STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365636	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pickerington Care and Rehabilitation	1300 Hill Road North Pickerington, OH 43147

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to ensure one resident (#175) was treated with respect and dignity. This affected one of one resident reviewed for dignity. The facility census was 72. Findings Include: Review of the medical record for Resident #175 revealed an initial admitted [DATE] with the diagnoses including but not limited to human metapneumovirus pneumonia, pneumonitis due to inhalation of food and vomit, pulmonary fibrosis, Parkinsonism, dementia with moderate mood disorder, dystonia, anxiety disorder, depression, presence of neurostimulator, insomnia, hypertension, gastro-esophageal reflux disease, history of malignant neoplasm of prostate, acquired absence of other genital organs, vitamin D deficiency, generalized muscle weakness, dysphagia, unspecified voice and resonance disorder and other symbolic dysfunctions. Review of the resident's admission assessment with baseline plan of care dated 07/18/24 revealed the resident was dependent on staff for all activities of daily living (ADL) care. The assessment indicated the resident was alert and oriented to name and place only and the resident's speech was unclear. The assessment indicated the resident was incontinent of bladder, however the resident's bowel continence was not assessed. Review of the plan of care dated 07/19/24 revealed the resident required assistance for ADL related to Parkinson's disease. Interventions included apply house moisture barrier cream after each incontinence episode, assist with choosing appropriate clothing as needed, encourage and allow resident to complete self care as able, inspect skin condition daily during personal care and report any impaired areas to the charge nurse, keep call light in reach while in bed, observe for changes in ADL ability and adjust assistance as needed, praise for ADL self-performance, provide assistive devices to increase ADL self care as needed, provide incontinence care with routine rounds and as needed, resident is totally dependent and does not participate in any aspect of the task, resident requires weight-bearing assistance, staff will anticipate needs, staff will assist as needed with daily hygiene and will assist with showering residents per facility policy weekly and therapy as ordered for improvement in ADL self care. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the assessment was still in progress. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/31/24 at 8:15 A.M. revealed Resident #175 was sitting up in his Broda chair with a hospital gown on and a blanket covering him. Observation on 07/31/24 at 9:05 A.M. revealed Resident #75 was sitting in his Broda chair with a hospital gown on and a blanket covering his legs. Further observation revealed the gown had fallen down to the resident's waist exposing his chest to staff and passerbys. On 07/31/24 at 11:30 A.M., interview with State tested Nursing Assistant (STNA) #642 revealed the resident normally did not keep his clothing on put will keep the hospital gown on. The STNA was informed of the multiple observations of the gown down around his waste with his chest exposed to passer [NAME] from the door. The STNA stated, Well night shift got him up. When asked if he had to stay in the hospital gown all day due to night shift getting him up the STNA stated, I don't know, I didn't think about it, I have been busy. The STNA verified the resident should have been dressed in his personal clothing. Observation on 07/31/24 at 9:50 A.M., revealed Resident #175 was being pushed down the hallway by a male visitor in his Broda chair. The resident remained in a hospital gown with a blanket covering his legs. The male visitor had placed shoes on the resident. Review of the facility policy titled, Resident Rights, dated 03/01/23 revealed the facility will ensure that all direct care staff members, including contractors and volunteers are educated on the right of residents and the responsibility of the facility to properly care for its resident's.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview and Long Term Care Facility Resident Assessment Instrument 3.0 Manual review, the facility failed to complete an initial comprehensive, accurate standardized Minimum Data Assessment (MDS) within the first 14 days following admission to the facility for two residents (#175 and #177) and failed to accurately assess and code the oral status of one resident (#30) on the annual MDS. This affected three residents (Resident #175,#177, and #20) of 20 sampled residents. The facility census was 72. Findings Include: 1. Review of the medical record for Resident #175 revealed an initial admitted [DATE] with the diagnoses including but not limited to human metapneumovirus pneumonia, pneumonitis due to inhalation of food and vomit, pulmonary fibrosis, Parkinsonism, dementia with moderate mood disorder, dystonia, anxiety disorder, depression, presence of neurostimulator, insomnia, hypertension, gastro-esophageal reflux disease, history of malignant neoplasm of prostate, acquired absence of other genital organs, vitamin D deficiency, generalized muscle weakness, dysphagia, unspecified voice and resonance disorder and other symbolic dysfunctions. Review of the resident's Minimum Data Set (MDS) list revealed the resident admitted to the facility on [DATE] with an initial comprehensive assessment reference date (ARD) of 07/22/24. The comprehensive MDS assessment with the ARD date of 07/22/24 remains in progress. On 08/01/24 at 10:31 A.M., interview with Licensed Practical Nurse (LPN) #519 MDS Coordinator revealed she completed the MDS assessments, however a corporate Registered Nurse (RN) signs the assessment as being completed and accurate. On 08/01/24 at 10:43 A.M., interview with LPN #519 verified the initial comprehensive MDS assessment was not completed within the first 14 days of the resident's stay at the facility as required. 2. Review of the medical record for Resident #177 revealed an initial admitted [DATE] with the diagnoses including but no limited to metabolic encephalopathy, acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, sepsis, diabetes mellitus, severe morbid obesity, pneumonia, dependence on ventilator, hyperlipidemia, hypotension, anxiety disorder, retention of urine, dependence on other enabling machines and devices, obstructive sleep apnea, dependence on supplemental oxygen, pulmonary hypertension, bed confinement status, gastro-esophageal reflux disease, hypothyroidism, chronic pain and anemia. Review of the resident's Minimum Data Set (MDS) list revealed the resident admitted to the facility on [DATE] with an initial comprehensive assessment reference date (ARD) of 07/16/24. The comprehensive MDS assessment with the ARD date of 07/16/24 remains in progress. On 08/01/24 at 10:31 A.M., interview with LPN #519 MDS Coordinator revealed she completed the MDS assessments, however a corporate Registered Nurse (RN) signs the assessment as being completed and accurate. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/24 at 10:43 A.M., interview with LPN #519 verified the initial comprehensive MDS assessment was not completed within the first 14 days of the resident's stay at the facility as required. 3. Review of the medical record for Resident #30 revealed an admitted [DATE] and diagnoses of dementia and delusional disorder. He was on a regular diet. An oral assessment completed 10/05/23 stated the resident had no natural teeth or had fragments (edentulous). The denture section was blank and there were no comments on the assessment to describe the resident's dental condition. The annual minimum data set assessment completed 10/05/23 documented no to the resident being edentulous or having tooth fragments. Oral assessments completed by the facility on 02/23/24 and 05/23/24 documented no to the resident being edentulous or having tooth fragments. There was no further description of the residents dental status on the assessments by the facility. Review of dental consultations revealed on 04/11/24 the resident was noted to have three root tips only and no dentures. On 05/28/24 the dental consult notes described the resident as edentulous. Observations on 07/29/24 at 11:26 A.M. revealed Resident #30 not to have any visible teeth. Interview with Minimum Data Set (MDS) nurse #519 on 08/01/24 at 2:00 P.M. confirmed the annual MDS was not coded accurately to reflect the resident's edentulous status. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 Manual dated 10/23 revealed a MDS assessment must be completed on all residents in the facility. The initial comprehensive MDS assessment must be completed by the fourteenth day of the resident's admission (admitted plus 13 calendar days).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, medical record review, staff interview, and policy review, the facility failed to comprehensively assess residents for possible medication side effects. This affected two (Resident #11 and Resident #19) of 20 sampled residents. The facility census was 72. Findings include: 1. Review of the medical record for Resident #19 revealed an admitted [DATE] and diagnoses of schizophrenia and parkinson's disease. The resident was receiving an antipsychotic medication (Seroquel 250 milligrams daily), an atypical antipsychotic (nuplazid 34 mg daily), an anticonvulsant medication (Depakote 1000 mg daily), an antidepressant/sedative medication (trazodone 50 mg daily), an antianxiety medication (Ativan 1 mg daily), an anxiolytic medication (buspar 15 mg daily), an antidepressant medication (sertraline 100 mg daily), and a sleep aide (melatonin 6 mg daily). Review of a minimum data set assessment of 07/01/24 revealed a brief interview for mental status score of 15 out of 15, indicating intact cognition. Observations on 07/31/24 at 9:01 A.M. and 1:36 P.M. and on 08/01/24 at 7:24 A.M. revealed Resident #19 to have movements of her mouth of like a chewing movement. Interview with Resident #19 on 07/31/24 at 9:01 A.M. revealed she does not even know that she does the movement with her mouth. Review of the plan of care dated 12/24/19 revealed the resident was on antipsychotic therapy and the goal was to remain free from adverse effects. Interventions included monitoring for extrapyramidal side effects (a group of side effects that can affect the motor system and occur due to the use of certain medications, especially antipsychotics and can include involuntary movements, muscle stiffness, and tremors). The plan of care indicated using an AIMS test (abnormal involuntary movement scale) every six months and as needed to assess the severity of involuntary movements. It also stated to monitor and report side effects. The plan of care stated to observe, document, and report any movement disorders. Review of AIMS evaluations completed for Resident #19 on 11/16/23, 02/16/24, and 05/17/24 indicated no facial movements, no lip movements, no jaw movements, and no tongue movements. In addition, review of medication administration records for May, June, and July 2024 revealed monitoring for medication side effects each shift documented no side effects related to movement disorder. Review of psychiatry progress notes for 07/29/24 revealed it was documented the resident had no abnormal movements. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #560 on 08/01/24 at 7:29 A.M. confirmed Resident #19 had involuntary mouth movements for many years. She stated it was possibly due to the psychiatric medications she was taking or could be due to parkinsons disease. She stated AIMS testing was done to monitor for this. Interview with the Administrator and Director of Nursing on 08/01/24 at 8:32 A.M. confirmed the AIMS testing for Resident #19 and the psychiatry progress notes did not identify any involuntary, abnormal movements for Resident #19. 2. Review of the medical record for Resident #11 revealed an admitted [DATE] and diagnoses including schizoaffective disorder. He was receiving an antipsychotic medication (Risperdal 3 mg daily), an antianxiety medication (Vistaril 75 mg daily), a central nervous system agent (nuedexta 20-10 mg daily), and an anticonvulsant medication (valproate sodium 750 mg three times daily). A minimum data set assessment completed 05/02/24 indicated short and long term memory impairment. Observations on 07/31/24 at 9:07 A.M. and 1:36 P.M. revealed Resident #11 to have upper body tremors including his arms and hands. On 08/01/24 at 7:26 A.M. he was noted with a tremor of his left hand. Interview with Registered Nurse #572 on 07/31/24 at 9:07 A.M. confirmed the upper body tremors. She confirmed he had been on the medications for at least two years. She stated she was not aware of him having any tremors and would report it to the psychiatric nurse practitioner. Review of the plan of care dated 06/06/23 revealed a potential for adverse side effects of psychotropic drug use. The goal was for no side effects. Interventions included AIMS per policy and as needed, document side effects including movement disorders, and notify physician. Review of AIMS evaluations completed revealed on 05/22/23 he was noted to have minimal facial movements. The section on arms and hands was blank. Mild movements of legs, knees were noted. Minimal movements of neck, shoulders was noted. Review of additional AIMS evaluations on 08/23/23, 11/23/23, 02/28/24, and 05/28/24 revealed no involuntary movements were noted at all. Review of nurses notes for the past three months did not identify any tremors or involuntary movements. In addition, review of medication administration records for May, June, and July 2024 revealed monitoring for medication side effects each shift documented no side effects related to movement disorder. Review of psychiatry progress notes for 11/06/23, 03/25/24, 06/17/24, and 07/15/24 revealed fine tremors of hand documented. There was no further assessment or documentation related to what was causing or any treatment for this. Interview with the Administrator and Director of Nursing on 08/01/24 at 8:44 A.M. confirmed the recent AIMS evaluations did not identify any involuntary movements for the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy dated 3/16 and titled Aims Assessment revealed it is the intent of the facility that residents who are on psychoactive medications be routinely monitored for indications of side effects. The AIMS assessment will be used to assess the baseline status of a resident who is admitted on a psychoactive medication or who is put on one after admission. Residents who are on a psychoactive medication will have the AIMS completed routinely and as needed if demonstrate signs/symptoms that may indicated the resident is having side effects. If the assessment shows indications of a side effect or if there is a change since the previous AIMS assessment, the physician will be notified.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview and facility policy review, the facility failed to document the reason for decline in gradual does reduction of antipsychotropic medications for one resident (#8). This affected one (Resident #8) of five residents reviewed for unnecessary medications. The facility census was 72. Findings Include: Review of the medical record for Resident #8 revealed an initial admitted [DATE] with the latest readmission of 01/02/24 with diagnoses including acute and chronic respiratory failure with hypoxia or hyercapnia, Duchenne or [NAME] muscular dystrophy, ileus, protein calorie malnutrition, dependence on ventilator, pain, pleural effusion, acute kidney failure with tubular necrosis, neuromuscular dysfunction, anxiety disorder, hypothyroidism, depression, contracture of muscles, gastrostomy, tracheostomy, anemia, GERD, cardiomyopathy, constipation, tachycardia, contracture of left hand, dysphagia and cognitive communication deficit. Review of the plan of care dated 01/02/24 revealed the resident had potential for side effects of psychotropic drug use, antidepressant and anxiolytic drug therapy related to depression and anxiety. Interventions included AIMS per policy/as needed, document side effects of medication, observe document, report to physician as needed of signs or symptoms of drug related complications, obtain vital signs as ordered and report abnormalities to physician, report pertinent lab results to physician and review for ability to decrease dosage or discontinue as needed. Review of the resident's quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. Review of the mood and behavior revealed the resident displayed no behaviors. The assessment indicated the resident received antianxiety, antidepressant, anticoagulant, antibiotic, opioid medications. Review of the resident's monthly physician orders for August 2024 identified orders dated 01/02/24 Buspar 10 mg via peg-tube daily for anxiety, 03/10/24 Lexapro 5 milligrams (mg) via peg-tube daily for depression and 07/24/24 Ativan 0.5 mg via peg-tube every six hours as needed for 14 days for anxiety. Review of the pharmacy recommendation dated 10/24/23 revealed the pharmacist recommended a gradual dose reduction (GDR) on the medication Lexapro 5 milligrams (mg) via peg-tube daily. The Certified Nurse Practitioner (CNP) addressed the recommendation on 11/10/24 and disagreed with the recommendation. The CNP marked a box that stated additional attempts would likely cause increased distressed behavior. The recommendation contained no rationale and/or symptoms from the CNP for the denial of the GDR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy recommendation dated 01/23/24 revealed the pharmacist recommended a gradual dose reduction (GDR) for Buspar 10 mg via peg-tube three times a day. The Certified Nurse Practitioner (CNP) addressed the recommendation on 02/14/24 and disagreed with the recommendation. The CNP marked a box that stated reduction causes target symptoms to return and/or worsen. The recommendation contained no rationale and/or symptoms from the CNP for the denial of the GDR. Review of the pharmacy recommendation dated 04/19/24 revealed the pharmacist recommended a GDR on the medication Lexapro 5 mg via peg-tube daily. The Certified Nurse Practitioner (CNP) addressed the recommendation on 04/29/24 and disagreed with the recommendation. The CNP marked a box that stated additional attempts would likely cause increased distressed behavior. The recommendation contained no rationale and/or symptoms from the CNP for the denial of the GDR. On 08/01/24 at 2:55 P.M., interview with the Director of Nursing (DON) revealed the CNP should have documented the reason for the decline in the GDR on the pharmacy recommendation. Review of the facility policy titled, Consulting Pharmacist Monthly Drug Regimen, dated 2016 revealed the resident's attending physician must document in the medical record that the identified irregularity has been reviewed and what if any action had been taken to address it. If there is to be non change in medication, the attending physician must document his or her rationale in the resident's medical record at the physician's next visit or within timeframe.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, interview and review of manufacture's guidelines, the facility failed to dispose expired Covid 19 vaccine syringes. This had the potential to affect any resident receiving a Covid 19 vaccine or booster vaccine. The facility census was 72. Findings Include: Observation on [DATE] at 10:58 A.M. revealed an opened box of Spikevax (Covid 19) vaccine located in the back drawer of the medication storage refrigerator located in the North unit's medication storage room. Inside the opened box were two pre-filled syringes remaining out of the original ten pre-filled syringes with lot number #3032713 and expiration date [DATE]. There were no opened dates observed on the box or on the syringes. Interview on [DATE] at 11:10 A.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) # 560 confirmed the two pre-filled syringes in the opened box of Spikevax (Covid 19) vaccine with expiration date [DATE]. LPN UM #560 stated the vaccines would be administered on request from resident. Review of the manufactures guidelines for Moderna Spikevax (Covid 19 Vaccine) Suspension for injection revised ,d+[DATE] revealed, Single dose pre-filled syringes may be stored refrigerated between 36 degrees and 46 degrees for up 30 days prior to use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to maintain infection control practices to prevent the potential spread of infection in the area of droplet isolation. This affected one resident (#175) of three residents reviewed for transmission based precautions (TBP). The facility census was 72. Findings Include: Review of the medical record for Resident #175 revealed an initial admitted [DATE] with the diagnoses including but not limited to human metapneumovirus pneumonia, pneumonitis due to inhalation of food and vomit, pulmonary fibrosis, Parkinsonism, dementia with moderate mood disorder, dystonia, anxiety disorder, depression, presence of neurostimulator, insomnia, hypertension, gastro-esophageal reflux disease, history of malignant neoplasm of prostate, acquired absence of other genital organs, vitamin D deficiency, generalized muscle weakness, dysphagia, unspecified voice and resonance disorder and other symbolic dysfunctions. Review of the resident's nurses note dated 07/18/24 at 9:45 P.M. revealed the resident was admitted to the facility following an acute care hospital stay for human metapneumovirus pneumonia and was to be placed on droplet isolation. Review of the plan of care dated 07/19/24 revealed the resident required droplet isolation/quarantine due to human metapneumovirus. Interventions included activities staff to visit resident and decide on activities of choice the resident can do during isolation time period, encourage family and friends to visit as often as possible, isolation/quarantine maintained by staff during acute infection period, isolation/quarantine to be discontinued as soon as infection no longer exists and staff to observe resident for signs and symptoms of depression and notify psych services as needed. Review of the plan of care dated 07/19/24 revealed the resident had signs and symptoms of pneumonia. Interventions included administer antibiotics as ordered/indicated, elevate head of bed to promote better air exchange, encourage coughing and deep breathing, encourage resident to increase fluid intake if able, isolation as ordered/indicated, notify physician/family of changes in condition, observe for increase in shortness of breath, obtain oxygen saturation rate as ordered/indicated, respiratory treatments as ordered/indicated, review for increased confusion further making resident at risk for falls and suction as ordered/needed. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the assessment was still in progress. Review of the resident's monthly physician orders for July 2024 identified orders dated 07/18/24 observe for signs/symptoms of lower respiratory to include coughing, sneezing, runny nose and fever. If noted lower respiratory symptoms please notify physician, 07/24/24 Cedi 300 milligrams (mg) by mouth twice daily for aspiration pneumonia for 10 days, 07/29/24 droplet precautions maintained every shift for Human Metapneumovirus until 08/04/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/29/24 at 9:59 A.M., observation of Resident #175 revealed Registered Nurse (RN) #617 was in the resident's room taking his blood pressure with the unit's electronic vital signs machine without the required personal protection equipment (PPE) of gown, gloves and surgical mask. Interview with RN #617 verified the lack of PPE at the time of the observation. On 07/31/24 at 9:05 A.M., observation of the Housekeeper #558 clean Resident #175's room revealed the Housekeeper was cleaning the room with a mask placed under her nose and only gloves. On 07/31/24 at 9:15 A.M., an interview with Housekeeper #558 verified the surgical mask was not being worn properly and the required PPE was not utilized. Review of the facility policy titled, Transmission Based (Isolation) Precautions, dated 09/01/22 revealed it was the facility's policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogen's mode of transmission. Droplet precautions intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Healthcare personnel will wear a facemask for close contact with infectious resident. Based upon the pathogen or clinical syndrome, if there is risk of exposure of mucous membranes or substantial spraying of respiratory secretions were anticipated gloves, and gown as well as goggles or face shield should be worn. Residents on droplet precautions who must be transported outside of the room should wear a facemask as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365636	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pickerington Care and Rehabilitation	1300 Hill Road North Pickerington, OH 43147

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 32654 Based on observation, interview and facility policy review, the facility failed to ensure one resident's (#181) call light was within reach to call staff for assistance. This affected one of 20 sampled residents. The facility census was 72. Findings Include: On 07/30/24 at 1:59 P.M., observation of Resident #181 revealed his call light was laying on the floor on a floor mat next to his bed out of reach. On 07/30/24 at 2:30 P.M., interview with State tested Nursing Assistant (STNA) #553 revealed the resident had no speech, was dependent on staff for activities of daily living and the call light was the only means to alert staff of any needs. STNA #553 verified the resident's call light was on the floor out of his reach. On 07/31/24 at 1:59 P.M., observation of Resident #181 revealed the resident's call light was laying on the floor on a floor mat next to his bed. STNA #590 verified the resident's call light was not within reach and had no ability to summon facility staff for needs. Review of the facility policy titled, Call Lights: Accessibility and Timely Response, dated 04/01/22 revealed the facility will assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will relay directly relay to a staff member or centralized location to ensure appropriate response. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of the resident and secured as needed. This deficiency represents non-compliance investigated under Complaint Number OH00155613.