STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365756	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitehouse Country Manor	11239 Waterville St Whitehouse, OH 43571

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, resident and staff interviews, medical record review, and policy review, the facility failed to ensure residents were afforded the ability to smoke during designated smoking times. This affected one (#69) of one residents reviewed for smoking. The facility census was 84. Findings include: Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses of heart failure and type II diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/24, revealed Resident #69 had intact cognition. Review of the smoking assessment, completed 02/12/25, revealed Resident #69 smoked five (5) to 10 times per day. Interview on 02/10/25 at 8:30 P.M. with Resident #69 revealed he was frustrated because he was not allowed to smoke on three occasions because he was told he showed up too late for the scheduled smoking time. Resident #69 stated he had a clock in his room and was on time for the scheduled smoking break. Observation on 02/12/25 at 1:58 P.M. revealed Resident #69 in his wheelchair in the common area asking for a cigarette. Interview on 02/12/25 at 1:58 P.M. with Registered Nurse (RN) #367 stated Resident #69's smoke time was 1:45 P.M. and residents were allowed a ten minute grace period. RN #367 stated residents could arrive until 1:55 P.M. and still be allowed to smoke during the scheduled smoke time. Interview on 02/12/25 at 1:59 P.M. with Certified Nurse Aide (CNA) #348 stated she did not take residents out for the 1:45 P.M. smoke break. CNA #348 further stated residents had a 10 minute grace period to arrive for the assigned smoking time. (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: 365756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025

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Whitehouse Country Manor	11239 Waterville St Whitehouse, OH 43571

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/12/25 at 2:00 P.M. with CNA #330 revealed she was responsible for the 1:45 P.M. smoking break. CNA #330 repeatedly stated Resident #69 arrived at 1:52 P.M. and was not allowed to smoke because CNA #330 understood residents had to be present by 1:50 P.M. to be allowed to smoke during the break. CNA #330 could not clarify if residents were allowed a ten minute grace period. CNA #330 repeated residents had to be present by ten minutes before the hour to be allowed to smoke during the 1:45 P.M. smoke break. Interview on 02/12/25 at 2:02 P.M. with the Director of Nursing (DON) confirmed residents were allowed a ten minute grace period to arrive for the assigned smoke break. The DON stated if Resident #69 arrived at 1:52 P.M. he should have been allowed to smoke. The DON stated she would ensure Resident #69 was taken out to smoke to make up for the missed smoke time. Further interview with the DON revealed the smoking policy does not include guidance for a ten minute grace period but stated it was something the staff were trained to accommodate. Review of the smoking policy, dated 08/26/24, revealed the facility will make every best effort to establish and maintain safe resident smoking practices that accommodate the resident's needs. This deficiency represents non-compliance investigated under Complaint Number OH00162567.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER: Whitehouse Country Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 11239 Waterville St Whitehouse, OH 43571	

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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 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** 44815 Based on observation, resident and staff interview, and policy review, the facility failed to repair or replace broken window blinds. This affected two (#15 and #68) of three residents reviewed for environmental concerns. The facility census was 84. Findings include: 1. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses of schizoaffective disorder and hemiplegia and hemiparesis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/24/25, revealed Resident #15 had intact cognition. Observation on 02/11/25 at 6:59 A.M. in Resident #15's room revealed the vertical blinds had missing slats and a blanket covering up half of the window blinds. Concurrent interview with Resident #15 confirmed the missing slats bothered her and she used the blanket to further block sunlight. Interview and observation on 02/12/25 at 2:26 P.M. with Registered Nurse (RN) #367 confirmed there were five missing blind slats and an additional missing slat under the blanket. RN #367 confirmed she was aware the blinds were missing but did not report it because she thought somebody else had reported it. Interview on 02/18/25 at 4:00 P.M. with Maintenance Director #400 revealed he was unaware of the missing vertical slats in Resident #15's room. 51513 2. Review of the medical record for Resident #68 revealed an admitted [DATE] with diagnoses of Huntington's disease, major depressive disorder, and anxiety. Review of quarterly MDS assessment dated [DATE] revealed Resident #68 had impaired cognition and was receiving hospice care. Observation on 02/10/25 at approximately 7:30 P.M. revealed Resident #68 had horizontal blinds covering window next to bed. Further observation revealed approximately six to ten blind slats broken or missing. Interview on 02/12/25 at 11:41 A.M. with Certified Nurse Aide (CNA) #311 confirmed the missing or broken blind slats in Resident #68's room. CNA #311 stated she was aware the blinds were broken and there was a maintenance request form to fill out for facility repairs but had not filled out a request form for the blinds. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whitehouse Country Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 11239 Waterville St Whitehouse, OH 43571	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Quality of Life - Homelike Environment, revised 05/2017, revealed the facility will maximize a clean, sanitary and orderly environment and comfortable (minimum glare) yet adequate lighting.

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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 49742

Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure fall interventions were in place as ordered and care planned. This affected two (#27 and #33) of three residents reviewed for falls. The facility census was 84.

Findings Include:

1. Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, atrial fibrillation, history of COVID-19, atherosclerotic heart disease, generalized muscle weakness, neurosyphilis, seizures, bipolar disorder, unspecified abnormalities of gait and abnormalities, schizophrenia, hypothyroidism, and dementia.

Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 01/21/25, revealed Resident #27 was cognitively intact.

Review of Resident #27's current physician orders revealed an order for this resident to utilize a reacher/grabber when items are out of reach.

Review of Resident #27's current comprehensive care plan revealed the resident was at risk for falls with interventions including a mat on floor next to the bed on both sides and utilize a reacher/grabber when items are out of reach.

Observation on 02/18/25 at 7:48 A.M. of Resident #27's room revealed no fall mat on either side of his bed and no reacher/grabber to utilize when items are out of reach.

An interview on 02/18/25 at 7:50 A.M. with Resident #27 revealed he does not have a reacher/grabber or fall mats. Further interview with Resident #27 revealed he had no knowledge of these items.

An interview on 02/18/25 at 7:53 A.M. with Licensed Practical Nurse (LPN) # 365 verified there was no reacher/grabber or floor mats on either side of the bed.

44815

2. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses of dementia and epilepsy.

Review of the modified quarterly MDS assessment, dated 12/18/24, revealed Resident #33 had impaired cognition and was mobile with a walker and/or wheelchair. Resident #33 required supervision or touching assistance for personal hygiene and dressing and bed mobility. Further review revealed Resident #33 had no falls since the previous assessment.

Review of the fall risk assessment, completed 01/05/25, revealed Resident #33 was at high risk for falls.

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NAME OF PROVIDER OR SUPPLIER Whitehouse Country Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 11239 Waterville St Whitehouse, OH 43571	

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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	Review of a current physician order initiated 05/02/23 revealed Resident #33 should have a motion sensor alarm above the bathroom door for fall prevention. Review of a current physician order initiated 07/03/23 revealed Resident #33 should have non-skid strips on floor in front of the closet. Review of a current physician order initiated 08/15/23 revealed Resident #33 should have non-skid strips in front of the bed for fall prevention. Observation and interview on 02/18/25 at approximately 7:45 A.M. with Certified Nurse Aide (CNA) #348 in Resident #33's room revealed no non-skid strips were on the floor near the bed or in front of the closet. CNA #348 stated Resident #33 had not moved rooms recently. Interview on 02/18/25 at 8:34 A.M. with the Director of Nursing (DON) stated Resident #33 was recently moved from another room after Resident #33 tested positive for COVID-19. Observation in Resident #33's previous room revealed non-skid strips in front of her closet. The DON confirmed fall interventions were not in place in Resident #33's current room. Observation and interview on 02/18/25 at 8:37 A.M. revealed Unit Manager (UM) #365 placing non-skid strips in front of the closet in Resident #33's room. UM #365 confirmed no door alarm was on the bathroom door in Resident #33's room. Further observation revealed a door alarm on the bathroom door in Resident #33's old room. Review of the falls policy, dated 01/01/2016, revealed it is the policy of the facility to insure the safety and well-being of residents who are at risk for falls. Additional review revealed the facility would implement interventions to guard against another fall of the same type. This deficiency represents non-compliance investigated under Complaint Number OH00162567.

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	365756	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 49742 Based on observation, staff interview, medical record review, review of facility policy, and review of manufacturers instructions, the facility failed to ensure Novolog insulin was properly removed from use after it was opened past 28 days. This affected one (#10) of 21 residents with orders for insulin. The facility census was 84. Findings Include: Review of Resident #10's medical record revealed an admitted [DATE] with diagnoses including hemiplegia, vitamin D deficiency, bipolar disorder, type two diabetes mellitus, hypertension, and schizoaffective disorder. Review of the most recent annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact. Observation on 02/12/25 at 9:42 A.M. of a medication storage cart revealed a Novolog Flex Pen for Resident #10 was opened, contained approximately 210 units of insulin, and was labeled with an open date of 12/25/24. Interview on 02/12/25 at 9:44 A.M. with the Director of Nursing (DON) confirmed the Novolog Flex Pen for Resident #10 contained approximately 210 units and was labeled with an open date of 12/25/24. The DON stated the facility policy indicated for staff to discard Novolog Flex Pens 28 days after the date they are opened. Review of the manufacturers package insert for Novolog Flex Pen revealed when the pen was stored at room temperature after opening it should be thrown away after 28 days. Review of the facility policy titled, PCA (Pharmacy Care Associates) Expiration Dates, dated November 2018, revealed Novolog Flex Pen should be discarded 28 days after opening.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31638 Based on observation, staff interview, and policy review, the facility failed to store food in a safe and sanitary manner. This had the potential to affect all but five (#16, #32, #48, #50, and #64) residents who eat food from the kitchen. The facility census was 84. Findings included: Observation of of the kitchen reach in refrigerator on 02/10/25 at 6:48 P.M. revealed a clear plastic bag of 12 chicken strips was found to not be dated nor labeled. An additional bag of nine hamburger patties were found to be undated. Further observation of the reach in freezer found a bag of mixed vegetables which failed to be securely closed and the contents were open to air. Interview with Dietary Manager #366 on 02/10/25 at 6:57 P.M. verified the chicken and beef patties were not labeled and the mixed vegetables were improperly stored. Review of the undated facility policy titled, Food and Supply Storage Procedures, revealed food should be covered, labeled, and dated. Further review revealed staff were to wrap food tightly to prevent freezer burn.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, medical record review, staff interview, and review of a facility policy, the facility failed to ensure information contained in a resident's medical record was accurate. This affected one (#33) of three residents reviewed for falls. The facility census was 84. Findings Include: Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses of dementia and epilepsy. Review of the modified quarterly Minimum Data Set (MDS) assessment, dated 12/18/24, revealed Resident #33 had impaired cognition and was mobile with a walker and/or wheelchair. Further review revealed Resident #33 had no falls since the previous assessment. Review of a current physician order initiated 05/02/23 revealed Resident #33 should have a motion sensor alarm above bathroom door for fall prevention. Review of a current physician order initiated 07/03/23 revealed Resident #33 should have non-skid strips on floor in front of the closet. Review of a current physician order initiated 08/15/23 revealed Resident #33 should have non-skid strips in front of the bed for fall prevention. Observation and interview on 02/18/25 at approximately 7:45 A.M. with Certified Nurse Aide (CNA) #348 in Resident #33's room revealed no non-skid strips were on the floor near the bed or in front of the closet. CNA #348 stated Resident #33 had not moved rooms recently. Interview on 02/18/25 at 8:34 A.M. with the Director of Nursing (DON) stated Resident #33 was recently moved from another room after Resident #33 tested positive for COVID-19. Observation in Resident #33's previous room revealed non-skid strips in front of her closet. The DON confirmed fall interventions were not in place in Resident #33's current room. Further interview, along with concurrent review of Resident #33's electronic medical record (EMR), revealed staff charted the non-skid strips were in place in Resident #33's room. The DON confirmed the charting was inaccurate. Observation and interview on 02/18/25 at 8:37 A.M. revealed Unit Manager (UM) #365 placing non-skid strips in front of the closet in Resident #33's room. UM #365 confirmed no door alarm was on the bathroom door in Resident #33's room. Further observation revealed a door alarm on the bathroom door in Resident #33's old room. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/18/25 at 8:47 A.M. with Licensed Practical Nurse (LPN) #331, and concurrent review of Resident #33's EMR, revealed LPN #331 charted fall interventions were in place on 02/17/25 for Resident #33. LPN #331 stated she was aware the door alarm was not in the room with Resident #33, and further stated the door alarm was nonfunctional and required new batteries. LPN # further confirmed she documented on 02/17/25 in the EMR Resident #33's placement and function of the door alarm with a y to indicate it was in place and functional. LPN #331 again confirmed the door alarm was nonfunctional and the charting was not accurate. Observation and interview on 02/18/25 at approximately 9:00 A.M. with the DON confirmed the door alarm on the bathroom door in Resident #33's old room was not working. Additionally, the DON confirmed charting in the resident's EMR reflected the door alarm was in place in Resident #33's room and was in functional, and verified the door alarm was not actually in Resident #33's room and was not functional. Review of the facility policy titled, Charting and Documentation, with a revision date of 07/17, revealed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 44815

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	365756	A. Building B. Wing	02/18/2025

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Whitehouse Country Manor	11239 Waterville St Whitehouse, OH 43571

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44815

Based on observation, medical record review, staff interview, review of the Centers for Disease Control and Prevention (CDC) website, and review of an infection control facility assessment document, the facility failed to ensure staff members wore appropriate personal protective equipment (PPE) while handling soiled laundry and failed to wear, dispose of, and perform adequate hand hygiene after removing PPE while in resident rooms who were on infection control precautions due to COVID-19 infection. This had the potential to affect all 84 residents in the facility. The census was 84.

Findings include:

1. Observation on 02/12/25 at 1:49 P.M. revealed Housekeeping Supervisor (HS) #397 in the laundry room not wearing any personal protective equipment (PPE). Further observation revealed a laundry basket of dry clothes beneath a washing machine with some dry items loaded into the washing machine. Concurrent interview with HS #397 confirmed she was in the middle of loading the washing machine with soiled items and was not wearing PPE. HS #397 further confirmed she should be wearing PPE while handling soiled clothing or linens. HS #397 further stated the items she was loading in the washing machine were not from rooms where residents were in isolation for infections.

Review of a document titled, Infection Control Facility Assessment, revised 08/2019, revealed environmental staff should follow standard practice when handling linen, including avoiding direct body contact with soiled items.

51513

2. Review of the medical record for Resident #36 revealed an admitted [DATE] with a diagnosis of cerebrovascular accident.

Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively intact and required staff assistance for all activities of daily living (ADLs).

Review a physicians order dated 02/10/25 revealed Resident #36 was in contact/droplet precautions every shift for COVID-19 for ten days.

Observation on 02/11/25 at 7:33 A.M. revealed signage on Resident #36's door indicating the resident was on droplet precautions that required everyone must wash hands before entering and exiting the room. Further observation revealed additional signage indicating proper steps for putting on (donning) PPE before entering the room and taking off (doffing) PPE upon exiting the room. Observation of the steps for doffing the PPE included first removing gloves and discarding, then remove goggles or face shield, then remove gown, followed by removing mask or respirator, and last step was to wash hands or use an alcohol based hand sanitizer immediately after removing PPE.

Observation on 02/11/25 at 7:33 A.M. revealed Certified Nurse Aide (CNA) #396 delivered a food tray into Resident #36's room without an N95 mask on. CNA #396 wore two surgical masks along with a gown and gloves into the room.

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NAME OF PROVIDER OR SUPPLIER Whitehouse Country Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 11239 Waterville St Whitehouse, OH 43571	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 02/11/25 at 7:35 revealed CNA #396 exiting the room then she removed her left glove before she removed the gown then removed the right glove and placed the rolled up, used PPE on the floor. CNA #396 then failed to perform hand hygiene after exiting room. CNA #396 then walked down the entire hall past resident rooms, into a staff office, then down another corridor never performing hand hygiene. Interview on 02/11/25 at 7:42 A.M. with CNA #396 confirmed she did not wear an N95 mask as it was her understanding two surgical masks would be appropriate for droplet precautions. Further, CNA #396 confirmed she did not appropriate hand hygiene, and stated she placed the used PPE on the floor outside Resident #36's room because there was no garbage can inside the room and she was going to retrieve a garbage can for the room. 49742 3. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses of dementia, depression, hypercholesterolemia, type two diabetes mellitus, osteoarthritis, vitamin D deficiency, vitamin B deficiency, and epilepsy. Review of the modified quarterly MDS assessment, dated 12/18/24, revealed Resident #33 was moderately cognitively impaired. Review of Resident #33's physician orders revealed an order dated 02/10/25 for the resident to be on contact/droplet isolation every shift for COVID-19. Observation on 02/11/25 at 7:36 A.M. revealed CNA #330 delivered a meal tray to Resident #33 donning only a gown and a surgical mask. Interview on 02/11/25 at 7:41 A.M. with CNA #330 verified while delivering a tray to Resident #33 she did not wear a face shield or goggles, did not donned gloves in Resident #33's room after entry, and did not take off the surgical mask she wore prior to leaving Resident #33's room. 4. Review of Resident #29's medical record revealed an admitted [DATE] with diagnoses including dementia, schizoaffective disorder, paranoid schizophrenia, heart disease, anxiety, dysphagia, COVID-19, cognitive communication deficit, and abnormalities of gait and mobility. Review of the most recent quarterly MDS assessment for Resident #29, dated 01/31/25, revealed the resident was cognitively intact. Review of Resident #29's physician orders revealed an order dated 02/10/25 for the resident to be on contact/droplet isolation precautions every shift for COVID-19. 5. Review of Resident #34's medical record revealed an admitted [DATE] with diagnoses including dementia, muscle wasting and atrophy, anxiety, COVID-19, generalized muscle weakness, depression, and chronic obstructive pulmonary disease. Review of Resident #34's medical record revealed an order dated 02/10/25 for the resident to be on contact/droplet isolation precautions every shift for COVID-19. (continued on next page)

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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 - Many	Observation on 02/11/25 at 10:19 A.M. revealed Housekeeper #402 he was cleaning inside the room shared by Resident #29 and Resident #34 wearing no PPE other than a surgical mask. Interview on 02/11/25 at 10:20 A.M. with Housekeeper #402 verified he did not wear any PPE other than a surgical mask while cleaning the room shared by Resident #29 and Resident #34. Review of the CDC website at https://www.cdc.gov/covid/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html under the section titled, Infection Control Guidance: SARS-CoV-2, dated 06/24/24, revealed healthcare personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 (COVID-19) infection should adhere to standard precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of the the CDC website at https://www.cdc.gov/niosh/learning/safetyculturehc/module-3/8.html, under the section titled, Donning and Doffing PPE: Proper Wearing, Removal, and Disposal, dated 10/03/22, revealed donning means to put on and use PPE properly to achieve the intended protection and minimize the risk of exposure and doffing means removing PPE in a way that avoids self-contamination. Further review revealed individuals wearing PPE should remove the PPE before entering any non-clinical areas including restrooms, breakrooms, and administrative areas, always wash hands with soap and water before wearing and after removal of PPE, and dispose of all PPE in appropriate waste containers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365756	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Whitehouse Country Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 11239 Waterville St Whitehouse, OH 43571	

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 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** 49742 Based on observation, staff interview, and review of facility policy, the facility failed to ensure the resident call light system was functioning appropriately and relaying the calls to a centralized staff work area or to a staff member. This affected two (#204 and #207) of 24 rooms located on the 200 Hall. The census was 84. Findings Include: Observation on 02/18/25 at 9:05 A.M. revealed the call lights for room [ROOM NUMBER] and room [ROOM NUMBER] were illuminated in the hall above the doors entering the room. Continued observation revealed both call lights were not relaying the call to a staff member or a monitoring system located at the centralized staff work area. Interview on 02/18/25 at 9:08 A.M. with Housekeeper #397 verified revealed the call lights for room [ROOM NUMBER] and room [ROOM NUMBER] were illuminated in the hall above the doors entering the room, but were not relayed to the centralized monitoring system located in the staff work area. Interview on 02/18/25 at 9:15 A.M. with Licensed Practical Nurse (LPN) #365 revealed the centralized monitoring system located in the staff work area had received call light signals for approximately a week and one-half. LPN #365 revealed she was unsure of when the call lights would be repaired or what actions the maintenance department had taken to fix the call lights. Interview on 02/18/25 at 11:14 A.M. with Maintenance Director (MD) #400 verified the call light monitoring system located in the staff work area where room [ROOM NUMBER] and room [ROOM NUMBER] were located had not been functional for approximately two and one-half weeks. MD #400 stated he had not had someone evaluate the call light system to determine what was needed to repair the communication system located in the staff work area. Review of the facility policy titled, Call Light Policy and Procedure, dated December 2020, revealed the call light was used by a resident to notify staff of the nursing facility that the resident has a need that they would like addressed. This deficiency represents non-compliance investigated under Complaint Number OH00162567.