STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365672	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

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** 41526 Based on interview, record review, and facility policy review, the facility failed to treat Resident #86 with dignity and respect. This affected one resident (#86) and had the potential to affect all 106 residents who resided in the facility. Findings include: Review of the medical record for Resident #86 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type two with neuropathy, chronic respiratory failure, tracheostomy status, disturbances of salivary secretion, gastrostomy status, essential primary hypertension and depression. Interview on 01/21/25 at 8:05 A.M. with Resident #86 complained about a recent confrontation with Licensed Practical Nurse (LPN) #287 who when questioned about her medication schedule, responded rudely and thereafter retaliated by ignoring Resident #86, giving all other residents medications first before administering hers, making them late. Resident #86 detailed the nurse's rudeness, indicating LPN #287 angrily went to the room door then shouted back at Resident #86 of knowing how to read a computer before abruptly leaving. Resident #86 stated LPN #287 thereafter was dismissive and never addressed her questions or concerns. Review of Resident #86's medication administration record (MAR) from January 2025 indicated orders dated 01/15/25 for midodrine 5 milligrams (mg) enterally three times daily for hypotension, Vistaril 50 mg enterally three times daily for anxiety, and gabapentin 300 mg enterally three times daily for difficulty in walking. All medications were scheduled for administration at early, noon and HS (bedtime). Review of Resident #86's MAR from January 2024 and medication administration audit report (MAAR) from 01/13/25 to 01/19/25 for medications administered by LPN #287 revealed the following late administrations: On 01/15/25, the noon dose of midodrine was not administered until 5:20 P.M. On 01/16/25, the noon doses of midodrine, Vistaril and gabapentin were not administered until 3:35 P.M. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/18/25, the noon doses of midodrine, Vistaril and gabapentin were not administered until 3:21 P.M. On 01/19/25, the noon doses of midodrine, Vistaril and gabapentin were not administered until 3:14 P.M. Interview on 01/23/25 at 8:14 A.M. with Director of Nursing (DON) verified the above medication administration findings. Interview on 01/23/25 at 10:22 A.M. with LPN #287 via telephone confirmed a confrontation with Resident #86 had occurred including shouting back at the resident about knowing how to read a computer. LPN #287 presented as defensive, dismissive and curt during the interview. When questioned for clarification of facts, LPN #287 responded, Do not ask me questions three times in different ways. I answered the question already. When asked as to why LPN #287 was contentious, LPN #287 retorted, Sorry I don't have a cute mousey voice. LPN #287's combativeness impeded the survey process, so the interview was concluded. Therefore, further investigation could not be completed. Review of facility policy, Medication Administration Schedule, dated July 2016, revealed early was a routine schedule of 6:00 A.M. to 10:00 A.M., noon was 11:00 A.M. to 2:00 P.M., PM was 3:00 P.M. to 7:00 P.M. and HS was 8:00 P.M. to 12:00 A.M. Review of the undated facility policy, Medication Administration - General Guidelines revealed medications were administered within 60 minutes of scheduled times. This deficiency represents non-compliance investigated under Master Complaint Number OH00161540 and Complaint Number OH00161212.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365672	A. Building B. Wing	01/28/2025

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Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41526

Based on interview, record review, and facility policy review, the facility failed to administer medications as ordered by the prescriber. This affected three residents (#1, #27 and #86) out of three residents reviewed for medication administration and had the potential to affect all 106 residents residing in the facility.

Findings include:

1. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, encephalopathy, epilepsy, tracheostomy status, gastrostomy status, persistent vegetative state and multiple sclerosis.

Review of Resident #1's medication administration record (MAR) from January 2025 indicated an order dated 11/08/24 for valproic acid 250 milligrams (mg) per five milliliters (ml), give ten ml enterally four times daily for seizures at early (6:00 A.M. to 10:00 A.M.), noon (11:00 A.M. to 2:00 P.M.), PM (3:00 P.M. to 7:00 P.M.) and HS (8:00 P.M. to 12:00 A.M.).

Review of Resident #1's MAR from January 2024 and medication administration audit report (MAAR) from 01/13/25 to 01/19/25 for valproic acid revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose and PM dose were not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M. and the PM dose was administered at the same time as the noon dose at 3:20 P.M.

Review of Resident #1's MAR from January 2025 indicated an order dated 11/08/24 for guaifenesin 400 mg enterally four times daily for secretions at early, noon, PM and HS.

Review of Resident #1's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for guaifenesin revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose and PM dose were not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M., and the PM dose was administered at the same time as the noon dose at 3:20 P.M.

Review of Resident #1's MAR from January 2025 indicated an order dated 12/04/24 for baclofen 20 mg enterally four times daily for muscle spasms at early, noon, PM and HS.

Review of Resident #1's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for baclofen revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose and PM dose were not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M. and the PM dose was administered at the same time as the noon dose at 3:20 P.M.

Review of Resident #1's MAR from January 2025 indicated an order dated 11/08/24 for gabapentin 600 mg enterally three times daily for neuropathy at early, noon, and HS.

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NAME OF PROVIDER OR SUPPLIER Autumn Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2565 Niles Vienna Rd Niles, OH 44446	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for gabapentin revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose was not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M. Interview on 01/23/25 at 8:14 A.M. with Director of Nursing (DON) verified the above medication administration findings. 2. Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, chronic respiratory failure, quadriplegia, tracheostomy status, gastrostomy status, epilepsy, encephalopathy, persistent vegetative state and lumbar intervertebral disc degeneration. Review of Resident #27's MAR from January 2025 indicated an order dated 12/23/24 for pregabalin 150 mg enterally three times daily for lumbar intervertebral disc degeneration at early, noon and HS. Review of Resident #27's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for pregabalin revealed on 01/14/25, the noon dose was not administered until 5:45 P.M. On 01/15/25, the noon dose was not administered until 4:03 P.M. On 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/17/25, the noon dose was not administered as ordered. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:15 P.M. Review of Resident #27's MAR from January 2025 indicated an order dated 12/23/24 for valproic acid 500 mg per ten ml and give 15 ml enterally three times daily for epilepsy at early, noon and HS. Review of Resident #27's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for valproic acid revealed on 01/14/25, the noon dose was not administered until 5:45 P.M. On 01/15/25, the noon dose was not administered until 4:04 P.M. On 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/17/25, the noon dose was not administered as ordered. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:15 P.M. Interview on 01/23/25 at 8:14 A.M. with DON verified the above medication administration findings. 3. Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, chronic respiratory failure, quadriplegia, tracheostomy status, gastrostomy status, epilepsy, encephalopathy, persistent vegetative state and lumbar intervertebral disc degeneration. Interview on 01/22/25 at 4:49 P.M. with power of attorney (POA) for Resident #27 complained the facility had just informed that Resident #27 was started on Synthroid for hypothyroidism, but over one month ago, they had already received notification the medication was supposedly started. Additional medical record review for Resident #27 revealed a diagnosis of hypothyroidism was added on 01/22/25. Review of the laboratory testing for TSH (thyroid-stimulating hormone) for Resident #27 was completed on 12/05/24 with an abnormally high result of 19.6 with a normal range value expected between 0.34 to 5.5. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2565 Niles Vienna Rd Niles, OH 44446	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse practitioner progress note dated 12/10/24 indicated Resident #27 was examined for follow-up. Labs indicated an elevated TSH level. Add Synthroid 25 micrograms (mcg) daily and recheck TSH in four weeks. POA for Resident #27 made aware. Review of the plan of care initiated 12/11/24 revealed Resident #27 had hypothyroidism and received medication for management. Interventions included administering medication as ordered and monitoring laboratory values. Review of Resident #27's physician orders for December 2024 revealed on 12/04/24 a repeat TSH level was to be completed in three months. There was no order for the medication Synthroid. Review of nurse practitioner progress notes dated 12/16/24, 12/27/24 and 01/03/25 indicated Resident #27's MAR and labs were reviewed but there was no documentation related to Resident #27's hypothyroidism or Synthroid use. Review of nurse practitioner progress note dated 01/22/25 revealed Resident #27 was examined for follow-up. Resident #27 had hypothyroidism with intervention of Synthroid 25 mcg and recheck TSH level in four weeks. Review of Resident #27's physician orders from December 2024 to January 2025 revealed the medication Synthroid was not initiated until 01/22/25 for 25 mcg enterally every morning for hypothyroidism. Review of Resident #27's MAR from December 2024 to January 2025 revealed Synthroid was not ordered or administered until 01/22/25. Interview on 01/23/25 at 7:54 A.M. with DON and Administrator verified the above findings and confirmed when Resident #27's medical record was audited by the facility on 01/22/25, an error was discovered. Resident #27's medication, Synthroid, was not initiated in December 2024 as directed by the nurse practitioner. 4. Review of the medical record for Resident #86 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type two with neuropathy, chronic respiratory failure, tracheostomy status, disturbances of salivary secretion, gastrostomy status, essential primary hypertension and depression. Interview on 01/21/25 at 8:05 A.M. with Resident #86 complained about a recent confrontation with Licensed Practical Nurse (LPN) #287 who when questioned about her medication schedule, responded rudely and thereafter retaliated by ignoring Resident #86, giving all other residents medications first before administering hers, making them late. Review of Resident #86's MAR from January 2025 indicated an order dated 01/15/25 for midodrine five mg enterally three times daily for hypotension at early, noon and HS. Review of Resident #86's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for midodrine revealed on 01/15/25, the noon dose was not administered until 5:20 P.M. On 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:14 P.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2565 Niles Vienna Rd Niles, OH 44446	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #86's MAR from January 2025 indicated an order dated 01/15/25 for Vistaril 50 mg enterally three times daily for anxiety at early, noon and HS. Review of Resident #86's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for Vistaril revealed on 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:14 P.M. Review of Resident #86's MAR from January 2025 indicated an order dated 01/15/25 for gabapentin 300 mg enterally three times daily for difficulty in walking at early, noon and HS. Review of Resident #86's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for gabapentin revealed on 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:14 P.M. Interview on 01/23/25 at 8:14 A.M. with DON verified the above medication administration findings. Review of the facility policy, Medication Administration Schedule, dated July 2016 revealed early was a routine schedule of 6:00 A.M. to 10:00 A.M., noon was 11:00 A.M. to 2:00 P.M., PM was 3:00 P.M. to 7:00 P. M. and HS was 8:00 P.M. to 12:00 A.M Review of the undated facility policy, Medication Administration - General Guidelines revealed medications were administered within 60 minutes of scheduled time and the individual who administered the medication dose recorded the administration on the electronic MAR directly after the medication was given. At the end of each medication pass, the person administering medications reviewed the electronic MAR to ensure necessary doses were administered and documented. In no case should an individual who administered medications report off-duty without first recording the administration of any medications. This deficiency represents non-compliance investigated under Master Complaint Number OH00161540.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39973

Based on observation, interview, record review, review of video recordings provided by Resident #27's fiancee/power of attorney (POA), review of center for Medicare and Medicaid Services (CMS) and Health and Human Services (HHS) memorandum QSO-24-08-NH and facility policy review, the facility did not ensure proper infection control measures were followed including during wound care and donning enhanced barriers precautions (EBP) during care for Resident #27. This affected one resident (#27) out of three residents reviewed for wound care and EBP. This had the potential to affect seven additional residents identified by the facility with wounds (#22, #62, #70, #80, #88, #102, and #109) and 27 residents (#1, #5, #9, #10, #16, #18, #20, #23, #39, #42, #48, #52, #53, #67, #69, #78, #80, #81, #84, #86, #87, #93, #97, #100, #101, #102, and #107) identified by the facility on EBP. The facility census was 106.

Findings include:

Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, quadriplegia, and persistent vegetative state.

Review of the December 2024 and January 2025 physician's orders revealed Resident #27 had the following orders: suction as needed, dated 12/04/24; tracheostomy care every shift and as needed, dated 12/04/24; Jevity (enteral tube feeding) 1.5 60 milliliters (ml) per hour continuous per peg tube, dated 12/05/24; cleanse percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube that is surgically placed into the stomach through the abdomen) site with soap and water daily, dated 12/05/24; assess tracheostomy stoma every shift and as needed, dated 12/08/24; cleanse with normal saline, apply Medi honey (honey based product for wound care) and calcium alginate (water soluble wound care product to manage moderate to heavy drainage) and cover with foam dressing every shift, dated 12/19/24; cleanse sacrum with normal saline and apply calcium alginate and cover with foam dressing, dated 01/02/25. The physician orders revealed EBP due to tracheostomy and PEG tube were not ordered until 01/22/25 after brought to facility attention that they did not have an order.

Review of the care plan dated 12/05/24 revealed Resident #27 was dependent on staff with activities of daily living (ADL) due to anoxic brain damage and persistent vegetative state. Interventions included turning and repositioning every two hours, staff to provide incontinence care with routine rounds, and staff to provide all care as he was dependent and did not participate in any aspect of his ADL care. There was nothing in the care plan regarding EBP during ADL care.

Review of the care plan dated 12/05/24 revealed Resident #27 was at risk for impaired skin integrity secondary to bowel and bladder incontinence and impaired mobility. He required total staff dependence for all his care needs. Interventions included elevating heels off mattress, inspecting skin during routine daily care, lift sheet on chair/bed for positioning, lotion to skin as needed, incontinence care after each incontinent episode, pressure reduction mattress to bed, and treatments as ordered. There was nothing in the care plan regarding EBP during his wound care.

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Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 12/05/24 revealed Resident #27 had an alteration in respiratory function related to respiratory failure. He had a tracheostomy with continuous oxygen. He was unable to clear secretions himself and required suctioning. Interventions included checking oxygen saturation levels every shift, elevating the head of the bed, evaluating for shortness of breath, and respiratory treatments as needed. There was nothing in the care plan regarding EBP. Review of the undated video recording provided by Resident #27's fiancee/ POA revealed Licensed Practical Nurse (LPN) #214 and Certified Nursing Assistant (CNA) #201 were in Resident #27's room providing the following care with a mask, gloves and without a gown: They rolled Resident #27 towards LPN #214 as Resident #27 was in direct contact with both their uniform tops. LPN #214 moved his catheter bag and oxygen support that was hooked to his tracheostomy. CNA #201 then proceeded to provide incontinence care and provide a full bed linen change. They then provided to roll Resident #27 towards CNA #201 as LPN #201 completed his incontinence care and changing of linen. During the care, Resident #27 was completely dependent on staff as he was in a persistent vegetative state. It was visible in the video that Resident #27 was connected to enteral feeding per PEGtube and had a tracheostomy. Review of the video recording dated 01/14/25 at 2:22 P.M. and provided by Resident #27's fiancee/POA revealed Wound Nurse/LPN #209 and LPN #287 were in Resident #27's room observed rolling Resident #27 towards the door as he was dependent on staff with bed mobility. Wound Nurse/LPN #209 and LPN #287 both were only wearing gloves but no other EBP including gowns. Wound Nurse/LPN #209 then proceeded to remove the dressing to his sacrum area. She proceeded to cleanse the area and apply a new dressing without performing hand hygiene after she removed the old dressing. Interview on 01/21/25 at 10:08 A.M. and 01/22/25 at 4:49 P.M. with Resident #27's fiancee/POA verified she took the video on 01/14/25 at 2:22 P.M. and acknowledged that staff were not wearing gowns when providing care for Resident #27 as well as Wound Nurse/LPN #209 changed his dressing without washing her hands throughout the process. She revealed the other video she did not have the exact date of when the video was taken but within the last two weeks and acknowledged that staff were not wearing gowns. She revealed she never witnessed staff wearing gowns in any of the videos or when she was present at the facility as she did not know that was a requirement. She revealed today, 01/21/25 when she observed everyone entering his room with a gown that she thought he must have been diagnosed with COVID-19 but instead she found out that they were wearing the gowns because a surveyor was in the building which she did not feel was right. Observation with the Director of Nursing (DON) on 01/21/24 at 2:22 P.M. and 2:44 P.M. of video recording dated 01/14/24 at 2:22 P.M. revealed Wound Nurse/LPN #209 and LPN #287 were rolling Resident #27 over and Wound Nurse/LPN #209 performed wound care. She verified that both Wound Nurse/LPN #209 and LPN #287 were not wearing gowns as indicated for EBP since Resident #27 had a pressure ulcer, tracheostomy, and PEG tube site. The DON also verified Wound Nurse/LPN #209 had performed wound care without performing hand hygiene after she had removed the old dressing on Resident #27's sacrum. The DON also observed the undated video that showed LPN #214 and CNA #201 in Resident #27's room completing direct care including turning Resident #27 and providing incontinence care without a gown in place. The DON verified Resident #27 was to be on EBP, and they should have utilized a gown during his care. (continued on next page)

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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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/21/25 at 3:20 P.M. with Wound Nurse/LPN #209 observed the video recording dated 01/14/24 at 2:22 P.M. and verified that she was not wearing EBP when she changed Resident #27's wound dressing including a gown. She also verified she had removed the old dressing to his sacrum area, cleansed the area, and applied a new treatment without performing hand hygiene. She verified she should have washed her hands after removing the old dressing. Interview on 01/23/25 at 8:47 A.M. with CNA #201 revealed he most likely was not wearing a gown during the undated video. He revealed he never wore a gown when he entered Resident #27's room as he did not know he needed to. He revealed he had seen nurses several times in Resident #27's room, and that they never had a gown on, so he assumed it was not required. He revealed he was not sure what EBP were and/or which residents required this precaution. Interview on 01/23/25 at 10:20 A.M. with LPN #287 stated if it was on the video that she was not wearing a gown for Resident #27's care, she was most likely not wearing one. She revealed she never received detailed training on what EBP were. Review of the facility policy labeled, Enhanced Barrier Precautions, dated March 2024, revealed the purpose of the policy was to reduce the transmission of multi resistant organism (MDRO) when high contact resident care activities for residents with known to be colonized or infected with MDRO as well as those at increased risk to acquire MDRO. The policy revealed residents with the following triggers would receive EBP including residents with wounds, and/or indwelling medical devices. Indwelling medical devices include feeding tubes and tracheostomies. The policy revealed high contact resident care activities requiring gown and glove use included providing hygiene, changing briefs, assisting with toileting, and device care. Review of the CMS and HHS memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed EBP are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. Review of the undated facility policy, Pressure Ulcer Prevention Intervention revealed cleanse with normal saline, portable water or with surfactants that have antimicrobial agents for suspected infection. There were no step-by-step guidelines in regard to during wound care when hands were to be washed. Review of the undated facility procedure labeled, Dressing Change- Clean revealed the purpose was to provide guidelines for proper application of dressing. The procedure revealed the nurse was to wash and dry her hands thoroughly before starting a dressing change and apply gloves. The nurse was to remove the dressing and discard and then wash her hands. This deficiency represents non-compliance investigated under Master Complaint Number OH00161540 and Focused Infection Control Survey.