STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365735	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Koester Pavilion	3232 North County Road 25a Troy, OH 45373

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, resident representative interview, and staff interview, the facility failed to notify resident representative of new order for antibiotic and reason for the use of the medication. This affected one (#1) resident out of two residents reviewed for antibiotic use. The facility census was 99. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included quadriplegia, chronic respiratory failure, anoxic brain damage, persistent vegetative state, and tracheostomy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/30/24, revealed Resident #1 was in a persistent vegetative state. Review of the physician order dated 07/18/24 revealed an order for amoxicillin-pot Clavulanate (Augmentin) 875-125 (antibiotic) milligram (mg) one tablet via gastrostomy (g-tube) every 12 hours for bacterial infection. Review of the physician note, dated 07/18/24, revealed Resident #1 was seen due to redness and swelling of the right jaw. Resident #1's examination was positive for swollen glands and was ordered Augmentin 875-125 mg via g-tube every 12 hours for seven days. Review of the nurse progress note, dated 07/24/24 at 11:21 A.M., revealed Resident #1 continued on Augmentin for swollen lymph node to the right neck. The medical record for Resident #1 revealed no documentation to support the facility notified Resident #1's representative of the order for antibiotic to treat a bacterial infection. Interview on 07/22/24 at 11:11 A.M. with Resident #1's representative stated she was notified Resident #1 was on an antibiotic a few days after the antibiotic started and was told the antibiotic was for a throat infection. Resident #1's representative stated she was not aware of the name of the antibiotic or for how long Resident #01 was to receive the medication. Interview on 07/24/24 at 11:21 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #1 did not contain documentation to support Resident #1's representative was notified of the order for the antibiotic or the reason for the use of the medication. The DON stated the facility did not have a policy for notifying the resident and/or resident representative of order changes.

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: 365735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Koester Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE 3232 North County Road 25a Troy, OH 45373	

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on record review and staff interview, the facility failed to provide the residents with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) and the Notice of Medicare Provider Non-Coverage (NOMNC). This affected two (#58 and #91) of three residents reviewed for beneficiary notices. The facility census was 99. Findings include: 1. Review of the medical record of Resident #58 revealed an admitted [DATE]. Review of the SNF ABN for Resident #58 revealed the last covered day of Part A service was 03/11/24. Review of the NOMNC indicated the service will end on 03/11/24. A handwritten note by Quality Assurance (QA) #328 stated the daughter was notified of LCD (last covered day) for skilled care to end on 03/11/24 and the right to appeal Livanta (third party auditor to review documentation to cover Medicare) at [PHONE NUMBER]. The note was signed on 03/06/24. The form was not signed by Resident #58 or family. Interview on 07/24/24 at 9:44 A.M. with QA #328 revealed she had called the responsible party for Resident #58 and had sent the letter via certified mail. QA #238 stated the facility had no verification the letter had been sent. 2. Review of the medical record for Resident #91 revealed an admitted [DATE]. Review of the SNF ABN for Resident #91 revealed the last covered day of Part A service was 03/08/24. Review of the NOMNC indicated the service will end on 03/08/24. A handwritten note by Quality Assurance #328 stated the daughter was notified of LCD (last covered day) for skilled care to end on 03/08/24 and the right to appeal Livanta (third party auditor to review documentation to cover Medicare) at [PHONE NUMBER]. The note was signed on 03/06/24. The form was not signed by Resident #91 or family. Interview on 07/24/24 at 9:44 A.M. with QA #328 revealed she had called the responsible party for Resident #91 and had sent the letter via certified mail. QA #238 stated the facility had no verification the letter had been sent.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff and resident interviews, and policy review, the facility failed to make prompt efforts to resolve a resident's grievance related to missing property. This affected one (#83) of three residents reviewed for missing property. The facility census was 99. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE]. Diagnoses included diabetes mellitus with diabetic peripheral angiopathy, peripheral vascular disease, and congestive heart failure. Resident #83 was admitted to the hospital on 05/29/24 and returned to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was cognitively intact. Interview on 07/22/24 at 9:26 A.M. with Resident #83 stated she was hospitalized in early June 2024 and while she was at the hospital, her roommate at the facility had discharged . Resident #83 stated her roommate's family packed all the roommate's belongings and took the items home. Resident #83 stated when she returned to the facility, she noticed three of her blankets were missing and she notified Social Service of the missing items. Resident #83 stated she had not heard any updates related to her missing blankets. Interview on 07/24/24 at 10:06 A.M. with Social Service (SS) #329 confirmed Resident #83 informed her that she was missing three blankets upon her return to the facility in early June 2024. SS #329 stated Resident #83's roommate discharged at the time Resident #83 was in the hospital and she believed the roommate's family took Resident #83's blankets home. SS #329 stated she called Resident #83's roommate's family to determine if they accidentally took Resident #83's blankets home but did not get an answer and left a message. SS #329 stated she had not followed up on the missing blankets since the initial call to Resident #83's roommate's family. SS #329 confirmed Resident #83's concern related to missing blankets was not documented on the grievance log or in Resident #83's medical record. Review of the facility policy titled Lost and Found revealed the facility shall assist all personnel and residents in safeguarding their personal property. The policy stated the resident or family complaints of missing items must be reported to the DON and reports of misappropriation or treatment of resident property are immediately investigated.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, policy review, and review of the Resident Assessment Instrument (RAI) manual 3.0, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed timely after a resident experienced a significant change of condition. This affected one (#83) of seven residents reviewed for significant change in condition. The facility census was 99. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE]. Diagnoses included nondisplaced intertrochanteric fracture of right femur and right clavicle, diabetes mellitus with diabetic peripheral angiopathy, peripheral vascular disease, and congestive heart failure. Resident #83 was admitted to the hospital on 05/29/24 and returned to the facility on [DATE]. Review of the Medicare five-day MDS assessment, dated 04/14/24, revealed Resident #83 was cognitively intact and required supervision or touching assistance with toilet hygiene, transfers, and toilet transfers, partial/moderate staff assistance with showers and was independent with bed mobility. Resident #83 did not ambulate, did not have a pressure ulcer, and did not have weight loss. The quarterly MDS assessment, dated 05/13/24, revealed Resident #83 was cognitively intact and was dependent upon staff for toilet hygiene, bed mobility, and transfers, required substantial/maximum staff assistance for bathing, and did not ambulate. Resident #83 had no weight loss and did not have a pressure ulcer. Review of the Skin/Wound note dated 05/20/24 revealed Resident #83 had a Stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) to the sacrum. Review of the nutrition/dietary note, dated 06/25/24, revealed Resident #83 had a significant weight loss within the last 30 days. The note stated Resident #83's weight loss was nine pounds or 5.4% weight loss in 30 days. The note stated Resident #83's weight was 156.2 pounds. The nutrition/dietary note, dated 07/09/24, revealed Resident #83 was noted to have 16.6-pound unplanned significant weight loss or 10% in 180 days and weighed 148.6 pounds. Review of Resident #83's MDS assessments from 05/13/24 to 07/23/24 revealed the facility had not completed a significant change MDS assessment for Resident #83. Interview on 07/24/24 at 4:17 P.M. with Quality Assurance (QA) nurse #328 confirmed the facility had not completed a significant change MDS assessment after Resident #83 had a significant weight loss, development of a Stage III pressure ulcer, and decline in two or more Activities of Daily Living (ADLs). QA Nurse #328 stated the facility utilized the RAI 3.0 manual for guidelines on when to complete a significant change MDS assessment. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Change in Resident's Condition or Status, stated a significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without intervention by the staff or implementing standard disease-related clinical interventions and impacts more than one area of the resident's health status. The policy also stated if a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition would be conducted as outlined in the MDS RAI manual. Review of the RAI manual 3.0 October 2023 pages two through 24 stated a significant change is a major decline in a resident's status that would not normally resolve without intervention by staff or by implementing standard disease-related clinical interventions, impacts ore than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. The RAI manual stated a significant change MDS is appropriate when the resident's condition was not expected to return to baseline within two weeks. The RAI manual also stated a resident must have a decline in two or more areas that included any decline in ADL physical functioning area, emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days), and the emergence of a new pressure ulcer at Stage II or higher.

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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** 35031 Based on medical record review and staff interview, the facility failed to ensure a resident had a care plan in place for his behavior with wandering and residing on a secure unit. This affected one (Resident #20) of 27 residents reviewed for care plans. The facility census was 99. Findings include: Review of the medical record of Resident #20 revealed an admitted d of 05/13/24. Diagnoses included dementia with behavioral disturbance and Alzheimer's disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was at a risk for wandering. Review of the form Wandering Risk assessment dated [DATE] revealed Resident #20 was at a high risk for wandering. Review of Resident #20's care plan revealed there was no focus area of wandering or residing on a secure unit. Interview on 07/24/24 at 3:27 P.M. with Licensed Practical Nurse (LPN) #327 verified Resident #20's care plan contained no focus or interventions for wandering or residing in a secure unit.

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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 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** 35035 Based on observation, policy review, record review, and staff interview, the facility failed to follow proper mechanical lift protocols during a resident's transfer from the bed to a wheelchair. This affected one resident (#47) of three residents reviewed for transfers with lifts. The facility census was 99. Findings include: Record review for Resident #47 revealed the resident was originally admitted to the facility on [DATE]. Diagnoses for Resident #47 included cerebral infarction, diabetes mellitus type two, obesity, and heart disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had impaired cognition and was dependent on staff for transfers. Review of Resident #47's care plans dated 05/01/17 revealed a focus for falls and injuries relating to mobility. Resident #47 utilized a lift for transfers. Interventions included using a Hoyer lift for all transfers with two staff members. Continuous observation on 07/23/24 from 9:16 A.M. to 9:30 A.M. revealed State tested Nurse Aide (STNA) #271 was observed pulling a mechanical lift into Resident #47's room where Resident #47 was observed laying in bed. At 9:30 A.M., STNA #271 was observed opening the door and pulling the lift out of the resident's room. Resident #47 was observed sitting in her wheelchair at 9:30 A.M. During the continuous observation from 9:16 A.M. to 9:30 A.M., there was no other staff observed entering or exiting or standing in Resident #47's room. Interview on 07/23/24 at 9:32 A.M. with STNA #271 verified she was the only staff to use the mechanical lift to transfer Resident #47 at the time of the observation. STNA #271 verified it was in the resident's care plan she was to be transferred using two staff members in the lift. Review of the undated facility policy titled 'Mechanical Lift Policy' revealed two trained staff are to be present at all times while using the mechanical lift.

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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** 46613 Based on medical record review and staff interview, the facility failed to ensure a resident with an indwelling catheter had a valid medical justification for the use. This affected one (Resident #50) of three residents reviewed for indwelling catheter. The facility census was 99. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included right above the knee amputation (AKA), atrial fibrillation, diabetes mellitus, hypertension, peripheral vascular disease, and anemia. Review of the admission Minimum Data Set (MDS) assessment revealed Resident #50 had moderate cognitive impairment and was dependent upon staff for toileting, and had an indwelling catheter. Review of Resident #50's physician order dated 05/28/24 revealed an order for an indwelling urinary catheter 16 French with 10 milliliter (ml) balloon to continuous drainage. There was diagnosis for the use of the catheter on the physician order. Review of the bladder and bowel assessment, dated 06/22/24, revealed Resident #50 had a history of bladder continence, used a urinal, and required extensive assistance with toileting. The assessment also noted Resident #50 had an indwelling catheter in place upon admission to the facility. Interview on 07/24/24 at 2:02 P.M. with Director of Nursing (DON) stated Resident #50 was admitted to the facility with an indwelling catheter because of urinary obstruction while hospitalized . The DON confirmed the medical record for Resident #50 did not contain documentation to support the medical justification for the continued use of the indwelling catheter or that the facility attempted to discontinue the catheter. The DON stated the facility did not have a policy related to use of indwelling catheter but only on how to care for an indwelling catheter.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on record review, review of the facility policy, observation, and staff interview the facility failed to assess the need for bed rails on a resident's bed. This affected one (Resident #21) of three residents reviewed for bed rails. The facility census was 99. Findings include: Record review for Resident #21 revealed the resident was admitted to the facility on [DATE] and started to receive hospice services on 10/05/23. Diagnoses for Resident #21 included Alzheimer's disease, dementia, weakness, kidney failure, and heart disease. Review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had impaired cognition, was not using bed rails, and was receiving hospice services. Review of Resident #21's documentation revealed as of 09/2014 the resident's daughter was medical Power of Attorney (POA). The census record revealed Resident #21's daughter was designated as the POA and emergency contact family representative. Review of a consent form dated 10/05/23 revealed half partial rails for the left and right upper bed to be used at all times. No purpose for the side rails, no release schedule, and no other release orders or physician orders were noted on the consent form. Resident #21's signature with the date of 10/05/23 was noted on the form. No POA or family representative signature or physician signature was noted on the form. Review of Resident #21's care plans dated 10/05/23 revealed a focus for required assistance with Activities of Daily Living (ADL) related to dementia. Interventions included for the resident to use half upper side rails bilaterally for bed mobility. Review of Resident #21's physician orders dating from 10/05/23 to 07/23/24 revealed no order for bed rails in the medical records. Review of Resident #21's progress notes and assessments from 10/05/23 to 07/23/24 revealed there were no bed rail assessments. Observation on 07/24/24 at 8:50 A.M. revealed State tested Nurse Aide (STNA) #298 provided incontinence care for Resident #21. After incontinence care was provided, STNA #298 lowered the bed and raised both bilateral half bed rails at the head of the bed. Interview on 07/24/24 at 9:00 A.M. with STNA #298 verified Resident #21's half bilateral bed rails were to be used for the resident. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/24/24 at 10:20 A.M. with Quality Assurance (QA) Nurse #238 verified for the MDS assessments dating from 10/2023 to 05/2024, no bed rails were coded as being used for Resident #21. QA Nurse #238 stated bed rails were not considered restraints so despite being used in care the facility, they did not code in the MDS assessments for the use of the bed rails. QA Nurse #238 verified the only bed rail assessment completed for Resident #21 was completed on 12/05/22 from a prior admission. QA #238 verified there were no current bed rail assessments for the 10/05/23 admission for Resident #21. Review of the facility policy titled 'Bed Safety and Bed Rails', dated 08/2022, revealed the use of bed rails are prohibited unless the criteria had been met for the use, alternatives have been assessed, resident assessment completed, and the interdisciplinary team has evaluated the appropriateness of the bed rails use.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on record review and staff interview, the facility failed to ensure pharmacy recommendations were responded to in a timely manner. This affected one (Resident #23) of five residents reviewed for unnecessary medication use. The facility census was 99. Findings include: Record review for Resident #23 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #23 include Parkinson's disease, depression, anxiety, vascular dementia, and unspecified psychosis. Review of Resident #23's Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition, no behaviors, and was receiving an antipsychotic medication. Review of Resident #23's care plans dated 10/23/13 revealed a focus for complications of vitamin deficiency. Interventions include administer medications per order, monitor lab results and report abnormalities to physician, and schedule/arrange for resident to attend diagnostic testing as ordered. Review of the pharmacy recommendation dated 04/21/24 revealed the pharmacist recommended vitamin B12 level, vitamin D level and an iron panel be completed for Resident #23. The physician responded on 04/25/24 to have the labs drawn on the next laboratory draw. Review of Resident #23's laboratory results revealed on 07/09/24 the vitamin B12, iron panel, and the vitamin D level orders were completed. Resident #23 had a laboratory draw on 05/01/24 but it did not include vitamin B12, iron panel and vitamin D level. Interview on 07/25/24 with the Director of Nursing (DON) verified the physician signed the recommendation for the vitamin and iron panels to be ordered on next laboratory draw on 04/25/24. Per the DON, the orders for the vitamin B12, vitamin D, and iron panel were not ordered until 07/2024, three months after the recommendation. The DON verified the next lab draw for Resident #23 was dated 05/01/24.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on medical record review, outside provider interview, and physician interview, the facility failed to ensure residents were free from unnecessary medication use. This affected one (Resident #38) of five residents reviewed for unnecessary medication use. The facility census was 99. Findings include: Review of the medical record of Resident #38 revealed an admitted [DATE]. Diagnoses include acquired absence of kidney and renal cancer. Review of the medical record revealed Resident #38 had been diagnosed with a urinary tract infection (UTI) on 10/02/23, 02/25/24, and 03/19/24. Review of the physician orders dated 04/03/24 revealed an order for Macrodantin macrocrystal 50 milligrams one time daily for prophylactic/indefinitely. Review of a outside practitioners report dated 05/16/24 revealed Resident #38 was seen for a follow-up regarding a UTI. The report indicated Resident #38 was currently experiencing nocturnal one time per night, but was not experiencing hematuria, dysuria, urinary frequency, fever, chills, nausea, vomiting or urgency. The form indicated doing well, continue Macrodantin and Estrace. A follow-up was needed in one year. A telephone interview on 07/25/24 at 12:56 P.M. with Doctor #505 revealed Resident #38 was on the antibiotic as recommended by the urologist related to frequent UTIs. A telephone interview on 07/25/24 at 1:29 P.M. with Urology Nurse Practitioner (UNP) #506 revealed Resident #38 was a newer patient of the practice and had been prescribed Trimethoprim but was changed to Macrodantin indefinitely on 10/26/23. The goal of the antibiotic was to prevent any further UTIs and to guard the one remaining kidney. UNP #506 stated Resident #38 has experienced four UTIs in the past year but could give no dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Koester Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE 3232 North County Road 25a Troy, OH 45373	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on observation, medical record review, staff interview, review of Medscape guidance, review of the insulin pen quick reference guide, and policy review, the facility failed to prime an insulin pen per manufacturer instructions prior to administration, resulting in a significant medication error. This affected one (#83) of three residents observed for medication administration. The facility census was 99. Findings include: Review of the medical record for Resident #83 revealed an admitted [DATE]. Diagnosis included diabetes mellitus (DM). Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/13/24, revealed Resident #83 was cognitively intact and received insulin. Review of the physician order dated 07/08/24 for Humalog Kwikpen 100 unit per milliliter (ml) solution pen injector, inject 10 units of insulin subcutaneous (SQ) before meals related to DM. Observation on 07/23/24 at 7:45 A.M. revealed Licensed Practical Nurse (LPN) #248 prepared Humalog kwikpen for Resident #83. LPN #248 attached the needle to injector pen and set the dose on the pen to 10 units of insulin. The observation revealed LPN #248 did not prime the insulin syringe prior to setting the dose to 10 units. LPN #248 was observed to administer the Humalog Kwikpen 10 units SQ to Resident #83's abdomen. Interview on 07/23/24 at 7:58 A.M. with LPN #248 confirmed she did not prime the Humalog Kwikpen injector with two units for air shot prior to administration of 10 units of insulin. Review of the facility policy titled, Administering medications, revised April 2019, revealed medications are to be administered in a safe and timely manner, and as prescribed and only by persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. Prior to the administration of insulin with the insulin pen, the nurse verified that the correct pen is used for that resident. Review of Medscape guidance titled Intermittent Insulin Injections Insulin Overview dated 11/05/20 and located at https://emedicine.medscape.com/article/2049311-overview#a1 revealed to avoid air and to ensure proper dose, you will need to prime the syringe each time; to do this, dial two units; hold the pen with the needle pointing up and tap the cartridge gently a few times to get rid of any air bubble; press the push button all the way in until the dose selector returns to zero; a drop of insulin must appear at the needle tip; if not, change the needle and repeat the procedure. Review of the Kwikpen reference guide stated to prep the injection pen by doing an appropriate air shot before each use of the insulin pens. The reference guide stated to use two units air shots before each use.

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NAME OF PROVIDER OR SUPPLIER Koester Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE 3232 North County Road 25a Troy, OH 45373	

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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** 46613 Based on observation, resident and staff interviews, medical record review, and policy review, the facility failed to ensure medications were consumed at the time of administration and not left at the resident's bed side unsupervised. This affected one (#302) resident out of the three residents reviewed for medication administration. The facility census was 99. Findings include: Review of the medical record for Resident #302 revealed an admitted [DATE]. Diagnoses included aftercare following joint replacement, acquired absence of right hip joint, anemia, anxiety, and hypertension. Review of the admission assessment, dated 07/17/24, revealed Resident #302 was alert and oriented to person, place, time, and situation. Review of the physician orders dated 07/23/24 to be administered at 8:00 A.M. revealed celecoxib (anti-inflammatory drug) 200 milligram (mg) one tablet by mouth, cholecalciferol (supplement) 1,000 units one tablet by mouth, Cymbalta (anti-depressant) 60 mg one tablet by mouth, folic acid (vitamin) one mg one tablet by mouth, leflunomide (treats rheumatoid arthritis) 20 mg one tablet by mouth, metoprolol (lowers blood pressure) 25 mg one tablet by mouth, multivitamin one tablet by mouth, aspirin 81 mg one tablet by mouth, rifampin (antibiotic) 300 mg one tablet by mouth, ferrous sulfate (vitamin) 325 mg one tablet by mouth, gabapentin (treats nerve pain) 300 mg one tablet by mouth, and pantoprazole (treats gastroesophageal reflux disease) 40 mg one tablet by mouth. Observation with interview with Resident #302 on 07/23/24 at 8:48 A.M. revealed a medication cup with medications in the cup sitting on Resident #302's bedside table. Resident #302 stated the nurse left the medications sitting at the bedside while Licensed Practical Nurse (LPN) #259 went to get supplies for her intravenous medication. There was no nurse observed to be in Resident #302's room or in the hallway. Interview on 07/23/24 at 8:52 A.M. with LPN #259 confirmed she did not observe Resident #302 consume medications and left the medication cup with all Resident #302's medications due at 8:00 A.M. sitting on her bedside table while she left to get supplies for the intravenous medication. Review of the facility policy titled Administering Medications, revised April 2019, revealed medications are to be administered in a safe and timely manner, and as prescribed and only by persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. Medications are to be administered in accordance with prescriber orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Koester Pavilion	3232 North County Road 25a Troy, OH 45373

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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** 35035 Based on observation, staff interview, record review and review of the facility policy the facility failed to follow isolation protocols while providing care to residents. This affected one (Resident #47) of five residents reviewed for isolation precautions. The facility census was 99. Findings include: Record review for Resident #47 revealed the resident was originally admitted to the facility on [DATE]. Diagnoses for Resident #47 included cerebral infarction, diabetes type two mellitus, and heart disease. Review of the care plan dated 08/02/22 revealed Resident #47 was at risk for infection. Interventions included isolation protocols per policy. There was also a focus for wounds and skin breakdown. Interventions included to follow isolation protocols per policy. Review of the facility's infection control list dated 07/22/24 for all residents requiring isolation protocols, revealed Resident #47 was on the list for a wound. Observation on 07/22/24 at 9:00 A.M. of Resident #47's hallway revealed hanging on the doorway to the resident's room was a posted sign reading Enhanced Barrier Precautions (EBP). Per the sign, all caregivers were to don a gown and gloves to provide care to the resident. Observation on 07/23/24 at 9:16 A.M. of Resident #47's care provided by State tested Nursing Aide (STNA) #271 revealed STNA #271 entered the room with the mechanical lift and did not don any gloves or gown. No gown or gloves were observed in the resident's room. STNA #271 performed personal care which included incontinence care and transfer from the bed to the wheelchair. Interview on 07/23/24 at 9:32 A.M. with STNA #271 verified she did not follow the proper EBP. STNA #271 verified she did not wear gloves or a gown while providing personal care and transferring Resident #47. Interview on 07/24/23 at 11:00 A.M. with the Infection Control Preventionist (ICP) #326 revealed Resident #47 was in isolation protocols for the open wounds. ICP #326 stated it was the facility's policy to place all residents with active infections or open wounds into EBP precautions to prevent the spread of infection. LPN #326 stated all staff were to wear appropriate PPE while providing personal care, including transferring, for Resident #47 per the EBP protocols. Review of the facility policy titled 'Enhanced Barrier Precautions', dated 07/15/22, revealed it is the policy to place all residents who have wounds into EBP. While providing care which included dressing, transferring, and changing linens, all staff are to wear gowns and gloves to prevent the spread of infection.