Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER: Wood Glen Alzheimer's Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 3800 Summit Glen Drive Dayton, OH 45449	

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on observation, staff interview, medical record review, and policy review, the facility failed to administer enteral feeding (tube feeding) as ordered. This affected one (#137) out of the three residents reviewed for enteral feedings. The facility census was 140. Findings include: Review of the medical record for Resident #137 revealed an admitted [DATE] with medical diagnoses of dementia, chronic kidney disease stage III, hypertensive heart disease, dysphagia. Review of the medical record for Resident #137 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #137 had severe cognitive impairment and required substantial staff assistance for eating, dressing bed mobility and transfers. Review of the MDS revealed Resident #137 received 51% or more proportion of total calories through parenteral or tube feeding. Review of the medical record for Resident #137 revealed a physician order dated 01/28/24 for enteral feed order as needed for tube patency, check for residual prior to each intermittent feeding: if greater than or equal to 100 cubic centimeters (CC), hold tube feeding and check residual again in two hours and notify physician and/or nurse practitioner when appropriate. Review of the medical record revealed an order dated 04/09/24 for nothing by mouth (NPO) status and an order dated 06/23/24 for Jevity 1.5, 55 milliliter (ml) per hour for 22 hours via pump, on at 10 P.M., off when total volume of 1,210 ml infused. Review of the medical record for Resident #137 revealed a nurse progress note dated 07/10/24 at 11:58 A. M. which stated the tube feeding was placed on temporary hold at approximately 10:15 A.M. due to approximately 50 ml of residual volume. The note stated Resident #137 did not have any discomfort, abdomen was soft and round, placement checked, no distension noted, and not signs of distress noted. The note stated the nurse practitioner was notified, ordered to follow up within two hours and notified to continue the tube feeding. Observation on 07/10/24 at 8:40 A.M. of Resident #137 revealed tube feeding was being administered via pump at 55 ml per hour. Observation on 07/10/28 at 11:40 A.M. of Resident #137 revealed the tube feeding pump was turned off and Resident #137 was not receiving any tube feeding. (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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/10/24 at 11:45 A.M. with Licensed Practical Nurse (LPN) #217 stated she had checked Resident #137's tube feeding residual at 10:15 A.M. and it was between 50-60 ml so she turned off the tube feeding for a little while. LPN #217 stated Resident #137 was not in any distress or showing any signs or symptoms of aspiration. LPN #217 stated the amount of tube feeding that had been infused was about 900 ml. Review of the facility policy titled, Enteral General Nutritional (tube feeding) Guidelines, stated continuous nutritional meals will utilize an electronic programmable pump to deliver the required amount of solution over time unless the physician and/or RD determined that the specific needs for a resident would require gravity with manual control instead of automated delivery using a pump. Continuous delivery provides for short, interrupted periods when nutrition is not being delivered such as during showers or other procedures or when the physician orders a temporary delivery stop but is not considered intermittent delivery. This deficiency represents non-compliance investigated under Complaint Number OH00155361.

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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** 46613 Based on observation, medical record review, staff interviews, and policy review, the facility failed to follow infection control policies. This affected one (#30) out of three residents reviewed for enteral feedings. The facility census was 140. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE] with medical diagnoses of right sided hemiplegia status post cerebral infarction, Alzheimer's disease, adult failure to thrive (AFTT), diabetes mellitus, atrial fibrillation, and dysphagia. Review of the medical record for Resident #30 revealed an admission Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #30 was severely cognitively impaired and was dependent upon staff for toilet hygiene and bathing and required substantial staff assistance with dressing, transfers, and bed mobility. The MDS indicated Resident #30 received 51% or more proportion of total calories through parenteral or tube feeding. Review of the medical record for Resident #30 revealed a physician order dated 05/07/24 for nothing by mouth status (NPO) and orders dated 06/04/24 for Nepro 1.8 to provide 200 milliliter (ml) every four hours to provide 1200 ml formula per day via gastrointestinal tube (g-tube), 100 ml of water flush to g-tube before and after each tube feeding every four hours and enhanced barrier precautions (EBP) related to enteral tube when dressing/bathing, showering/transferring in room or therapy gym, during personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. Observation on 07/10/24 at 8:40 A.M. revealed Registered Nurse (RN) #275 administered bolus tube feeding to Resident #30. RN #275 obtained all the supplies for the administration, performed hand hygiene, and donned gloves. RN #275 administered bolus tube feeding, and water flushes as ordered. The observation revealed an EBP sign posted on Resident #30's door but no personal protective equipment (PPE) was located outside or inside of Resident #30's room. The observation revealed RN #275 did not don a gown prior to tube feeding administration. Interview on 07/10/24 at 9:06 A.M. with RN #275 confirmed Resident #30 had an order for EBP, an EBP sign was posted on Resident #30's door, and Resident #30's room did not contain PPE for staff use. RN #275 confirmed she donned gloves but did not don a gown prior to administering bolus tube feedings to Resident #30. Interview on 07/10/24 at 9:48 A.M. with Director of Nursing (DON) confirmed staff should follow EBP during administration of tube feedings via g-tube and all residents with orders for EBP should have PPE available in the resident rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Enhanced Barrier Precautions, revealed EBP was an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care. This deficiency is based on incidental findings discovered during the course of this complaint investigation.