STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365693	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Hills Retirement Village	6210 Cleves Warsaw Pike Cincinnati, OH 45233

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, interview, review of the facility's Self-Reported Incidents (SRI), and policy review, the facility failed to timely report an allegation of abuse to the state agency. This affected one resident (#29) out of one resident reviewed for abuse. The facility census was 100. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included unspecified dementia, delirium due to known physiological condition, depression, anxiety disorder, gout, type two diabetes mellitus with diabetic polyneuropathy, mild protein-calorie malnutrition, congestive heart failure, hyperlipidemia, neuromuscular dysfunction of bladder, dysphagia, peripheral vascular disease, arthropathy, rheumatoid arthritis, other giant cell arteritis, and disorder of thyroid. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/29/24, revealed Resident #29 had severely impaired cognition. Resident #29 was assessed to require setup assistance for eating and oral hygiene, supervision for bed mobility and transfer, partial to moderate assistance for toileting, bathing, upper body dressing, and personal hygiene, and substantial to maximal assistance for lower body dressing. Review of the SRIs submitted by the facility revealed none had been submitted between 04/14/24 and 07/16/24. Review of the progress note dated 06/16/24 revealed Resident #29 was crying and reported she had been beat up by some guys and she could barely move due to the back pain. The note indicated Resident #29 was assessed and the nurse practitioner was notified with new orders for a urinalysis and blood work. Interview on 10/24/24 at 9:45 A.M. with the Administrator revealed she was not aware of the allegation involving Resident #29. The Administrator stated the facility had started an investigation and filed an SRI regarding the allegation of abuse from Resident #29. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Abuse, Neglect, Misappropriation and Exploitation, reviewed 10/16/19, revealed alleged violations would be reported to the Administrator and state agency immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, interview, review of Self-Reported Incidents, and policy review, the facility failed to timely investigate an allegation of abuse. This affected one resident (#29) out of one resident reviewed for abuse. The facility census was 100. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included unspecified dementia, delirium due to known physiological condition, depression, anxiety disorder, gout, type two diabetes mellitus with diabetic polyneuropathy, mild protein-calorie malnutrition, congestive heart failure, hyperlipidemia, neuromuscular dysfunction of bladder, dysphagia, peripheral vascular disease, arthropathy, rheumatoid arthritis, other giant cell arteritis, and disorder of thyroid. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/29/24, revealed Resident #29 had severely impaired cognition. Resident #29 was assessed to require setup assistance for eating, and oral hygiene, supervision for bed mobility, and transfer, partial to moderate assistance for toileting, bathing, upper body dressing, and personal hygiene, and substantial to maximal assistance for lower body dressing. Review of the progress note dated 06/16/24 revealed Resident #29 was crying and reported she had been beat up by some guys and she could barely move due to the back pain. The note indicated Resident #29 was assessed and the nurse practitioner was notified with new orders for a urinalysis and blood work. Review of the facility's Self-Reported Incidents (SRIs) revealed an investigation was not completed. Interview on 10/24/24 at 9:45 A.M. with the Administrator revealed she was not aware of the allegation involving Resident #29, and that the facility had started an investigation. Review of the policy titled, Abuse, Neglect, Misappropriation and Exploitation, reviewed 10/16/19, revealed an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review and staff interview, the facility failed to ensure care plans reflected the resident's current status. This affected one resident (#91) of five residents reviewed for care planning. The facility census was 100. Findings include: Review of the medical record for Resident #91 revealed an admitted [DATE] with diagnoses of cerebral infarction with hemiplegia and hemiparesis (unspecified side), dementia, diabetes mellitus type II and gastrostomy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 had moderate cognitive impairment and was always continent of bowel and had an indwelling Foley catheter. The resident required set up assistance with eating, supervision with oral and personal hygiene, bed mobility, and transfers, moderate assistance for dressing, and was dependent for toileting and bathing. Review of Resident #91's progress noted dated 07/18/24 at 11:14 A.M. revealed Resident #91 was observed on the floor outside of his room. The State tested Nursing Assistant (STNA) notified the nurse of the fall. Review of Resident #91's fall risk measurement dated 07/18/24 at 11:17 A.M. noted Resident #91 had no history of falls in the past three months and was at risk for falls. Review of Resident #91's plan of care initiated 06/26/26 and completed 09/26/24 revealed Resident #91 had not been identified as a risk for falls. Review of Resident #91's care conference summary dated 09/09/24 made no reference to the fall experienced by Resident #91 on 07/18/24. Interview on 10/24/24 at 12:14 P.M. with the Director of Nursing verified Resident #91's plan of care had not been updated to identify falls as a risk. Review of the policy for, Comprehensive Care Plans, undated, revealed the purpose of the policy was to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The policy stated, the comprehensive care plan will be prepared by an interdisciplinary team and will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, staff interview, and policy review, the facility failed to ensure fall interventions were in place at the time of a fall. This affected one (Resident #98) of four residents reviewed for falls. The facility census was 100. Findings include: Review of the medical record of Resident #98 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, left hip fracture, anxiety, depression, and cognitive communication deficit. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident required partial/moderate assistance with toileting, bed mobility, and transfers. Review of the fall risk assessment dated [DATE] revealed the resident was a moderate risk for falls. Review of the baseline care plan dated 07/23/24 and updated 08/05/24 revealed the resident was at risk for falls and was to have bilateral safety mats and bring to the common area when yelling in room. Review of the incident note dated 08/03/24 at 1:15 A.M. revealed the State tested Nursing Assistant (STNA) reported to the nurse Resident #98 rolled out of bed onto the floor. The bed was in the lowest position. No injuries were noted. Review of the fall investigation dated 08/03/24 revealed a new intervention for fall mats at the bedside when the resident is in bed. Review of the fall investigation dated 08/05/24 at 7:50 P.M. revealed on 08/05/24 at 7:20 P.M., a family member alerted the nurse Resident #98 was on the floor, hollering for help. No injuries were noted. The resident was assisted onto the bed then to the wheelchair and brought to the common area for observation as the resident was restless. Review of the fall investigation dated 08/05/24 revealed the resident was found on the floor, laying on her abdomen and screaming. A new intervention was started to bring the resident to the common area when yelling in the room. Review of the occurrence note dated 08/08/24 at 10:41 A.M. revealed on 08/08/24 at 8:40 A.M., Resident #98 was observed on the floor and it appeared she had rolled out of the bed. The resident was observed on the right side of the bed, lying face down, between the bed and the nightstand, with the flat sheet beneath her and her legs extended outward. The resident complained of 10 out of 10 pain in her lower back and coccyx area. Corrective actions were to send the resident to the hospital for evaluation and for a safety mat to be placed at the right side of the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the fall investigation dated 08/08/24 revealed Housekeeper #220 alerted staff that Resident #98 was found lying on the floor face down with the flat sheet below the resident. Staff statements indicated it appeared the resident had rolled out of bed. Staff statements from State tested Nursing Assistant (STNA) #170 and Housekeeper #220 indicated Resident #98 was found laying on the floor/ground. The resident complained of lower back and coccyx area pain and an intervention of a safety mat to the right side of the bed was implemented. Further review revealed, upon IDT (interdisciplinary team) review, the intervention was changed to provide signage in the room to call for assistance with transfers. Interview on 10/23/24 at 4:49 P.M., the Director of Nursing (DON) stated a fall mat is a thicker mat and a safety mat has a beveled edge. The DON verified both would not be used at the same time. Interview on 10/24/24 at 11:38 A.M., Housekeeper #220 confirmed he found Resident #98 on the floor and alerted the nursing staff immediately. Housekeeper #220 stated he did not recall seeing fall mats on the floor next to Resident #98's bed and stated Resident #98 was observed directly on the floor. Interview on 10/24/24 at 1:12 P.M., the DON stated, following the fall on 08/08/24, the intervention was changed from a fall mat to the right side of the bed, to bringing resident to the common area when yelling because the resident was already supposed to have a fall mats to both sides of the bed. Interview on 10/24/24 at 1:31 P.M., Licensed Practical Nurse (LPN) #155 stated, at the time of the fall, Resident #98 had a fall mat present on the left side of the bed, but not the right side of the bed. LPN #155 stated she ordered a fall mat to the right side of the bed since the resident fell out of the right side of the bed and no fall mat was present. LPN #155 stated a fall mat and safety mat was the same thing. Review of the facility policy titled, Fall Management, dated 01/2021, revealed each resident would receive the care and services in accordance with the level of risk to minimize the likelihood of falls. The facility would provide interventions that addressed unique risk factors measured by the risk assessment tool.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, staff interview, and review of facility policy, the facility failed to ensure antipsychotic medications were used only when necessary and appropriate. This affected three residents (#22, #29 and #75) of five residents reviewed for unnecessary medications. The facility census was 100. Findings include: 1. Review of the medical record revealed Resident #22 was admitted on [DATE] with diagnoses of vascular dementia, protein-calorie malnutrition, agitation and restlessness and unspecified psychosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had severe cognitive impairment and was frequently incontinent of bowel and bladder. The resident required set up assistance with eating, maximal assistance with oral hygiene, toileting, bathing, dressing, and transfers and moderate assistance with personal hygiene and bed mobility. Review of Resident #22's physician orders revealed Resident #22 had an order dated 10/18/24 for Seroquel Oral Tablet 25 Milligrams (mg) (Quetiapine Fumarate), give 0.5 tablet by mouth two times a day related to vascular dementia for 7 Days. Review of Resident #22's physician orders revealed Resident #22 had a prior order dated 08/02/24 for Seroquel Oral Tablet 25 mg (Quetiapine Fumarate), give 3 tablets by mouth at bedtime related to vascular dementia. This physician order was discontinued on 10/18/24. Review of Resident #22's physician order for Seroquel oral tablet (Quetiapine Fumarate) revealed a pharmacy Black Box Warning (BBW) increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Interview on 10/24/24 at 10:28 A.M. with the Director of Nursing verified that Seroquel (Quetiapine Fumarate) was not indicated for residents with a diagnosis of vascular dementia. 2. Review of the medical record revealed Resident #29 was admitted on [DATE] with diagnoses of diabetes mellitus type II, anxiety, mild protein-calorie malnutrition and rheumatoid arthritis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 has severe cognitive impairment and is frequently incontinent of bowel and bladder. The resident requires set up assistance with eating and oral hygiene, moderate assistance with toileting bathing, personal hygiene, and transfers, maximal assistance with dressing, and supervision with bed mobility. Review of Resident #29's admitting history and physical dated 02/27/24 revealed Resident #29 had a history of dementia and depression. The history and physical revealed no mention of Resident #29 having a diagnosis of delirium. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's nurse practitioner note dated 02/28/24 revealed Resident #29 had diagnoses of non-rheumatic aortic valve stenosis, congestive heart failure, coronary artery disease, dementia, acute respiratory failure with hypoxia, diabetes mellitus type II with polyneuropathy and acute delirium. Review of Resident #29's nurse practitioner note dated 03/15/24 revealed Resident #29 had newly admitted to long-term care (LTC), having intermittent bouts of exit seeking and agitation. Recent labs/urinalysis non-acute. Is redirectable most times, though can become quite agitated per the family. Restarted on Seroquel at admission to LTC. Review of Resident #29's physician orders revealed Resident #29 had an order dated 03/10/24 for Seroquel Oral Tablet 50 mg (Quetiapine Fumarate), give 1 tablet by mouth at bedtime related to delirium. Review of Resident #29's physician order for Seroquel oral tablet 50 mg (Quetiapine Fumarate) revealed a pharmacy Black Box Warning (BBW) which stated increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Interview on 10/24/24 at 10:28 A.M. with the Director of Nursing verified that Seroquel (Quetiapine Fumarate) was not indicated for residents with a diagnosis of delirium. 3. Review of the medical record revealed Resident #75 was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia, depression and repeated falls. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #75 had severe cognitive impairment and was frequently incontinent of bowel and occasionally incontinent of bladder. The resident required set up assistance for eating, moderate assistance for oral and personal hygiene, toileting, dressing, and bed mobility, was dependent for bathing, and required maximal assistance for transfers. Review of Resident #75's physician orders revealed Resident #75 had an order dated 10/03/24 for Quetiapine Fumarate Oral Tablet (Quetiapine Fumarate), give 12.5 mg by mouth one time a day related to dementia and give 25 mg by mouth at bedtime related to dementia. Review of Resident #75's pharmacy report dated 09/26/24 revealed Resident #75 was receiving Quetiapine 37.5 mg daily (total). Interview on 10/24/24 at 10:28 A.M. with the Director of Nursing verified that Seroquel (Quetiapine Fumarate) was not indicated for residents with a diagnosis of Alzheimer's dementia. Review of the 2021 [NAME] Pocket Drug Guide for Nurses revealed Seroquel (Quetiapine Fumarate) was classified as an antipsychotic and has a Black Box Warning (BBW) stating do not use in elderly patients with dementia-related psychosis; increased risk of cardio-vascular (CV) mortality, including stroke, myocardial infarction (MI). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 2021 [NAME] Pocket Drug Guide for Nurses revealed Seroquel (Quetiapine Fumarate) had indications for treatment of schizophrenia, manic episodes of bipolar 1 disorder, treatment of depressive episodes of bipolar 1 disorder and treatment of major depressive disorder. Review of the facility's psychotropic medication use policy, undated, revealed the facility will comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services (CMS), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42731 Based on observation and staff interview, the facility failed to ensure vents in the kitchen were maintained in a clean and sanitary manner. This had the potential to affect all 100 residents in the facility. The facility census was 100. Findings include: Observation on 10/21/24 at 8:55 A.M. revealed a duct in the center of the kitchen food preparation and service area with two vents on each side, fully coated in a dark gray and fuzzy substance. Interview at the same time with Dietary Director (DD) #65 verified the four vents were coated in a dark gray fuzzy substance. DD #65 stated the vents were cleaned monthly and needed to be cleaned again. Observation on 10/23/24 at 11:55 A.M. revealed the duct in the center of the kitchen food preparation and service area had an additional five vents that were coated in varying levels of a dark gray and fuzzy substance. Interview at the same time with DD #65 verified all vents were coated in varying levels of a dark gray and fuzzy substance. DD #65 stated the vents had been cleaned within the last month but needed to be cleaned again. Interview on 10/24/24 at approximately 3:30 P.M., the Administrator stated the facility did not have a policy on kitchen sanitation, however the kitchen followed a routine cleaning schedule of all areas of the kitchen.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review and interview, the facility failed to ensure medical records were complete and accurate related to a change in condition. This affected one resident (#26) out of 20 residents reviewed for resident records. The facility census was 100. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type two diabetes mellitus with diabetic neuropathy, nondisplaced fracture of medial condyle of left femur initial encounter for closed fracture, multiple fractures of pelvis without disruption of pelvic ring initial encounter for closed fracture, age-related osteoporosis without current pathological fracture, chronic obstructive pulmonary disease, generalized anxiety disorder, major depressive disorder, edema, benign prostatic hyperplasia with lower urinary tract symptoms, primary insomnia, hyperlipidemia, and unspecified protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/02/24, revealed Resident #26 was cognitively intact. Resident #26 was assessed to require setup assistance for eating, substantial to maximal assistance for upper body dressing and personal hygiene, and was dependent for oral hygiene, toileting, bathing, lower body dressing, and bed mobility. Review of the progress note dated 08/11/24 revealed Resident #26 was having pain and was offered another x-ray of his leg, which he was agreeable to. Review of the progress notes from 08/11/24 to 08/12/24 revealed no documentation related to Resident #26 being transferred to the emergency room . Review of hospital paperwork dated 08/12/24 revealed Resident #26 was evaluated in the emergency room for a femur fracture. Review of the progress notes from 08/12/24 to 08/14/24 revealed no documentation related to Resident #26 returning from the emergency room , or of any further treatment recommendations for Resident #26's fracture. Interview on 10/24/24 at 1:09 P.M. with the Director of Nursing (DON) verified no documentation related to Resident #26's transfer to the emergency room , or of any treatment recommendations or follow-up related to the fracture.

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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** 50007 Based on observation, record review, and interview, the facility failed to ensure Foley catheter bags were managed in a manner to prevent the potential spread of infection. This affected one resident (#32) of two residents reviewed for Foley catheters. The facility census was 100. Findings include: Medical record review of Resident #32 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, chronic atrial fibrillation, heart failure, chronic pancreatitis, neuromuscular dysfunction of bladder, major depressive disorder, personal history of urinary tract infections, general anxiety disorder, sepsis, dysphagia, vascular dementia, and urinary incontinence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had short term memory problems and exhibited no behaviors. Resident #32 required set up assistance from staff for eating, oral hygiene, and personal hygiene. Substantial or maximal assistance was required for toileting, bathing, and lower body dressing. Resident #32 was dependent on staff for putting on and removing footwear and she received assistance of one to two staff for transfers. Review of physicians orders for Resident #32 revealed the resident had an indwelling Foley catheter. Physicians orders included position catheter bag and tubing below the level of the bladder and away from entrance room door, check tubing for kinks each shift, enhanced barrier precautions per Medical Doctor (MD) order, and monitor and document intake and output as per facility policy. Review of the care plan revealed Resident #32 had an indwelling Foley catheter related to neuromuscular dysfunction of the bladder. Observation on 10/22/24 at 8:53 A.M. of Resident #32 revealed the Foley catheter bag on the floor at the foot of the left side of the resident's bed. This was confirmed by Licensed Practical Nurse (LPN) #149 on 10/22/24 at 9:01 A.M. who stated the catheter bag was supposed to be on the right side of the bed in the privacy cover. Interview with the Administrator on 10/24/24 at 9:59 A.M. revealed the facility does not have a policy for Foley catheter care. She stated the facility follows standard procedures for catheter care. Interview with the Director of Nursing (DON) on 10/24/24 at 1:12 P.M. confirmed the facility does not have a policy for Foley catheter care. She stated the standard procedures for a Foley catheter bag are that it should not be placed on the floor and it should be placed in a privacy bag on the side of the bed away from the door.