| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365799 | A. Building<br>B. Wing | 03/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| West Park Care Center LLC | 1700 Heinzerling Drive<br>Columbus, OH 43223 |

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on observation, record review, staff interview, and facility policy review, the facility failed to treat Resident #143 in a dignified manner. This affected one resident (#143) of one resident reviewed for dignity. The facility census was 84.<br><br>Findings include:<br><br>Review of the medical record for Resident #143 revealed an initial admitted [DATE] with diagnoses including atrial fibrillation, diabetes mellitus, panlobular emphysema, dementia, obstructive and reflux uropathy, artificial openings of urinary tract, hyperlipidemia, hypertension, constipation, acquired absence of other genital organs and urinary tract infection (UTI).<br><br>Review of Resident #143's admission evaluation dated 02/18/25 revealed the resident was alert and oriented on admission. The assessment indicated the resident required extensive assistance with bed mobility, was dependent on staff for transfers and toilet use, and required supervision with eating.<br><br>Review of the plan of care dated 02/18/25 revealed Resident #143 had an Activities of Daily Living (ADL) self-care performance deficit related to fatigue. Interventions included the resident's ADL level varied with tasks and the time of day, staff could provide more assistance at times to maintain safety as needed, the resident required one person assistance with bed mobility, dressing, personal hygiene, toilet use and transfers, staff were to encourage the resident to participate to the fullest extent possible with each interaction, and to monitor/document/report any changes as needed.<br><br>Observation on 02/24/25 at 2:44 P.M. of Resident #143 revealed he remained in a hospital gown while personal clothing was available to dress.<br><br>Observation on 02/25/25 at 10:28 A.M. of Resident #143 revealed he was sitting up in his wheelchair in his room in a hospital gown. Further observation revealed the resident's personal clothing was folded up and laying on the stand.<br><br>Interview on 02/25/25 at 11:50 A.M. with Certified Nurse Aide (CNA) #151 confirmed Resident #143 remained in a hospital gown and had clothing available to dress.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled, Dignity, dated 09/21/23 revealed it was the policy of the facility that each resident would be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. The policy stated residents would be treated with dignity and respect at all times and when assisting with care, residents were to be supported in exercising their rights, for example encouraging them to dress in clothing that they preferred. |

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| F 0570<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assure the security of all personal funds of residents deposited with the facility.<br><br>37100<br><br>Based on facility financial record review and staff interview, the facility failed to secure a surety bond that covered all of the resident funds. This had the potential to affect 42 residents (#2, #3, #4, #5, #6, #7, #9, #11, #13, #14, #15, #16, #18, #19, #21, #22, #23, #24, #25, #26, #28, #32, #33, #39, #40, #43, #44, #45, #46, #51, #52, #54, #55, #56, #57, #58, #60, #63, #64, #72, #76, #82) of 42 residents who had funds managed by the facility. The census was 84.<br><br>Findings Include:<br><br>Review of 42 residents (#2, #3, #4, #5, #6, #7, #9, #11, #13, #14, #15, #16, #18, #19, #21, #22, #23, #24, #25, #26, #28, #32, #33, #39, #40, #43, #44, #45, #46, #51, #52, #54, #55, #56, #57, #58, #60, #63, #64, #72, #76, #82) current financial records revealed the total for all funds managed by the facility was $158,125.48.<br><br>Review of facility surety bond, dated 05/31/24, revealed the bond amount was increased from $40,000 to $50,000. There was no documentation or evidence to support the surety bond amount was increased again to meet the needs of all the funds managed by the facility.<br><br>Interview with the Administrator on 02/27/25 at 2:15 P.M. and the Director of Nursing (DON) on 02/27/25 at 3:00 P.M. confirmed they did not have evidence that the surety bond amount was increased to meet the amount of money the facility managed for the residents. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on record review, staff interview, and facility policy review, the facility failed to notify Resident #140's primary care physician (PCP) of a weight gain outside of the physician ordered parameters. This affected one resident (#140) of five residents reviewed for unnecessary medications. The facility census was 84.<br><br>Findings Include:<br><br>Review of the medical record for Resident #140 revealed an initial admitted [DATE] with the diagnoses including light chain (AL) amyloidosis, congestive heart failure, hypertensive heart disease, atrial fibrillation, lymphedema, respiratory syncytial virus (RSV), type one diabetes mellitus, morbid obesity, cardiomyopathy, hyperlipidemia, anemia, chronic kidney disease, hydrocephalus, anxiety disorder, depression, orthopnea, solitary pulmonary nodule, bilateral conductive hearing loss and constipation.<br><br>Review of Resident #140's admission evaluation dated 02/18/25 revealed the resident had no cognitive deficit.<br><br>Review of Resident #140's monthly physician orders for February 2025 identified orders dated 02/19/25 for 1800 milliliter (ml) fluid restriction and daily weights with instructions to notify the physician if the resident had greater than two pounds weight gain per day over a two day period or five pounds in a week.<br><br>Review of Resident #140's weights revealed on 02/19/25 the resident weighed 300 pounds, on 02/20/25 the resident weighed 300.4 pounds, on 02/21/25 the resident weighed 298 pounds, on 02/22/25 the resident weighed 297.6 pounds, on 02/23/25 the resident's weight was not obtained, on 02/24/25 the resident weighed 307.8 pounds and on 02/25/25 the resident weighed 295.5 pounds.<br><br>Review of the medical record revealed no documented evidence that Resident #140's primary care physician was notified of the greater than two pound weight gain on 02/24/25.<br><br>On 02/25/25 at 2:14 P.M., interview with Registered Nurse (RN) #250 confirmed Resident #140's PCP was not notified of the greater than two pound weight gain as physician ordered.<br><br>Review of the facility policy titled, Change in Condition Notification, dated 08/09/23 revealed the nurse would notify the resident, the resident's physician/practitioner, and the resident's designated representative when there was a significant change in the resident's physical, mental or psychosocial status such as deterioration which included life threatening conditions or clinical complications. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100<br><br>Based on medical record review, staff interview, and facility policy review, the facility failed to adequately revise resident care plans. This affected one (Resident #81) of 18 resident care plans reviewed.<br><br>Findings Include:<br><br>Review of Resident #81's record revealed she was admitted to the facility on [DATE]. Her diagnoses included complete traumatic amputation between knee and ankle, atrial fibrillation, Crohn's disease, aortic insufficiency, venous insufficiency, hypertension, hyperlipidemia, vitamin D deficiency, other primary thrombophilia, hypokalemia, anxiety disorder, depression, pressure ulcer to right heel (stage II), polyosteoarthritis, edema, and dementia.<br><br>Review of Resident #81's Minimum Data Set (MDS) assessment, dated 02/04/25, revealed she had a severe cognitive impairment.<br><br>Review of Resident #81's behavior logs, dated 11/25/24 to 01/13/25, revealed 24 different entries in which she rejected care, which included the treatment and care for her right heel pressure ulcer.<br><br>Review of Resident #81's progress notes revealed Resident #81 was admitted to the hospital on 01/13/25 due to a declining right heel pressure ulcer. Resident #81 was readmitted to the facility on [DATE] after having a below the knee amputation on her right leg.<br><br>Review of Resident #81's Changes in Mood and Behavior care plan, dated 01/03/25, revealed an area of care for refuses treatment was added. Even though the refuses treatment care area was added, there were no interventions to address the added area of concern.<br><br>Review of Resident #81's At Risk for Skin Integrity care plan, dated 01/03/25, revealed an area of care for non compliant with dressing changes was added. Even though the non compliant with dressing changes care area was added, there were no interventions to address added area of concern.<br><br>Interview with the Director of Nursing (DON) on 02/27/25 at 9:55 A.M., 10:25 A.M., and 1:20 P.M. confirmed the addition of rejection of care and non-compliance were not added to Resident #81 care plans until 01/03/25. She also confirmed there were no interventions added to the care plans to address Resident #81's rejection of care and there should have been interventions added.<br><br>Review of facility Skin and Wound Guidelines, dated 03/20/24, revealed the policy overview was to describe the process steps required for identification of residents at risk for the development of pressure injuries, identify prevention techniques, and interventions to assist with the management of pressure injuries and skin alterations. The individualized comprehensive care plan addressed the resident's problem (i.e. resident skin breakdown or actual wound), the goal for prevention and/or treatment, and individualized interventions to address the resident's specific risk factors and the plan for reduction of risk. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on record review, observation, resident interview, staff interview, and facility policy review, the facility failed to ensure one resident (#140) received routine showers. This affected one resident (#140) out of three residents reviewed for activities of daily living (ADL). The facility census was 84.<br><br>Findings Include:<br><br>Review of the medical record for Resident #140 revealed an initial admitted [DATE] with the diagnoses including but not limited to light chain (AL) amyloidosis, congestive heart failure, hypertensive heart disease, atrial fibrillation, lymphedema, respiratory syncytial virus (RSV), type one diabetes mellitus, morbid obesity, cardiomyopathy, hyperlipidemia, anemia, chronic kidney disease, hydrocephalus, anxiety disorder, depression, orthopnea, solitary pulmonary nodule, bilateral conductive hearing loss and constipation.<br><br>Review of Resident #140's admission evaluation dated 02/18/25 revealed the resident had no cognitive deficit. The assessment indicated the resident was independent with bed mobility, toilet use, eating and required supervision with transfers.<br><br>Review of Resident #140's plan of care dated 02/19/25 revealed the resident had a self-care deficit related to decreased mobility, amyloidosis with chemotherapy, morbid obesity, hydrocephalus, diabetes mellitus, heart disease and incontinence. Interventions included the resident required one staff assistance with activities of daily living (ADL), assistance to bathe/shower as preferred per shower schedule and as needed, staff assistance with daily hygiene, grooming, dressing, oral care and eating as needed, break ADL tasks into sub-tasks for easier patient performance, encourage and/or assistance to reposition frequently, therapy to evaluate and treat per physician's orders and the resident required one person physical assistance with a gait belt for transfers.<br><br>Review of Resident #140's shower documentation revealed the resident had received one shower since admission. The shower was dated 02/20/25.<br><br>Review of the facility shower schedule revealed Resident #140 was scheduled for a shower every Wednesday and Saturday on the day shit.<br><br>On 02/24/25 at 2:12 P.M., observation and interview with Resident #140 revealed he only had one shower since admission and he remained in the same clothing. Observation of the resident's clothing at the time of the interview revealed the resident had dried food on his shirt and pants.<br><br>On 02/25/25 at 10:13 A.M., interview with Resident #140 revealed he reported he had a shower and his clothing changed after asking multiple staff members for a shower, including therapy.<br><br>On 02/25/25 at 10:18 A.M., interview with Certified Nursing Assistant (CNA) #151 revealed Resident #140 was begging her and therapy for a shower. She revealed she gave the resident a shower despite it not being his scheduled shower day.<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled, Showers, last revised on 01/07/25 revealed residents would be provided with showers per request and per facility schedule based upon resident preference and safety. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266<br><br>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to complete daily weights as ordered for one resident (Resident #5), failed to implement a physician-ordered fluid restriction for one resident (Resident #140), and failed to ensure lymphedema wraps and interventions were implemented as ordered for one resident (Resident #48). The deficient practices affected three residents (Residents #5, #48, and #140) of 18 reviewed for quality of care. The facility census was 84.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #5 revealed an initial admitted on 06/17/19 and a readmitted on 01/14/22. Medical diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with exacerbation, schizophrenia, chronic kidney disease stage III, dementia, and chronic diastolic (congestive) heart failure.<br><br>Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #5 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #5 required partial to substantial assistance from staff to complete Activities of Daily Living (ADLs).<br><br>Review of the Treatment Administration Record (TAR) dated February 2025 revealed Resident #5 had an order for daily weights with instructions that if the resident had a weight gain of three pounds (lbs) in a 24 hour period or five lbs in one week to call the Congestive Heart Failure (CHF) clinic dated to start 02/05/25 and discontinued 02/15/25. Resident #5 did not have a weight obtained on 02/11/25, 02/12/25, or 02/13/25.<br><br>Review of the Weights/Vitals tab in the electronic medical record revealed there was not a weight recorded between 02/09/25 through 02/14/25.<br><br>Review of the progress notes revealed there was no documentation to explain why Resident #5 did not have her weight checked on 02/11/25, 02/12/25, or 02/13/25.<br><br>Interview on 02/25/25 at 3:35 P.M. with the Director of Nursing (DON) confirmed Resident #5 did not have a weight completed as ordered on 02/11/25, 02/12/25, or 02/13/25.<br><br>Review of the facility policy, Weights, revised 02/01/24, revealed the policy stated daily weights may be ordered by the medical practitioner for a specific resident and may contain parameters. Weights are recorded in the Weights/Vitals tab of the electronic medical record.<br><br>32654<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the medical record for Resident #140 revealed an initial admitted [DATE] with the diagnoses including but not limited to light chain (AL) amyloidosis, congestive heart failure, hypertensive heart disease, atrial fibrillation, lymphedema, respiratory syncytial virus (RSV), type one diabetes mellitus, morbid obesity, cardiomyopathy, hyperlipidemia, anemia, chronic kidney disease, hydrocephalus, anxiety disorder, depression, orthopnea, solitary pulmonary nodule, bilateral conductive hearing loss and constipation.<br><br>Review of Resident #140's admission evaluation dated 02/18/25 revealed the resident had no cognitive deficit.<br><br>Review of Resident #140's plan of care revealed no baseline plan of care addressing the resident's 1800 milliliter (ml) fluid restriction.<br><br>Review of Resident #140's monthly physician orders for February 2025 identified an order dated 02/19/25 for an 1800 milliliter (ml) fluid restriction.<br><br>Review of Resident #140's medical record revealed the physician ordered 1800 ml fluid restriction with no evidence the fluid restriction had been implemented. Further review of the record revealed no breakdown of how many ml of fluids the nursing and the dietary department would each provide.<br><br>On 02/25/25 at 2:14 P.M., interview with Registered Nurse (RN) #151 confirmed Resident #140's 1800 ml fluid restriction was not implemented as ordered.<br><br>Review of the facility policy titled, Fluid Restriction Guidelines, last revised on 01/01/12 revealed it is the facility's policy that fluid restriction ordered by a physician are carried out by the nursing and the nutrition/food service departments. Nursing and dietary will work together to determine the amount of fluids each department will provide.<br><br>51524<br><br>3. Review of the medical record revealed Resident #48 was admitted on [DATE]. Her diagnoses included lymphedema, diabetes mellitus, mood disorder, and epilepsy.<br><br>Review of Resident #48's hospital After Visit Summary, dated 01/16/25, revealed the resident was to wear a Circaid Reduction Kit (adjustable compression wraps commonly used to treat lymphedema) to her lower left leg and Velcro wraps on both of her feet.<br><br>A review of Resident 48's Treatment Administration Record (TAR) for February 2025 listed an order for tubi-grips (compression stocking bandage) to be applied to bilateral lower extremities as tolerated with instructions for them to be applied in the morning and removed at bedtime. The TAR was signed by the nurses as received twice daily, at 9:00 A.M. and 9:00 P.M. and furthermore, the tubi-grip treatment was documented as completed at 09:00 A.M. on 02/26/25. The TAR additionally listed an order dated 01/17/25 for Circaid Reduction Kits to be on for 23 hours a day, applied at 6:00 A.M. and removed at 5:00 A.M. (the following day). The TAR was signed by the nurses as received twice daily, at 5:00 A.M. and 6:00 A.M. as ordered.<br><br>An observation of Resident #48 on 02/26/25 at 10:55 A.M. revealed the resident was not wearing tubi-grips on either leg, nor was she wearing the Circaid Reduction Kit on her left leg.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 02/26/25 at 11:25 A.M. with the Director of Nursing (DON) confirmed Resident #48 was not wearing the tubi-grips or the Circaid Reduction Kit as ordered. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on observation, staff interview, and facility policy review, the facility failed to ensure hot water temperatures were maintained below the maximum temperature of 120 degrees. This had the potential to affect 37 residents (#3, #6, #7, #8, #10, #11, #13, #16, #18, #23, #29, #32, #33, #37, #38, #39, #44, #45, #51, #57, #58, #60, #65, #68, #70, #73, #74, #78, #83, #138, #139, #140, #141, #142, #143, #238 and #239) who resided on the [NAME] hallway. In addition, based on medical record review, staff interview, and review of facility policy, the facility failed to ensure Resident #52's fall was documented and investigated. This affected one resident (#52) of ten residents reviewed for accidents. The facility census was 84 residents.<br><br>Findings Include:<br><br>1. a. On 02/24/25 at 10:42 A.M., observation of the water temperature from Resident #6's sink revealed a temperature of 124.5 degrees Fahrenheit (F).<br><br>b. On 02/24/25 at 10:56 A.M., observation of the water temperature from Resident #139's sink revealed a temperature of 122.4 degrees Fahrenheit (F).<br><br>c. On 02/24/25 at 11:00 A.M., observation of the water temperature from empty room [ROOM NUMBER]'s sink revealed a temperature of 121.3 degrees Fahrenheit (F).<br><br>d. On 02/24/25 at 11:15 A.M., observation of the water temperature from Resident #13's sink revealed a temperature of 123.8 degrees Fahrenheit (F).<br><br>e. On 02/24/25 at 11:21 A.M., observation of the water temperature from Resident #143's sink revealed a temperature of 122.4 degrees Fahrenheit (F).<br><br>On 02/24/25 at 4:00 P.M., an interview with Maintenance Director #142 verified the hot water temperatures were above the maximum temperature of 120 degrees.<br><br>Review of the facility policy titled, Water Temperatures, last revised 01/01/12 revealed it was the facility's policy to ensure the residents had hot and cold running water and that the water temperature ranges within the patient/resident areas were maintained at a safe and comfortable level. Resident areas would have both hot and cold running water and in those areas of the facility, the hot water temperatures would be maintained at the point of service between 105 and 120 degrees Fahrenheit (F).<br><br>50008<br><br>2. Review of the medical record for Resident #52 revealed that he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, protein calorie malnutrition, vascular dementia, psychotic disorder with delirium, muscle weakness, adjustment disorder with depressed mood, dysphagia, and cognitive communication deficit.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #52's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 09, indicative of moderately impaired cognition. Review of Resident #52's MDS significant change assessment for 01/17/25 revealed that a BIMS was not completed, as Resident #52 no longer was able to answer questions appropriately.<br><br>Review of Resident #52's medical record revealed he was being monitored via neurological checks on 02/22/25 and that he was status post fall day one. The clinical record was silent for the investigation or documentation related to a fall for Resident #52 on 02/21/25.<br><br>Interview with the Director of Nursing on 02/25/25 at 2:47 P.M. confirmed that Resident #52 had fallen on 02/21/25 and also confirmed that the facility did not investigate nor document a fall that occurred on 02/21/25 in the residents medical record.<br><br>Review of facility policy, dated 12/13/23, titled Fall Management Guidelines revealed that a fall risk evaluation would be completed in the medical record after a fall, and that the fall event would be documented in the resident's electronic medical record. |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on observation, record review, resident interview, staff interview, and review of facility policy and procedure, the facility failed to timely address Resident #143's leaking nephrostomy tube and accurately document the residents hospitalization and subsequent nephrostomy tube replacement. This affected one resident (#143) of one resident reviewed for nephrostomy tubes. The facility census was 84.<br><br>Findings include:<br><br>Review of the medical record for Resident #143 revealed an initial admitted [DATE] with the diagnoses including but not limited to atrial fibrillation, diabetes mellitus (DM), panlobular emphysema, dementia, obstructive and reflux uropathy, artificial openings of urinary tract, hyperlipidemia, hypertension, constipation, acquired absence of other genital organs and urinary tract infection (UTI).<br><br>Review of the resident's admission evaluation dated 02/18/25 revealed the resident was alert and oriented on admission. The assessment indicated the resident had an external catheter and was always incontinent of bowel. The assessment indicated the resident required extensive assistance with bed mobility, was dependent on staff for transfers, toilet use and required supervision with eating.<br><br>Review of the plan of care dated 02/18/25 revealed the resident had an activity of daily living (ADL) self care deficit related to weakness, nephrostomy, UTI, DM and dementia. Interventions included the resident required one assist with ADLs, assist to bathe/shower as preferred per shower schedule and as needed, assist with daily hygiene, grooming, dressing, oral care and eating as needed, break ADL tasks into sub-tasks for easier patient performance, encourage and/or assist to reposition frequently, therapy evaluation and treatment per physician orders and the resident required one person physical assist with gait belt.<br><br>Review of the resident's urinary incontinence/indwelling catheter assessment dated [DATE] revealed the resident had an indwelling catheter and the catheter was expected to be long term.<br><br>Observation on 02/24/25 at 11:18 A.M. of the resident's indwelling nephrostomy collection bag revealed the collection bag was wrapped in a white towel and in a clear plastic trash bag.<br><br>Interview on 02/24/25 at 3:00 P.M. with Registered Nurse (RN) #250 revealed she was unaware the resident's nephrostomy tube collection bag was leaking. RN #250 verified the nephrostomy tube was leaking and required a new bag, and that the nephrostomy collection bag should not be stored in a trash bag.<br><br>Interview and observation on 02/25/25 at 10:28 A.M. of Resident #143 revealed his nephrostomy tube urine collection bag was wrapped in a white towel inside a clear plastic trash bag. Interview with the resident at the time of the observation revealed his nephrostomy tube/collection bag was leaking so they placed it in the trash bag.<br><br>(continued on next page) |

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| F 0691<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the progress note dated 02/25/25 at 10:45 A.M. revealed Resident #143's urology office was contacted and a message was left regarding the resident's nephrostomy tube/collection bag was leaking. The facility was awaiting a return call.<br><br>Observation on 02/25/25 at 11:41 A.M. revealed the resident was on an ambulance stretcher being taken out of the facility.<br><br>Interview on 02/25/25 at 2:14 P.M. with RN #250 revealed she obtained an appointment for the resident with urology for 02/26/25, however, the Nurse Practitioner (NP) ordered to send him to the ER for replacement due to the nephrostomy collection bag leaking.<br><br>Review of the medical record revealed no documentation addressing the resident being transferred to the local emergency room (ER) and the resident's nephrostomy tube being replaced.<br><br>On 02/26/25 at 1:49 P.M., interview with the Director of Nursing (DON) verified Resident #143's nephrostomy was replaced during the hospital visit on 02/25/25. She further verified the resident's medical record contained no documented evidence of the resident being transferred to the ER and the nephrostomy tube being replaced.<br><br>Review of the facility policy titled, Documentation in the Medical Record, last revised 01/08/25 revealed the purpose of the policy was to provide guidelines for documentation in the medical record. Documentation should be factual, objective and resident centered. Documentation should be completed at the time of service or by the end of the shift in which the evaluation, observation or care service occurred. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008<br><br>Based on medical record review, staff interview, review of hospital records, and review of the facility policy, the facility failed to ensure a resident, who was identified at risk of malnutrition and dehydration, maintained acceptable parameters of nutritional status, failed to initiate appropriate nutritional interventions, and address significant and severe weight loss for Resident #52. This resulted in Actual Harm for one (Resident #52) resident who experienced a significant weight loss of 5.1 percent (%) in four weeks and had ongoing severe weight loss of 13.6% over less than three months, when on 12/10/24 was noted with increased lethargy, malaise and was difficult to arouse, resulting in hospitalization for failure to thrive and percutaneous endoscopic gastrostomy (PEG) tube placement for enteral nutrition support. Additionally, the facility failed to complete weight monitoring as required for a second (Resident #81) resident who was identified at risk for nutrition, placing the resident at risk for the potential for more than minimal harm. This affected two (#52 and #81) of five (#7, #22, #26, #52, #81) residents reviewed for nutrition. The facility identified a total of ten (#5, #31, #35, #44, #48, #52, #66, #74, #81, #140) residents as being at nutritional risk. The facility census was 84 residents.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #52 revealed that he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, protein calorie malnutrition, vascular dementia, psychotic disorder with delirium, muscle weakness, adjustment disorder with depressed mood, dysphagia, and cognitive communication deficit.<br><br>Review of Resident #52's nutrition care plan dated 04/12/23 revealed that Resident #52 was at risk of malnutrition related to dementia and dysphagia, and he was at risk of dehydration related to dementia. Care planned interventions included monitoring meal intakes, monitoring for signs of malnutrition, and monitoring and recording weights per the facility policy. The goal was for Resident #52 to eat over 50% of his meals and not to have any significant weight losses.<br><br>Review of Resident #52's nutrition assessment revealed the dietitian completed an assessment for the resident which was dated 04/18/24. The assessment revealed that Resident #52 was at risk for malnutrition related to dementia, which could contribute to a decreased hunger and thirst sensation. The dietitian recommended a Magic Cup supplement twice daily, which was put into place on 04/18/24. The goal was for the resident to be hydrated and nourished as his condition allowed.<br><br>Review of Resident #52's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicative of moderately impaired cognition. He was able to walk ten feet with supervision and touch assistance. The MDS stated that Resident #52 weighed 189 pounds and had not had any significant weight loss in the 1 month look back or 6 month look back periods.<br><br>Review of Resident #52's weights revealed that he weighed 196.8 pounds (lbs) on 09/03/24 and on 10/02/24 he experienced a significant 5.1% (10 lb) weight loss, weighing 186.8 lbs. Additionally, Resident #52 weighed 189.2 lbs on 11/08/24. He experienced a severe 13.6% (25.8 lbs) weight loss on 12/10/24, weighing 163.4 lbs.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #52's medical record revealed the record lacked documented evidence of a nutritional assessment and nutritional recommendations for Resident #52 in October 2024 or November 2024, and a Registered Dietitian Nutritionist (RDN) did not evaluate, assess, or address his significant weight losses in October 2024 or November 2024. Resident #52's medical record also lacked evidence of the psychiatric Nurse Practitioner (NP), the primary NP or the physician addressing any weight changes.<br><br>Review of Resident #52's orders and medical record revealed that no new interventions were put into place for Resident #52's significant weight loss from 10/02/24.<br><br>Review of Resident #52's meal intake records revealed that in September 2024, he consumed less than 50% of his meals on 11 occasions. In October 2024, he consumed<br><br>less that 50% of his meals on 17 occasions. In November 2024, he consumed less than 50% of his meals on 14 occasions. From 12/01/24 until his hospitalization on [DATE], he consumed less than 50% of his meals on six occasions.<br><br>Review of Resident #52's nutrition progress notes on 12/06/24 revealed that Dietitian #215 completed a note that Resident #52 previously had weight fluctuations and that he was trending down with his weight; however, Dietitian #215 did not address the root cause of the weight loss. Dietitian #215 did note that Resident #52 had a history of edema and that he was on a diuretic. Dietitian #215 did not address Resident #52's current edema status on 12/06/24.<br><br>Review of Resident #52's progress notes revealed that on 12/10/24, he had lethargy and decreased alertness. His weight was recorded at 7:25 A.M. on 12/10/24 as 163.4 lbs. He experienced a severe 13.6% (25.8 lb) weight loss. The NP was notified of his decreased alertness, and emergency laboratory (lab) tests were ordered. As the morning progressed on 12/10/24, the NP made the decision to send Resident #52 to the emergency room due to difficulty to arouse, lethargy and malaise.<br><br>Review of Resident #52's hospital record from 12/10/24 to 12/21/24 revealed that he was admitted to the emergency roiagnom on [DATE]. His hospital lab results revealed on 12/10/24 the resident had a serum sodium level of 166 millimoles per liter (mmol/L) [normal range from 135 to 147 mmol/L], a serum Blood Urea Nitrogen (BUN) level of 51 milligrams per deciliter (mg/dL)[normal range from 10 to 20 mg/dL], and a serum Creatinine level of 1.78 mg/dL (normal range from 0.6 to 1.2 mg/dL). The results revealed the resident ' s lab levels were all clinically elevated and could clinically indicate that Resident #52 was dehydrated on 12/10/24. The hospital physician noted that Resident #52 was hypovolemic, his blood pressure was low and that he had dry lips, which could also be clinical indications that Resident #52 was dehydrated on 12/10/24. Intravenous fluids were started on Resident #52 at the hospital.<br><br>Review of Resident #52's 12/21/24 re-admission nursing progress note revealed that on 12/21/24, he was readmitted to the facility with orders for a continuous enteral feeding of Jevity 1.5 calories via his PEG tube and a pureed diet with nectar thickened liquids.<br><br>Review of Resident #52's nurse practitioner progress notes on 12/24/24 revealed that Resident #52 was admitted to the hospital on 12/10/24 with failure to thrive, and a PEG tube was placed for nutrition support.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the nutrition assessment dated [DATE] noted that Resident #52 had a significant weight loss in the past six months; however, Dietitian #215 did not address the root cause of the weight loss. He noted that Resident #52 did not look like he had physically lost weight.<br><br>Review of Resident #52's orders revealed that he was admitted to hospice services on 01/10/25 with a terminal diagnosis of cerebral infarction.<br><br>Review of Resident #52's admitting hospice evaluation dated 01/10/25 revealed that Resident #52 had a general decline in his clinical status related to a weight loss of at least 10% of his weight in the past six months that was not due to reversible causes, such as use of diuretics. It noted that during a hospitalization for Resident #52, he had a PEG tube placed due to poor oral intakes.<br><br>Review of Resident #52's MDS significant change assessment for 01/17/25 revealed that a BIMS was not completed, as Resident #52 no longer was able to answer questions appropriately. He was no longer able to walk ten feet. The MDS revealed that he weighed 163 pounds and had an unplanned weight loss of over 10% in the past six months.<br><br>Review of Resident #52's January 2025 to February 2025 weights revealed that Resident #52 maintained a weight between 163 lbs and 164.4 lbs since 12/10/24.<br><br>Interview on 02/25/25 at 1:39 P.M. with Dietitian #215 revealed that in October 2024 when Resident #52 had a significant weight loss, the weight loss likely got missed by the dietitians responsible for monitoring the weights in the facility, as there was no permanent dietitian coverage for the facility in the month of October 2024. Dietitian #215 confirmed that on 12/10/24, Resident #52 had a significant weight loss, but that a root cause for the<br><br>weight loss was not investigated. Dietitian #215 explained that he did not know why Resident #52 lost a significant amount of weight, and that to him, Resident #52 did not physically appear to look any different than he did earlier in 2024; however, Dietitian #215 revealed that he had started working in the facility in November 2024.<br><br>Interview on 02/26/24 at 8:18 A.M. with Regional Dietitian #210 revealed that she had problems with clinical nutrition coverage and documentation throughout most of 2024, until she hired Dietitian #215 in November 2024. Regional Dietitian #210 revealed that she had a Quality Assurance and Performance Improvement (QAPI) project that she started in February 2024 about clinical nutrition documentation.<br><br>Review of the QAPI clinical nutrition documentation project revealed that there were no audits for October 2024 through December 2024 of clinical nutrition documentation.<br><br>Interview with Certified Nurse Aide (CNA) #182 on 02/26/25 at 10:35 A.M. revealed that Resident #52 used to walk around the facility and was even exit seeking until he was hospitalized on [DATE]. Interview confirmed that Resident #52 was able to be moved off of the memory care unit when he returned to the facility on [DATE], as he was now bed bound and unable to ambulate.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview with Licensed Practical Nurse (LPN) #147 on 02/26/25 at 10:37 A.M. revealed that Resident #52 used to walk around the facility and was even exit seeking until he was hospitalized on [DATE]. Interview confirmed that Resident #52 was able to be moved off of the memory care unit when he returned to the facility on [DATE], as he was now bed bound and unable to ambulate.<br><br>Interview with Hospice Administrator #211 and Hospice Registered Nurse #212 on 02/26/25 at 10:59 A.M. revealed that cerebral infarction was chosen as the terminal diagnosis for Resident #52 by the hospice Medical Director because he felt as it was the catalyst for Resident #52's eventual decline; however, his malnutrition diagnosis and the fact that Resident #52 had a severe weight loss over 10% in the past six months was considered when admitting Resident #52 to hospice services.<br><br>Interview with Regional Dietitian #210 on 02/27/25 at 8:31 A.M. revealed that although a dietitian could not directly diagnose a disease or condition, on 12/10/24 when Resident #52 had a severe 13.6% weight loss in 30 days, Resident #52 met the American Society of Parenteral and Enteral Nutrition (ASPEN) 2012 standardized guidelines for malnutrition criteria. Regional Dietitian #210 confirmed that Resident #52 did not have any new nutritional interventions put into place from 10/02/24 to 12/10/24 when he lost significant amounts of weight. Regional Dietitian #210 confirmed that Resident #52 did lose a significant amount of weight on 10/02/24 and 12/10/24.<br><br>Review of facility Weights policy, dated 02/01/24, revealed residents are weighed upon admission and then weekly for a total of four weeks. readmitted residents may or may not need weekly weights and this may be determined by the interdisciplinary team. The registered dietitian or designee is responsible for the weight management program to include compliance with weights being obtained, tracking and trending, nutritional assessments, interventions, care plans, and follow ups.<br><br>37100<br><br>2. Review of Resident #81's record revealed she was admitted to the facility on [DATE]. Her diagnoses were complete traumatic amputation between knee and ankle, atrial fibrillation, Crohn's disease, aortic insufficiency, venous insufficiency, hypertension, hyperlipidemia, vitamin D deficiency, other primary thrombophilia, hypokalemia, anxiety disorder, depression, pressure ulcer to right heel (stage II), polyosteoarthritis, edema, and dementia.<br><br>Review of Resident #81's Minimum Data Set (MDS) assessment dated [DATE] revealed she had a severe cognitive impairment.<br><br>Review of Resident #81's weights dated 11/25/24 to 01/03/25, revealed the following were the only weights obtained: 11/25/24 (233.4 pounds), 12/30/24 (238 pounds), and 01/03/25 (237.4 pounds). There was no documented evidence that Resident #81 had weekly weights obtained for the first four weeks after admission to the facility.<br><br>Review of Resident #81's nutritional notes dated 11/25/24 to 01/03/25 revealed no evidence of nutritional notes documenting weekly weights for four weeks upon admission, as expected.<br><br>Review of Resident #81's weights dated 01/03/25 to 02/05/25 revealed the following were obtained: 01/03/25 (237.4 pounds), 02/04/25 (198.4 pounds), and 02/05/25 (199.4 pounds).<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #81's progress notes dated 01/13/25 to 01/31/25 revealed Resident #81 was admitted to the hospital on 01/13/25 due to a declining right heel pressure ulcer. Resident #81 was readmitted to the facility on [DATE] after having a below the knee amputation on her right leg.<br><br>Review of Resident #81's progress and nutritional notes dated 01/29/25 to 02/07/25 revealed no weights or nutritional assessments were completed until 02/07/25. On 02/07/25, Resident #81 had a significant weight change; her current body weight was 199.4 pounds. There was no documentation to support Resident #81's weight was obtained upon readmission to the facility after the amputation.<br><br>Interview with Regional Dietitian #210 on 02/27/25 at 9:01 A.M. confirmed weights should have been obtained upon admission, each week for the first four weeks. She confirmed the initial weekly weights upon Resident #81's admission were not obtained as they should have been for proper monitoring of new admissions to the facility. Regional Dietician #210 also stated the facility should have received Resident #81's weight upon readmission, since she had a below the knee amputation completed. She confirmed she was not sure why the weights were not obtained. She confirmed there was a 38 pound decrease (16 percent (%)) from Resident #81's weight obtained prior to the hospital admission, and the first weight taken after readmission. She confirmed the typical below the knee amputation on one leg would be between six and seven percent weight decline, which would have been a total body weight for Resident #81 between 220.6 pounds and 223.2 pounds She confirmed she did not know how much weight was actually lost after Resident #81's amputation due to her not having a readmission weight obtained.<br><br>Review of the facility policy titled Weights, dated 02/01/24, revealed residents were to be weighed upon admission and then weekly for a total of four weeks. readmitted residents may or may not need weekly weights and this may be determined by the interdisciplinary team. The registered dietitian or designee was responsible for the weight management program to include compliance with weights being obtained, tracking and trending, nutritional assessments, interventions, care plans, and follow ups. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on observation, record review, and staff interview, the facility failed to ensure respiratory equipment was stored in a sanitary manner. This affected one resident (#143) of two residents reviewed for respiratory care. The facility census was 84.<br><br>Findings Include:<br><br>Review of the medical record for Resident #143 revealed an initial admitted [DATE] with diagnoses including atrial fibrillation, diabetes mellitus, panlobular emphysema, dementia, obstructive and reflux uropathy, artificial openings of urinary tract, hyperlipidemia, hypertension, constipation, acquired absence of other genital organs and urinary tract infection (UTI).<br><br>Review of Resident #143's admission evaluation dated 02/18/25 revealed the resident was alert and oriented on admission.<br><br>Review of Resident #143's monthly physician orders for February 2025 identified an order dated 02/18/25 for Ipratropium-Albuterol 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) with the special instruction to inhale 3 ml every six hours.<br><br>Observation on 02/24/25 at 11:18 A.M., of Resident #143's nebulizer delivery system revealed the delivery system was lying in the top drawer of his dresser with no protective bag.<br><br>Interview on 02/24/25 at 3:00 P.M., with Registered Nurse (RN) #250 verified the nebulizer delivery equipment was not stored properly. |

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| | 365799 | A. Building<br>B. Wing | 03/06/2025 |

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| West Park Care Center LLC | 1700 Heinzerling Drive<br>Columbus, OH 43223 |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51524<br><br>Based on medical record review, resident guardian interview, staff interview, facility Self-Reported Incident (SRI) review, and review of facility investigation, the facility failed to investigate and implement psychiatric recommendations to ensure Resident #82 had the ability to attain or maintain their highest physical, mental, and psychosocial wellbeing. Actual Harm occurred when the facility failed to fully investigate the root cause of Resident #82's potential hallucinations/behaviors, which contributed to the facility being unable to meet the residents behavioral health needs, resulting in a discharge from the facility. This affected one (Resident #82) of one resident reviewed for behavioral/emotional needs. The facility census was 84.<br><br>Findings include:<br><br>Review of medical record for Resident #82 revealed an admitted d of 12/06/24 and diagnoses including vascular dementia, anxiety disorder, adult failure to thrive and primary hypertension.<br><br>Review of Resident #82's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) of 10.<br><br>Review of Resident #82's comprehensive care plan dated 12/13/24 revealed the resident had impaired safety awareness. Further review documented a goal that the interdisciplinary team would work to address risk factors and provide for safety. The care plan included an intervention for staff to implement safety measures as indicated by fluctuations in cognitive status. The care plan revealed no evidence of interventions put in place by the facility to address her fear of others coming into her room to allegedly harm her.<br><br>Review of Resident #82's nursing note dated 12/10/24 revealed she had barricaded herself in her room due to her reporting that two men were coming into her room and stealing her things.<br><br>Review of the Resident #82's Nurse Practitioner #110 note, dated 12/13/24, revealed treatment recommendations for the unit manager to obtain clarification of the resident's statements of the men entering her room at night as it may have been another resident, who lived across the hall and had a history of wandering into other rooms. There was no evidence provided that the facility addressed Nurse Practitioner #110's recommendations to investigate and determine the validity of the resident's claims.<br><br>Review of Resident #82's nursing note dated 12/23/24 revealed she barricaded herself in her room again due to her alleging that two people entered her room, attacked her, and had the intent to [NAME] her. Resident #82 called the police to report the attack. Resident #82 requested a medical evaluation and treatment because her arm was hurting after the attack. A medical evaluation was completed that night and there was no injury determined.<br><br>Review of the facility SRI Investigation, dated 12/23/24, revealed the facility filed and investigated the allegation of someone coming in Resident #82's room and attacking her. They determined the allegation of abuse was unsubstantiated.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the facility investigation dated 12/23/24 revealed like residents were interviewed with no negative findings, head-to-toe assessments were completed on residents who were unable to be interviewed, staff were interviewed with no negative findings, and abuse education was provided to all staff. The investigation determined there was no evidence to support Resident #82's allegation of being attacked in her room. The investigation further revealed no evidence of a root cause analysis as to why the resident continued to make the allegations and the facility did not implement any new interventions to reduce Resident #82's fear of being attacked in her room.<br><br>Review of Resident #82's Nurse Practitioner #110 note dated 12/27/24, revealed Resident #82 told Nurse Practitioner #110, The two men keep coming into my room, and she was worried about them returning.<br><br>Review of Resident #82's nursing note dated 01/22/25 revealed the resident called the police to report a group of women coming into her room to [NAME] her and beat her up. There was no documented evidence that the facility took action to address Resident #82's claims.<br><br>Interview with Director of Nursing (DON) on 02/26/25 at 2:39 P.M. confirmed no further investigations were completed related to Resident #82's allegations, and there was no monitoring of Resident #82's behaviors regarding hallucinations, false allegations, or whether there was anyone who went into her room, to determine the validity of her allegations. The DON stated the facility spoke with Resident #82's guardian to let her know they could not meet the resident's needs due to her continued hallucinations and behavioral health issues. From that point, Resident #82's guardian found another nursing home to move her to.<br><br>Interview with Resident #82's guardian on 02/27/25 at 1:42 P.M. revealed because of the hallucinations and the residents reports of residents going in/out of her room constantly, the guardian wanted to find a new place for Resident #82 to live. She stated the facility did not give them a 30-day notice, but the facility did tell her that she would be better off in an in-patient psychiatric unit. She confirmed the facility did not implement any new interventions or aid with Resident #82's hallucinations of residents going in and out of her room. Resident #82's guardian confirmed she was not aware of the facility completing any investigation to determine the validity of Resident #82 claims of others going into her room. She would have preferred those interventions to have occurred, rather than Resident #82 being moved to another facility. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on observation, medical record review, staff interview, and facility policy review, the facility failed to administer medications as ordered, resulting in a medication administration error rate above 5 percent (%). Three errors out of 28 observed opportunities resulted in an error rate of 10.71%. This affected one (Resident #21) of three residents observed during the medication pass. The facility census was 84.<br><br>Findings include:<br><br>Review of the medical record for Resident #21 revealed an initial admitted [DATE] with the diagnoses including but not limited to dementia, chronic kidney disease, diabetes mellitus, lymphedema, hypertension, obstructive sleep apnea, insomnia, hyperlipidemia and constipation.<br><br>Review of the plan of care dated 02/08/23 revealed the resident was at risk for constipation related to decreased mobility, diagnoses of constipation, medication and age. Interventions included administer medications (stool softeners, laxatives, suppositories) as ordered, diet as ordered (monitor for the need for increased fluids, prune juice, high fiber, fruit juice), monitor bowel movement every shift, ensure the resident had a bowel movement every three days, notify physician of signs/symptoms of constipation as needed and Review medical record for medications that may have constipation as a side effect.<br><br>Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit.<br><br>Review of the resident's monthly physician orders for February 2025 identified orders dated 01/31/23 for Sennosides-Docusate Sodium 8.6-50 milligrams (mg) by mouth daily for constipation, Oyster shell calcium with vitamin D 500-5 mg/micrograms (mcg) by mouth daily for health and wellness and an order dated 02/06/23 for Aspirin 81 mg chewable tablet by mouth daily for health and wellness.<br><br>On 02/26/25 at 9:10 A.M., observation of Registered Nurse (RN) #260 prepare and administer Resident #21's morning medications revealed the RN place Aspirin enteric coated (EC) 81 mg tablet, Oyster shell calcium 500 mg tablet and a Senna 8.6 mg tablet into a clear plastic medication cup along with the rest of the resident's scheduled morning medications. RN #260 walked into the resident's room and observed the resident consume all medications.<br><br>On 02/25/25 at 9:38 A.M., interview with RN #260 confirmed he administered Aspirin EC 81 mg tablet instead of Aspirin 81 mg chewable tablet, Oyster shell calcium 500 mg tablet instead of Oyster shell calcium with vitamin D 500-5 mg/mcg and Senna 8.6 mg tablet instead of Sennosides-Docusate Sodium 8.6-50 mg tablet.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled, Medication Administration, dated 08/07/23 revealed medications were to be safely and accurately prepare and administer medication according to physician order, professional standards of practice and resident needs. Medications are administer in accordance with the following rights of medication administration, right resident, right medication, right dose, right route, right time and frequency, right documentation, right of resident to refuse and right clinical indication. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654<br><br>Based on observation, record review, interview, and facility policy review, the facility failed to ensure Resident #143's medication was secured in a locked medication cart. This affected one resident (#143) of 18 residents observed for medication storage. The facility census was 84.<br><br>Findings include:<br><br>Review of the medical record for Resident #143 revealed an initial admitted [DATE] with the diagnoses including but not limited to atrial fibrillation, diabetes mellitus, panlobular emphysema, dementia, obstructive and reflux uropathy, artificial openings of urinary tract, hyperlipidemia, hypertension, constipation, acquired absence of other genital organs and urinary tract infection (UTI).<br><br>Review of the resident's admission evaluation dated 02/18/25 revealed the resident was alert and oriented on admission.<br><br>Review of the medical record revealed an order dated 02/18/25 for Albuterol Sulfate (a medication administered by inhalation used to prevent and treat wheezing and shortness of breath) 108/90 micrograms (mcg) with the special instructions to inhale two puffs orally every six hours. Further review revealed no physician's order for the resident to have the inhaler at bedside.<br><br>Review of Resident #143's medical record revealed no self-administration of medication evaluation to determine if the resident was able to self-administer the medication Albuterol Sulfate.<br><br>On 02/24/25 at 2:39 P.M., observation of Resident #143 revealed he had an Albuterol Sulfate inhaler laying on his bedside stand.<br><br>On 02/24/25 at 3:00 P.M., interview with Registered Nurse (RN) #250 verified the resident had no physician's order to keep the Albuterol inhaler at bedside or self-administration of medication evaluation to determine if the resident was able to self-administer the medication.<br><br>Review of the facility policy titled, Medication and Treatment Storage, dated 08/07/23 revealed all medications and biologicals will be stored in locked compartments. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266<br><br>Based on observation, staff interviews, and record review, the facility failed to ensure hospice notes were readily available for one resident (Resident #44). This affected one resident (#44) out of one resident reviewed for hospice services.<br><br>Findings Include:<br><br>Review of the medical record for Resident #44 revealed an admitted on 04/07/22. Medical diagnoses included frontal lobe and executive function deficit following cerebral infarction, type two diabetes mellitus with diabetic retinopathy without macular edema, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, encounter for palliative care, chronic hepatitis, and syncope and collapse.<br><br>Review of the hospice contract dated 01/26/24 revealed the contract stated, Communication: hospice and facility shall communicate with each other regarding the hospice patient's condition through telephone, in person verbal communication, and if appropriate, written communication in the hospice patient's medical record.<br><br>Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 had intact cognition and scored a 14 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #44 required a varied amount of staff assistance from partial to total dependence. It noted that Resident #44 was receiving hospice services.<br><br>Observation on 02/27/25 at 10:10 A.M. of the hospice binder kept at the nurse's station for Resident #44 revealed the binder only included three skin grids, a hospice election of service form dated 01/24/25, and a Do Not Resuscitate (DNR) order dated 10/09/24. There were no hospice communication notes included in the binder.<br><br>Interview on 02/27/25 at 10:10 A.M. with Agency Registered Nurse (ARN) #500 confirmed there were not any hospice communication notes kept in the hospice binder for Resident #44.<br><br>Interview on 02/27/25 at 12:42 P.M. with Registered Nurse (RN) #160 confirmed Resident #44's hospice communication notes were not on-site at the facility until they were faxed over today, 02/27/25, from the hospice provider, following surveyor intervention. |