hypoxia, benign prostatic hyperplasia, hyperlipidemia, venous insufficiency chronic peripheral, lymphedema, type two diabetes mellitus with foot ulcer, cardiomyopathy, iron deficiency anemia, solitary pulmonary nodule, and unspecified hydronephrosis.</p> <p>Review of the 12/23/24 admission Minimum Data Set (MDS) revealed the resident is moderately cognitively impaired and uses a walker and wheelchair to aid in mobility. The resident is coded as having a venous or arterial ulcer.</p> <p>Review of an active Physician Order dated 01/15/25 revealed right heel diabetic ulcer: Cleanse with wound cleanser or normal saline. Apply calcium alginate to wound and cover with foam dressing. Change daily and as needed. Every day shift for wound care and as needed.</p> <p>Review of an active Physician Order dated 01/29/25 revealed enhanced barrier precautions due to wound.</p> <p>Review of the Wound Provider Consultation document dated 01/22/25 revealed Resident #74 had diabetic wound to the right foot heel.</p> <p>Observation on 01/30/25 at 12:54 P.M. revealed Registered Nurse (RN) #257 gathered supplies including wound cleanser, calcium alginate, and border gauze. There was a sign on the door stating enhance barrier precautions and personal protective equipment hanging from the door. RN #257 put on gloves and removed the soiled dressing. RN #257 did not use a gown while providing wound care for Resident #74. RN #257 removed gloves and put on clean gloves the nurse did not sanitize or wash her hands. RN #257 used wound cleanser on the wound and cleaned the wound area, and tried to open border gauze, took off gloves but the nurse did not sanitize or wash her hands and put on clean gloves. RN #257 applied calcium alginate to the wound bed and border gauze. RN #257 took off gloves gathered supplies and left the room at 1:04 P.M.</p> <p>Interview with RN #257 on 01/30/25 at 1:06 P.M. verified she did not wear a gown while completing a dressing change for Resident #74 who is on enhanced barrier precautions. RN #257 also verified she did not wash her hands or use hand sanitizer after removing soiled gloves and putting on new gloves twice during the dressing change procedure.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 03/20/24 facility enhanced barrier precautions policy revealed an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (chronic such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers). Make gown and gloves available immediately near or outside of the resident room.</p> <p>Review of the 01/30/25 hand hygiene policy revealed staff should use either soap and water or alcohol based hand rub before applying and after removing personal protective equipment, including gloves.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51069</p> <p>Based on observation, interview and record review, the facility failed to maintain an adequate resident call system to allow residents to call for staff assistance. This affected two residents (Residents # 48 and #20) of the 30 residents reviewed for call light function in the facility. The facility census was 94.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Record review of Resident #48 revealed an admitted [DATE] with diagnoses that included inflammatory neuropathy, heart failure, paraplegia and chronic obstructive pulmonary disease. 2. Record review of Resident #20 revealed an admitted [DATE] with diagnoses of radiculopathy, polyneuropathy, type II diabetes mellitus and chronic obstructive pulmonary disease. <p>Interview on 01/29/25 at 2:30 P.M. with Residents #48 and #20 revealed that the call light system was not functioning properly and had not been for months. Resident #48 reported that when the call light was activated the light in the hallway did not come on and did not alert staff of need for assistance.</p> <p>On 01/29/25 at 3:00 P.M., Resident #48 pressed his call light and observation was made that the hallway light used to alert staff of need for assistance did not light up. Staff were observed in hallway but were not aware of call light being pushed due to notification light not working.</p> <p>Interview on 01/29/25 at 3:10 P.M. with Certified Nursing Assistant (CNA) #231 confirmed that the call light for room [ROOM NUMBER] had not been functioning for at least 4 months. CNA #231 revealed that Residents #48 and #20 had notified staff on multiple occasions of need for repair.</p> <p>Review of a binder located on the 100 hallway labeled Maintenance Request Log revealed a maintenance request form dated 10/27/24 requesting repair for the hallway call light for Residents #48 and #20. The section of the form titled Work Completed was left blank as no action was taken.</p> <p>Interview with facility Administrator on 01/30/25 at 10:00 A.M. revealed Administrator was unaware of call light issue for Resident #48 and #20's room.</p> <p>Review of resident council meeting minutes dated 01/23/25 revealed a request to have the call light for room repaired.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on observation, staff interview, and resident interview, the facility failed to provide a functional comfortable environment when the walls were in disrepair. This affected one (Resident #65) of two residents reviewed for environmental issues. The facility census was 94.</p> <p>Findings include:</p> <p>Record review of Resident #65 revealed an admitted [DATE] with pertinent diagnoses of: atrial fibrillation, type two diabetes mellitus, peripheral vascular disease, congestive heart failure, and insomnia.</p> <p>Observation and Interview with Resident #65 on 01/27/25 at 11:28 A.M. revealed his room has multiple wall marks that need sanded and painted over by the bed. Resident #65 stated the walls have been like that since he was in the room.</p> <p>Observation on 01/30/25 at 02:38 P.M. with Maintenance Director #228 verified the wall marks in Resident #65 room that need sanded and painted.</p>