STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365734	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chamberlin Healthcare Center	3889 East Galbraith Road Cincinnati, OH 45236

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review and staff interview, the facility failed to ensure resident's code status matched in the hard (paper) and electronic chart. This affected two (#76 and #139) residents of 34 residents reviewed for advanced directives. The facility census was 146. Findings include: Review of the Resident #76's chart revealed Resident #76 admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, weakness, repeated falls, gastrostomy status, and hypothyroidism. Review of Resident #76's significant change Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's cognition was not assessed and Resident #76 required maximal assistance with upper body dressing, rolling left and right, sitting to lying, lying to sitting, sitting to standing, chair transfers, and walking ten feet. Resident #76 was dependent with oral hygiene, tub transfers, toileting, showering, lower body dressing, putting on and taking off footwear and personal hygiene. Review of Resident #76's electronic physician order dated 04/05/24 revealed Resident #76 was a do not resuscitate comfort care (DNRCC). The order was electronically signed by Resident #76's physician. Review of Resident #76's code status form in the hard chart dated 03/01/21 revealed Resident #76 was a do not resuscitate comfort care arrest (DNRCCA). The form was signed by Resident #76's physician. Interview on 07/23/24 at 4:01 P.M., with Corporate Registered Nurse (CRN) #182 verified Resident #76's code status did not match in the electronic chart and the hard chart. CRN #182 verified Resident #76 was listed as a DNRCC in the electronic chart and a DNRCCA in the hard chart. 44069 (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #139 revealed an admitted [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, unspecified severe protein-calorie malnutrition, hyperlipidemia, chronic atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, anemia, major depressive disorder, chronic kidney disease, aphasia, and unspecified psychosis not due to a substance or known physiological condition. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #139 had severely impaired cognition. Resident #139 was assessed to require supervision for eating, substantial/maximal assistance for oral hygiene, toileting, dressing, personal hygiene, bed mobility, and transfer, and was dependent for bathing. Review of the active physician orders in the electronic health record revealed an order for code status of Do Not Resuscitate Comfort Care Arrest (DNRCC-A). Review of the signed DNR paper form dated 07/10/24 revealed DNRCC was checked instead of DNRCC-A. Interview on 07/24/24 at 2:57 P.M., with CRN #183 verified the DNR paper form and the order in the electronic health record did not match.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, resident interview, staff interview, nursing home bill of rights review, and policy review, the facility failed to provide a clean and home like environment. This affected three (#22, #70, and #446) of 29 residents reviewed for environment. The facility census was 146. Findings Included: 1. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type two diabetes, Alzheimer's disease, dementia, and psychosis not due to a substance or physiological condition. Review of MDS dated [DATE] revealed Resident #22 was severely cognitively impaired. Resident #22 required supervision for eating. Resident #22 was dependent for oral hygiene, toileting, dressing upper and lower clothing, personal hygiene, bathing, and transfers. Review of plan of care dated 05/22/24 revealed resident was at risk for falls and to apply the Dycem to wheelchair, assess risk for falls on admission, bed in lowest position, educate resident and representative, ensure resident was wearing appropriate non-skid footwear, ensure resident's room was free of accident hazards, ensure that the bed was locks are engaged, nurse to do orthostatic blood pressure each shift for three days and report abnormalities, place a sheet of Dycem to wheelchair seat to prevent resident from sliding out of chair, provide activities, provide assistive devices as needed, physical therapy referral, and rearrange the room, and have personal items within reach. 2. Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnoses included vascular dementia, major depression, and mood disorder. Review of MDS dated [DATE] revealed Resident #70 was severely cognitively impaired. Resident #70 required partial moderate assistance for dressing upper body. Resident #70 substantial maximal assistance dressing lower body, transfers, personal hygiene, bathing, toileting use, and placing shoes on and off feet. Review of plan of care dated 07/22/24 revealed that Resident #70 was at risk for falls related to gait balance problems, impaired cognition, and incontinence. Interventions included assessing risk for falls, educate resident wearing appropriate nonskid shoes, place call light in reach, ensure the bed locks are engaged, and provide adequate lighting at night. Observation on 07/22/24 at 11:51 A.M., revealed the room Resident #22 and Resident #70 resided in was observed to have a greasy, slippery, dirty floor. The surveyor and State tested Nurse Aide (STNA) #393 both slide on the floor when walking into residents' rooms. Interview on 07/22/24 at 11:52 A.M., with STNA #393 verified it was very slippery and greasy to walk on. STNA #393 stated a resident could fall on this dirty floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #446 revealed an admission of 07/17/24. Diagnoses included psychosis, and dementia. Review of MDS assessment dated [DATE] revealed the MDS was in progress. Review of plan of care dated 07/22/24 revealed Resident #446 was at risk for a decrease in activity of daily living self-care performance related to dementia, and psychosis. Observation on 07/22/24 at 11:16 A.M., of Resident #446's room revealed the bed had no headboard, and clothes were in brown bags on top of her dresser. The dresser was observed to have old food crumbs, large brown harden unidentified stain, dried pink nail polish, and a full bottom drawer with clothes from the past resident. Interview on 07/22/24 at 11:16 A.M., with Resident #446 stated she had no headboard, and her dresser was dirty and had other resident's items in her dresser. Resident #446 stated she could not use the dresser due to it being filthy. Resident #446 stated she had been admitted six days ago, and the facility was a mess. Interview on 07/22/24 at 11:23 A.M., with Unit Manager (UM) #62 verified Resident #446 had no headboard, clothes were in brown bag on top of her dresser that was hers from her admission. UM #62 verified that Resident #446 dresser had old food crumbs, large brown unknown substance that was hardened, a yellow Lego piece, left over trash, dried pink nail polish, and a full bottom drawer with clothes from the past resident. Review of the undated policy titled, Housekeeping In Service revealed daily performance of damp mop of floor and use proper mop, germicide solution to disinfect the resident's floor. Review of the form titled, Nursing Home Residents [NAME] of Rights, dated 1987, revealed every resident had the right to receive medical care, nursing care, rehabilitative and restorative therapies, and personal hygiene in a safe, clean environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40471 Based on record review and staff interview, the facility failed to correctly code the Minimum Data Set (MDS) assessment for the proper discharge location. This affected one (#144) of three residents reviewed for discharge. The census was 146. Findings include: Review of Resident #144's medical record revealed an admitted [DATE] and discharge date of [DATE], with diagnoses including: cellulitis of right lower leg, schizophrenia, and schizoaffective disorder. Review of Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #144 was cognitively intact and required assistance for mobility, she was having hallucinations and delusions, and verbal behaviors. Review of care plan revealed a discharge plan to home or another facility. Review of progress note date 05/03/24 at 12:44 P.M., revealed Resident #144 signed out of facility against medical advice (AMA), it was explained to resident that by leaving against advice she cannot take medications with her and she releases the facility from all responsibility. Resident #144 verbalized understanding. Nurse practitioner aware. Review of the discharge MDS dated [DATE] revealed Section A2105 for Discharge Status revealed Resident #144 discharged to 04. Short-Term General Hospital (acute hospital, IPPS) rather than 01. Home/Community. Interview on 07/24/24 at 2:45 P.M., with Registered Nurse (RN) #181 verified Resident #144's MDS was coded incorrectly for the discharge destination to home.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, staff interview, and policy review, the facility failed to develop a care plan for a resident with vision impairment. This affected one (#52) of 29 residents reviewed for care planning. The facility census was 146. Findings include: Review of the Resident #52's medical record revealed an admitted [DATE], with diagnoses including type two diabetes mellitus with diabetic polyneuropathy, atherosclerotic heart disease of native coronary artery without angina pectoris, pure hypercholesterolemia, anxiety disorder, spinal stenosis, other intervertebral disc degeneration lumbar region, obsession compulsive disorder, depression, other chronic pain, insomnia, hypertension, chronic pain and tobacco use. Review of Resident #52's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be cognitively intact and Resident #52 required supervision with eating, oral hygiene, toileting, personal hygiene, lying to sitting, sitting to standing, chair transfers, toilet transfers, and tub transfers. Resident #52 required maximal assistance with showering and set up assistance with lower body dressing, upper body dressing, putting on and taking off footwear, rolling left and right, sitting to lying, and walking. Resident #52 had adequate vision with corrective lenses. Review of Resident #52's eye appointment dated 03/08/24 revealed Resident #52 had a cataract consult on 03/08/24 at 12:30 P.M. Review of Resident #52's post operative instructions for cataract surgery dated 04/11/24 revealed Resident #52 was to wear the eye shield while sleeping for seven nights after surgery. Review of Resident #52's care plan dated 07/23/24 revealed Resident #52 did not have a vision care plan or care plan for the use of corrective lenses or cataracts. Interview on 07/25/24 at 10:34 A.M., with Corporate Registered Nurse (CRN) #182 verified Resident #52 did not have a vision care plan. CRN #182 also confirmed Resident #52 had corrective lenses and a history of cataracts and cataract surgery. Review of the policy titled Plan of Care, dated 03/01/24, revealed the facility will provide a resident centered care plan that meets the psychosocial, physical, and emotional needs and concerns of the resident.

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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** 44069 Based on record review, staff interview, and policy review, the facility failed to ensure care plans were updated timely with fall interventions. This affected one (#139) of five residents reviewed for falls. The facility census was 146. Findings include: Review of the medical record for Resident #139 revealed an admitted [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, unspecified severe protein-calorie malnutrition, hyperlipidemia, chronic atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, anemia, major depressive disorder, chronic kidney disease, aphasia, and unspecified psychosis not due to a substance or known physiological condition. Review of the facility assessment titled Fall Risk Observation Tool, dated 05/11/24, revealed Resident #139 was at risk for falls. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #139 had severely impaired cognition. Resident #139 was assessed to require supervision for eating, substantial/maximal assistance for oral hygiene, toileting, dressing, personal hygiene, bed mobility, and transfer, and was dependent for bathing. Review of the Interdisciplinary Team (IDT) progress note dated 07/16/24 revealed Resident #139 had a fall on 07/15/24 while attempting to lay on her bedside table. The new intervention was to remove the bedside table for safety and only use during meals. Review of the plan of care revised on 07/23/24 revealed Resident #139 was at risk for falls related to dementia. Interventions included ensuring room is free of accident hazards, ensuring non-skid footwear is worn, place call light within reach, and ensuring bed locks are engaged. Interview on 07/25/24 at 2:26 P.M., with Corporate Nurse #182 confirmed the intervention related to the bedside table was not added to the care plan. Review of the policy titled Fall Prevention and Management, revised on 03/06/24, revealed care plans should be updated with new fall interventions.

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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** 44080 Based on observation, medical record review, resident interview, staff interview, and review of policies, the facility failed to provide safe storage for cigarettes and alcohol. This affected one (#128) of one resident reviewed for smoking. The facility failed to provide care planned fall interventions for residents at risk for falls. This affected two (#22, #103) of three residents reviewed for falls. The facility census was 146. Findings included: 1. Review of medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type two diabetes, Alzheimer's disease, dementia, and psychosis not due to a substance or physiological condition. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was assessed as having severe cognitive impairment. Resident #22 required supervision for eating. Resident #22 was dependent for oral hygiene, toileting, dressing upper and lower clothing, personal hygiene, bathing, and transfers. Resident #22 was able to ambulate by himself with no staff help or assisted devices. Review of Fall Risk Observation Tool dated 05/05/24 revealed that Resident #22 had poor recall and judgement, ambulatory without assistance, gait was weak walking and short steps, able to stand and walk, predisposing diseases and condition for three or more present. Review of plan of care dated 05/22/24 revealed interventions included: apply the dycem to wheelchair, assess risk for falls on admission, bed in lowest position, educate resident and representative, ensure resident was wearing appropriate non-skid footwear, ensure resident's room was free of accident hazards, ensure that the bed was locks are engaged, nurse to do orthostatic blood pressure each shift for three days and report abnormalities, place a sheet of dycem to wheelchair seat to prevent resident from sliding out of chair, provide activities, provide assistive devices as needed, physical therapy referral, and rearrange the room, and have personal items within reach. Observation on 07/22/24 at 2:10 P.M., revealed Resident #22 was walking the halls by himself with one regular sock on right foot, and right foot had a bare foot. Interview on 07/22/24 at 2:11 P.M., with State tested Nurse Aide (STNA) #393 verified Resident #22 was walking the hallways with one regular sock on and one foot barefoot. 2. Review of medical record for Resident #103 revealed an admitted [DATE]. Diagnoses included chronic pulmonary disease, Alzheimer's disease, illus, and cognitive communication deficit. Review of MDS assessment dated [DATE] revealed Resident #103 was severely cognitively impaired. Resident #103 required setups for all meals. Resident #103 required dependent oral hygiene, toileting, bathing, personal hygiene, dressing upper and lower body, and transfers. (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 plan of care dated 07/22/24 revealed Resident #103 was at risk for activity of daily living self-care related to assistance with activity of daily living, dementia, chronic pulmonary disease, and Alzheimer's. Interventions included grab bars to bed to aide with turning and repositioning, place shoes on and off, place call light within reach, and evaluation and treat per medical provider orders. Observation on 07/22/24 at 11:38 A.M., revealed Resident #103 was ambulating in lock down unit with her both bare feet and no socks on. Interview on 07/22/24 at 11:38 A.M., with STNA #22 confirmed Resident #103 had no shoes or nonskid socks on while ambulating in the hall. Review of the policy titled Fall Preventions and Management dated 03/06/24, stated an intervention was put in place after a fall to prevent future falls. Fall prevention and management was the process of identifying risk factors that can minimize the potential for falls and also a process to manage a resident's care if a fall occurs. 40471 3. Review of the medical record for Resident #128 revealed an admitted [DATE], with diagnoses including dementia with mild agitation, and bipolar disorder. Review of Resident #128's care plan revealed he had a substance use disorder related to alcohol use and were to observe resident's room for items. Review of policy entitled Resident Substance Abuse in facility was signed and dated by Resident #128 on 05/05/24 as acknowledgement of receipt. Interview and observation on 07/23/24 at 11:23 A.M., with Resident #128 revealed he had a pack of cigarettes on his person, with six cigarettes in it. Resident #128 stated he didn't smoke, that he used cigarettes for bargaining. Resident #128 also had an empty carton of hard tea (tea premixed with alcohol) and two individual serving boxes of wine in his room. Interview on 07/23/24 at 11:30 A.M., Registered Nurse (RN) #182 verified the presence of the drug-related items and the facility's policy was that cigarettes could not be traded or used to bargain. Review of the undated policy titled, Resident Substance Abuse in Facility, revealed residents may not possess, use or provide any illicit drugs or abuse drugs in any manner, and may not have drug-related paraphernalia in their possession while a resident in the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, staff interviews, and policy review, the facility failed to provide timely incontinence care for a resident dependent on staff for care. This affected one (#51) of one resident reviewed for incontinence care. The facility census was 146. Findings included: Review of medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, anxiety disorder, dementia, and major depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. Resident #51 required substantial maximal assistance for personal hygiene, bathing, transfers, lower body, toileting, and transfers. Resident #51 required partial assistance for dressing upper body. Review of plan of care dated 07/04/24 revealed that Resident #51 was at risk for incontinent of urine. Interventions were to apply barrier creams as needed, check resident for incontinence, and observe for signs and symptoms of urinary tract infection. Observation on 07/22/24, from 2:02 P.M. through 2:14 P.M., revealed Resident #51 walking around in the hallway wet and in view of other residents. Resident #51 was observed to be saturated with urine on her green scrub pants entire back side at bottom, around her waist and through the bottom of her shirt. Interview on 07/22/24 at 2:18 P.M., with Registered Nurse (RN) #113 verified Resident #51 was saturated in urine. RN #113 verified Resident #51 had moderate amount of saturated urine in brief, through her pants, at the waist of pants and through Resident #51's shirt. Interview on 07/24/24 at 2:35 P.M., with State tested Nurse Aide (STNA) #32 stated Resident #51 was a check and change. STNA #32 stated she had come in and checked and changed Resident #51, at the start of her shift, at 7:45 A.M. and again at 9:15 A.M. STNA #32 stated she had not got to check and change her before lunch. STNA #32 stated the nurse had come to tell her that the nurse did change her and Resident #51 was saturated with urine. Review of the policy titled, Perineal Care Male and Female dated 04/20/2017, revealed perineal care was performed on residents who were unable or unwilling to maintain body cleanliness and or who are incontinent of bowel and bladder. Perineal care will be care planned for each individual resident to meet his or her specific needs.

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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** 44080 Based on medical record, observation, staff interview, resident interview, and review of policies, the facility failed to ensure medications were provided with an open date when being utilized to ensure medications were not expired. This affected two (#13 and #127) residents observed during medication storage. The facility failed to ensure medications were not left at the bedside and were consumed when administered. This affected one (#117) randomly observed resident. The facility census was 146. Findings include: 1. Observation on [DATE] at 9:30 A.M., of the medication cart revealed Resident #13 had open bottle Keppra 100 mg/milliliter liquid and had no open date on bottle. Resident #13 also had an open bottle of Felbamate 600 mg/5 ml liquid with no open date on the bottle. Interview on [DATE] at 9:45 A.M., with Director of Nursing (DON) verified the nurse was to place a date on the medication when opened for both Keppra and Felbamate bottles. 2. Observation on [DATE] at 9:50 A.M., of the medication cart with Resident #127 had an open bottle of Valproic Acid 250 milligram/5 milliliter 16 ounces and had no open date. Resident #127 had second open bottle of Valproic Acid 250 mg/5 ml 16 ounces and had no open date. Interview on [DATE] at 9:55 A.M., with DON confirmed Resident #127 had two bottles of Valproic Acid were open, undated and had been used by staff for delivery of medication for Resident #127. Review of the policy titled, Storage of Medications, with revision date of [DATE], revealed the nurse shall place date opened sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations or guidelines require different dating. 40471 3. Review of medical record for Resident #117 revealed an admitted [DATE], with diagnoses including paranoid schizophrenia and delusional disorders. Review of physician's orders dated [DATE], revealed an order for risperidone 0.5 milligrams (mg) twice a day for paranoid schizophrenia; [DATE], Pantoprazole 40 mg daily for digestive aid; and Tamsulosin 0.4 mg daily for prostate health. Review of minimum data set assessment dated [DATE] revealed Resident #117 was cognitively intact and noted to refuse care at times. Resident #117 had a court appointed guardian. Observation and interview on [DATE] at 9:04 A.M., revealed a medication cup with three tablets in it, sitting on Resident #117's over the bedside table. Resident #117 verified the nurse had brought them in and left them so he could take them with his breakfast. (continued on next page)

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	365734	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chamberlin Healthcare Center	3889 East Galbraith Road Cincinnati, OH 45236

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 9:06 A.M., Registered Nurse (RN) #57 verified she did give Resident #117 medications but did not witness him take his medication, Resident #117 stated he wanted to take them with breakfast. RN #57 verified the medications were risperidone, Pantoprazole and Tamsulosin. Review of the policy titled, Storage of Medications, with revision date of [DATE], revealed only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) were permitted to access medications. Medication rooms, carts, and medication supplies are locked when they were not attended by persons with authorized access.

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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** 44080 Based on medical record, observation, resident interview, staff interview and policy reviews, the facility failed to ensure the proper transmission-based precautions were provided for a resident per physician orders. This affected one (#109) of one resident reviewed for infection control. The facility census was 146. Findings include: Review of medical record for Resident #109 revealed an admitted [DATE]. Diagnoses included chronic pulmonary disease, severe combined immunodeficiency with low T and B cells, and psychotic disorder with delusions. Review of physician order for Resident #109 dated 07/18/24 revealed an order for contact precautions every morning and bedtime due to Shingles. Resident #109 was allowed to come out of the room if rash was covered. Review of physician order for Resident #109 dated 07/20/24 revealed an order for the antibiotic Valtrex oral one gram to give one tablet twice a day for seven days for Shingles. Observation on 07/23/24 at 4:01 P.M., revealed Resident #109 had enhanced barrier precautions sign hanging on her door. Resident #109 was sitting in her room in wheelchair. Interview on 07/23/24 at 4:01 P.M., with Resident #109 stated she did not have shingles at this time. Interview on 07/23/24 at 4:02 P.M., with Licensed Practical Nurse (LPN) #52 stated she knew Resident #109 was on contact precaution. LPN #52 verified Resident #109 had only an enhanced barrier precaution sign hanging on her door. LPN #52 verified there should have been a contact precaution sign instead. Interview on 07/23/24 at 4:30 P.M., with Unit Manager (UM) #62 verified Resident #109 had shingles and a rash under her arm on the one side. UM #62 stated Resident #109 does not come out of her room at this time. UM #62 stated the facility did not make her stay in her room, Resident #109 stays in her room on her own choice. Review of the policy titled Surveillance for Infections, dated 02/28/22, revealed the purpose of policy was to provide guidance for monitoring infections for tracking, trending, and monitoring for outbreaks. Review of the policy titled Standard Precautions and Transmission Based Precautions dated 06/25/21, revealed the facility used two tier approach to precautions: standard precautions and transmission-based precautions based on resident's clinical condition utilizing Center of Disease Control (CDC) guidelines. The isolation precaution was the method of preventing the spread of contagious disease and microorganism transfer to others following CDC recommendations and guidelines.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, observation, resident interview, and staff interviews, the facility failed to ensure call lights were accessible to residents while in bed. This affected three (#51, #143, and #446) of three residents reviewed for call lights. The facility census was 146. Findings included: 1. Review of medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, anxiety disorder, dementia, and major depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. Resident #51 required supervision with meals, required partial and moderate assistance with oral care, substantial maximal assistance for personal hygiene, bathing, transfers, lower body, and transfers. Review of plan of care dated 06/21/24 revealed Resident #51 was at risk for falls related to injury related to decreased cognition and safety. Interventions included assess for risk for falls, educate resident or representative, ensure resident's room was free of potential visible hazards, ensure that the bed locks are engaged, observe medication for side effects that may increase for falls, and place call bell within reach, and remind to call for assistance. Observation on 07/22/24 at 2:18 P.M., with Registered Nurse (RN) #113 verified Resident #51's call light was wrapped up and hanging on the wall at the plug in for the call light. Interview on 07/22/24 at 2:22 P.M., with RN #113 verified the call light for Resident #51 was wrapped up on the wall and unable to be reached or used by the resident. 2. Review of the medical record for Resident #143 revealed an admitted [DATE]. Diagnoses included major depressive disorder, type two diabetes, and overactive bladder. Review of MDS assessment dated [DATE] revealed that Resident #143 Brief Interview of Mental Status was 04 that indicated she was cognitively impaired. Resident #143 required supervision with or without setup for meals, dressing upper and lower body, transfers, toileting, personal hygiene, and bathing. Review of plan of care dated 07/11/24 revealed Resident #132 was at risk for falls related to cognition deficit, communication deficit, and use of psychotropic medications. Interventions included assess for risk for falls, educated resident or representative, ensure resident room was free of accident hazards, ensure that the bed locks are engaged, place call bell within reach, and observe for medication side effects and report. Observation on 07/22/24 at 2:18 P.M., with Registered Nurse (RN) #113 verified Resident #143's call light was wrapped up and hanging on the wall at the plug in for the call light. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/22/24 at 2:22 P.M., with RN #113 verified the call lights for Resident #143 was wrapped up on the wall and unable to be reached or used by the resident. 3. Review of the medical record for Resident #446 revealed an admitted [DATE]. Diagnoses included psychosis and dementia. Review of MDS dated [DATE] revealed the assessment was in progress. Review of plan of care dated 07/22/24 revealed that Resident #446 was at risk for activity of daily living self-care performance related to dementia and psychosis. Observation on 07/22/24 at 11:16 A.M., of Resident #446 revealed the resident was in bed and the call light was under her mattress, between the frame and mattress. Interview on 07/22/24 at 11:16 A.M., with Resident #446 revealed she did not have a call light and had been at the facility for six days. Interview on 07/22/24 at 11:23 A.M., with Unit Manager #62 verified Resident #446's call light was under her mattress and unable to be reached.