

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER St Leonard Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 8100 Cloy Road Centerville, OH 45458	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</p> <p>Based on record review and staff interviews, the facility failed to notify family/Power of Attorney (POA) of an appointment scheduled for the resident and the facility sent the resident, who has Alzheimer's disease, to the appointment alone. This affected one (Resident #110) of three residents reviewed for appointments. The facility census was 123.</p> <p>Findings include:</p> <p>Record review revealed Resident #110 was admitted to the facility on [DATE]. Diagnoses included vascular dementia with psychotic disturbance and Alzheimer's disease with early onset. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 had severe cognition impairment. Resident #110 required supervision assistance from with ambulation. Resident #110 required substantial assistance from staff with toileting and transfers.</p> <p>Review of the hospital's Discharge Instructions dated 07/22/24 revealed an order stating: Follow-up with spine surgery in the clinic. Call to make an appointment. Resident #110 needs to follow with Neurosurgery, Spine Surgery for spine surgery follow up with Physician #500 and contact information including physical address and telephone number.</p> <p>Review of the physician orders and progress notes revealed there was no order or documentation for an appointment on 08/23/24.</p> <p>Review of the Order Listing Report - Appointments, dated 08/22/24 through 10/31/24 revealed no appointments for Resident #110.</p> <p>Review of the Facility Appointment Calendar dated 08/23/24 revealed an appointment at 11:45 A.M. with Physician #500, with a pick-up time of 10:45 A.M.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/22/24 at 12:52 A.M. with Administrative Assistant (AA) #330 stated when there was a new admission with an appointment already scheduled, the nurses will put an order in the system, complete a transportation paper and tell the nurse manager. The paper comes to AA #330 to schedule transportation. If the resident has a certain insurance or Medicare, then that will depend on what type of transportation they take. The facility has their own transportation vans and drivers so 90% of the appointments were scheduled to go through the facilities transportation. If the resident uses the facilities transportation, the form was forwarded to the transportation manager to schedule transport. If the appointment conflicts with another transport, they will call and get the appointment rescheduled for when transportation is available. AA #330 confirmed she did not call the family or POA for Resident #110 to inform her of the appointment and transportation on 08/23/24.</p> <p>Interview on 10/22/24 at 3:08 P.M. with Transportation Staff #560 revealed scheduling puts order into system for appointment and transportation pick up and appointment time. An appointment schedule was also placed at the nurse's station at the end of each day. Transportation Staff #560 confirmed she did not call the family or POA for Resident #110 to inform her of the appointment and transportation on 08/23/24. Transportation Staff #560 confirmed Resident #110 was taken to her appointment on 08/23/24 and left in the waiting area alone. Transportation Staff #560 confirmed Resident #110 does have dementia and should not have been left alone, but Resident #110 was not marked as needing an escort to the appointment.</p> <p>Interview on 10/22/24 at 3:38 P.M. with the Director of Nursing (DON) confirmed Resident #110 admitted on [DATE] with an order on her discharge paperwork to schedule an appointment with Physician #500 as soon as possible. The DON confirmed the facility made the appointment and should have notified the POA/family. The DON stated there was no policy for scheduling of appointments or notification of appointments.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157702.</p>		