STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365733	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Margaret Hall	1960 Madison Road Cincinnati, OH 45206

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, staff interviews and policy review, the facility failed to ensure medications were administered via the physician ordered route. This affected one (#31) of five residents observed for medication administration observation. The facility census was 69. Findings include: Medical record review for Resident #31 revealed an admission on 02/06/24 with diagnoses including but not limited to cerebral infarction, hypertensive cerebral ischemic attack chronic pain and hemiplegia and hemiparesis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #31 revealed a severely impaired cognition. Resident #31 was dependent for eating, bed mobility, toileting, and transfers. Review of the physician orders for Resident #31 for the month of April 2024 revealed an order for fluoxetine oral solution 20 milligrams (mg)/milliliter (ml) give 2.5 ml via gastrostomy (g-tube) in the morning, hydrochlorothiazide oral tablet 25 mg give 1 tablet via g-tube in the morning, levetiracetam oral solution 100 mg/ml give 5 ml via g-tube two times a day, metoprolol tartrate tablet give 12.5 mg by mouth two times a day, prohela 30 ml two times a day wound supplement every day administer into g-tube, hydroxyzine pamoate capsule 100 mg give one tablet via g-tube three times a day, keflex 500 mg give one capsule via g-tube three times a day, tramadol oral tablet 50 mg give one tablet via g-tube three times a day for pain, and diltiazem oral tablet 30 mg one tablet via g-tube every six hours. Review of the medication/treatment error report for Resident #31 dated 04/20/24 revealed the morning medications were given whole and should have been administered via g-tube. Family notified Director of Nursing (DON) about incident. Physician was notified. Further review of document revealed resident does receive meals by mouth. (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: 365733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/16/24 at 2:10 P.M. with DON stated the family notified her the following Monday of the incident where Resident #31's medications were not administered via the ordered route. The DON stated Resident #31's physician was notified. The DON stated the family indicated the nurse was observed via video live camera of the resident. The resident did not experience any negative effects from the incident. The document was signed by the physician, the nurse making the error in the medication route and the DON. Review of the facility policy titled Administering Medication, undated stated medication are administered in accordance with prescribers orders. This deficiency represents non-compliance investigated under Complaint Number OH00153089.

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NAME OF PROVIDER OR SUPPLIER Carecore at Margaret Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 1960 Madison Road Cincinnati, OH 45206	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39702 Based on medical record review, observations, staff interviews and policy review, the facility failed to ensure medications were securely stored. This affected two (#22 and #19) of five residents observed for medication administration. The facility census was 72. Findings include: 1. Review of the medical record for Resident #22 revealed an admission on 07/02/21 with diagnoses including but not limited to cerebral infarction, transient cerebral ischemic attack and vascular dementia. Review of the quarterly Minimum Data Set assessment (MDS) for Resident #22 dated 03/20/24 revealed an intact cognition. Resident #22 required set up for eating, and maximum assistance for transfers, bed mobility and total dependence for toileting. Review of physicians orders for Resident #22 for the month of May 2024 revealed an order for ibuprofen 200 milligrams (mg) tablet administer two tablets every eight hours as needed for musculoskeletal pain. Further review of Resident #22's medical record revealed there was no order or assessment permitting the resident to self-administer medications. Observation on 05/15/24 at 6:47 A.M. of Resident #22 sitting in his bed with the bedside table in front of him. On the bedside table was two tablets in applesauce with a spoon inside a medication administration cup. Further observation revealed no staff member in the room at the time of the observation. Interview on 05/15/24 at 6:49 A.M. with State tested Nursing Assistant (STNA) #17 stated the nurse left the medication at Resident #22's bedside and she was not currently on the unit at the time of the observation. Interview on 05/15/24 at 6:55 A.M. with Registered Nurse (RN) #113 verified Resident #22 had two pills in a medication cup with applesauce and spoon sitting on the bedside table without licensed nurse supervision. 2. Medical record review for Resident #19 revealed an admission on 06/11/21 with diagnoses including but not limited to cerebrovascular disease, anemia, hypertension, hyperlipidemia, and dementia. Review of the quarterly MDS assessment dated [DATE] for Resident #19 revealed an impaired cognition. Resident #19 required set up for meals, maximum assistance for bed mobility and . Resident #19 was dependent for toileting. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physicians orders for the month of May 2024 for Resident #19 revealed an order for Miralax 17 grams one capful daily with water. Further review of Resident #19's medical record revealed there was no order or assessment permitting the resident to self-administer medications. Observation of medication administration for Resident #19 on 05/15/24 at 8:01 A.M. revealed Licensed Practical Nurse (LPN) #202 prepare Miralax as ordered. LPN #202 attempted to give Resident #19 the medication and the resident only took a few sips and stated she would drink it after her breakfast. LPN #202 left the medication at bedside and stated she would come back later to pick it up after she was finished. Interview on 05/15/24 at 8:05 A.M. with LPN #202 verified that she left the Miralax for Resident #19 in her room for her to drink after breakfast. LPN #202 verified leaving the medication at bedside was acceptable for this resident. Interview on 05/15/24 at 12:10 P.M. with the Director of Nursing (DON) verified no medication should be left at the bedside for residents to take unsupervised. Further verified Resident #19 and Resident #22 are not allowed to self administer medications. Review of the facility policy titled Administrating Medication, undated revealed residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. This deficiency represents non-compliance investigated under Complaint Number OH00153089.

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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** 39702 Based on medical record review, staff interview, observations, policy review, review of manufacture's recommendations and review of the Centers of Disease Control website, the facility failed to disinfect a glucose monitoring device after usage with an appropriate disinfectant. This had the potential to affect two residents (#13 and #6) residing on the B unit of the second floor who share the glucose monitoring device. Additionally, the facility failed to ensure staff completed hand hygiene after removing wound dressing on resident in enhanced barrier precaution. This affected one (#34) out of three residents reviewed for infection control practices. The facility census was 72. Findings include: 1. Medical record review for Resident #13 revealed an admitted on 06/23/23 with diagnoses that include but not limited to cerebral infarction, hypertension, obstructive sleep apnea, type two diabetes mellitus and obesity. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #13 revealed an impaired cognition. Resident #13 required extensive assistance with bed mobility, transfers, and toileting. Resident #13 was supervised for eating. Resident #13 was coded as receiving insulin every day during the assessment period. Review of the physician orders for Resident #13 revealed an order for Humalog kwikpen subcutaneous pen injector 100 units/milliliter (ml), inject as per sliding scale if 70-175=0, if less that 70 call physician, 176-200 administer one unit, 201-250 administer two units, 251-299 administer three units, 300-350 administer 4 units, 351-399 administer six units, if blood sugar is over 400 call physician administers subcutaneously before meals and at bed time. Review of the Medication Administration Record (MAR) for the month of May 2024 revealed Resident #13 has blood sugar monitored four times a day at 6:30 A.M., 11:30 A.M., 4:30 P.M. and at 9:00 A.M. Observation on 05/15/24 at 6:06 A.M. of Licensed Practical Nurse (LPN) #92 perform a blood glucose test for Resident #13 without concerns. After completing the glucose test, LPN #92 placed the glucometer on the medication cart, pulled the keys from her uniform pockets, unlocked the medication cart, and placed the glucometer into the top right-hand drawer without cleaning the glucometer. The observations revealed LPN #92 did not cleanse or disinfect the glucose monitoring device. 2. Review of the medical record for Resident #6 revealed an admitted on 06/23/23 with diagnoses including but not limited to cerebral infarction, cellulitis, asthma, hypertension type two diabetes mellitus, venous insufficiency, atherosclerosis and aortic valve stenosis. Review of the quarterly MDS assessment dated [DATE] revealed Resident #6 was cognitively impaired. Resident #6 required extensive assistance with bed mobility, transfers, and toileting. Resident #6 was independent with eating. (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 active physician orders for Resident #6 revealed an order for Humalog kwikpen subcutaneous pen injector 100 units/ml, inject as per sliding scale if 70-175=0, if less that 70 call physician, 176-200 administer one unit, 201-250 administer two units, 251-299 administer three units, 300-350 administer 4 units, 351-399 administer six units, if blood sugar is over 400 call physician administers subcutaneously before meals and at bed time. Review of the MAR for the month of May 2024 revealed Resident #13 has blood sugar monitored four times a day at 6:30 A.M., 11:30 A.M., 4:30 P.M. and at 9:00 A.M. Observation on 05/15/24 at 6:18 A.M. of LPN #92 open the medication cart drawer and pulled out the blood glucose device that was previously used for Resident #6. LPN #92 laid the blood glucose testing device it on the medication cart surface without a barrier and without cleaning/disinfecting the device. LPN #92 collected accu check supplies and entered Resident #13's room. LPN #92 completed blood sugar monitoring. LPN #92 returned to the medication cart, placing the glucose monitoring unit onto the medication cart, pulled her keys from her pocket unlocking medication cart and placed the blood glucose unit into the top right-hand drawer without disinfecting it. Interview on 05/15/24 at 6:25 A.M. with LPN #92 verified she did not disinfect the blood glucose unit after completing blood sugar monitoring on Resident #13 or before using it on Resident #13. LPN #92 verified the medication cart had Sani Wipes available to use for disinfecting the blood glucose unit. LPN #92 stated she was unaware of the cleaning requirements related to the glucose monitoring unit. Interview on 05/15/23 at 11:22 A.M. with the Director of Nursing (DON) verified glucometer's should be cleaned with germicidal wipes between each resident. DON verified no active infectious diseases in the facility for the residents that use the multi-user glucose monitoring unit. The DON confirmed the blood glucose testing device LPN #92 used is shared between Resident #13 and #6. Review of the CDC's guidance titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration, dated 03/02/11, revealed CDC has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration. CDC is alerting all persons who assist with blood glucose monitoring of the following infection control requirements, which included: whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared. An underappreciated risk of blood glucose testing is the opportunity for exposure to bloodborne viruses (HBV, hepatitis C virus and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g. blood glucose meters, fingerstick devices) are shared. Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include using fingerstick devices for more than one person, using a blood glucose meter for more than one person without cleaning and disinfecting it between uses, and failing to change gloves and perform hand hygiene between fingerstick procedures. In addition, in healthcare settings, the recommendation for hand hygiene was to wear gloves during blood glucose monitoring and during any other procedures that involves potential exposure to blood or body fluids and perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other persons. (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 manufacture's recommendations for cleaning and disinfecting facility glucometer's stated minimize the risk for transmitting blood-borne pathogens the cleaning and disinfecting procedure should be performed using Clorox germicidal wipes, Super Sani-cloth germicidal wipes before and after the collection of the blood sample. Review of the facility's policy titled Obtaining a fingerstick Glucose level, undated states under number three always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. 3. Review of the medical record for Resident #34 revealed an admission on 02/02/24 with diagnoses including but not limited to encephalopathy, malnutrition, diabetes mellitus type two, hemiplegia and hemiparesis. Review of the quarterly MDS assessment for Resident #34 dated 05/05/24 revealed intact cognition. Resident #34 required maximum assistance for eating, toileting, bed mobility and transfers. Resident #34 was coded as having a diabetic ulcer during the assessment period. Review of the plan of care for Resident #34 revealed resident has a pressure ulcer to left gluteal, present on admission, risk for further decline and complications related to immobility. Interventions include administer medications as ordered, monitor/document for side effects, administer treatments as ordered, assess and monitor wound healing progress, report improvement and declines to the physician. Review of the physician's orders for May 2024 for Resident #34 revealed an order dated 04/24/24 to cleanse left ankle malleolus with wound cleaner, apply medi honey ointment and cover with foam border every other day and as needed for dislodgement or soiled, and an order for enhanced barrier precautions every shift for tube feed related to dysphagia dated 04/09/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/15/24 at 8:56 A.M. of wound care for Resident #34 revealed Nurse Practitioner (NP) #600 and Registered Nurse (RN) #113 donned personal protective equipment (gloves and gown) prior to entering resident room. RN #113 did not tie the gown around her neck and gown was ill-fitting. NP #600 removed Resident #34's old dressing, enclosed the dressing into her glove and discarded both gloves into trash can. NP #600 completed hand hygiene with alcohol based gel. RN #113 applied a barrier to the bed under the left extremity. RN #113 completed wound cleansing of left ankle. RN #113's gown came in contact with bed linen on three occasions during the dressing application. RN #113 applied the medi honey to wound followed by foam barrier. RN #113 did not have a pen to initial the dressing, removed her gloves, disposing them into trash can, then exiting the room to the hallways to collect her pen. RN #113 used alcohol based gel to complete hand hygiene and used the pen to sign and date wound dressing. R N #113 did not reapply gloves when entering Resident #34's room. RN #113 then removed the barrier from under Resident #34's left leg and accidentally pulled the foam dressing from the wound. RN #113 exited Resident #34's room to obtain additional wound dressing supplies and did not remove her gown as she unlocked the treatment cart in the hallway with keys from her uniform pocket under the personal protective equipment. RN #113's gown brushed against the black uniform jacket hanging on the end of the treatment cart. RN #113 then collected wound dressing supplies from multiple drawers and entered the room without changing her gown or applying gloves. RN #113 did not complete hand hygiene before applying new gloves. RN #113's removed the dressing from the left ankle and removed her gloves encasing the dressing before placing it in the trash can. RN #113 completed wound cleansing, applications of medi honey followed by foam border dressing with NP #600 assisting with leg support. NP #600 and RN #113 removed gown and gloves placing them into the trash can and completed hand hygiene. RN #113 then tied a knot in the trash bag containing the gowns, gloves, and old dressing, removed it from the trash can and placed it on the floor beside the door stating she would be back to get the trash later. RN #113 then exited the room and put on her black uniform jacket that was hanging on the end of the treatment cart. Interview on 05/15/24 at 9:16 A.M. with RN #113 verified that she left the room without removing the gown to get additional dressing supplies and should not have. RN #113 further verified that she did not complete hand hygiene after removing the second wound dressing and should have. RN #113 then removed the black uniform jacket from the treatment cart and put it on. RN #113 verified she was unaware that she had touched the barrier gown to the jacket when she exited the room for additional supplies and stated she would get a different jacket. Review of the facility policy titled Wound Care, undated, stated under number four and five put on exam glove. Loosen tape and remove dressing, pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. This deficiency represents non-compliance investigated under Complaint Number OH00153089.