STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365978	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scarlet Oaks Nursing and Rehabilitation Center	440 Lafayette Avenue Cincinnati, OH 45220

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, staff interviews and record review, the facility failed to ensure dependent residents were provided assistance with eating in a timely manner. This affected five (#35, #42 #47, #48, and #67) of the nine residents identified by the facility who required assistance with eating. The facility census was 62. Findings include: Review of Resident #42's medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included cachexia, mass and lump in the neck, chronic obstructive pulmonary disease, heart failure, insomnia, male erectile dysfunction, hypertensive heart disease with heart and diverticulosis of large intestine without perforation or abscess without bleeding. Review of Resident #42 admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was severely cognitively impaired and dependent on staff for eating. Observation of the third floor on 11/18/24 at 11:59 A.M. revealed the meal trays arrived on the floor. Certified Nursing Assistant (CNA) #47 and CNA #57 started to pass trays. Observation of the third floor on 11/18/24 at 12:34 P.M. revealed five residents (#35, #42 #47, #48, and #67) had not received their room meal trays. Interview with CNA #47 on 11/18/24 at 12:34 P.M. revealed the third floor had seven Residents (#35, #42 #47, #48, #55, #56, and #67) who were dependent on staff for assistance with eating and reported that the facility had two CNAs on the third floor to assist with feeding the seven residents. CNA #47 reported the scheduler, medical records staff member and two nurses were supposed to assist with feeding residents on the third floor. Observation of the third floor on 11/18/24 at 12:51 P.M. revealed Resident #42's meal tray was still sitting on the meal cart. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Licensed Practical Nurse (LPN) #37 and LPN #501 on 11/18/24 at 12:51 P.M. revealed both LPN #37 and LPN #501 had not assisted any residents with eating on 11/18/24. Both LPN #37 and LPN #501 reported that they were busy with medication pass and other nurse duties and were not able to feed the residents. LPN #501 reported the scheduler and medical records staff member were also unavailable to feed residents. LPN #501 verified Resident #42 had not received his meal or assistance with eating because the facility only had two CNAs to feed eight residents. Review of the facility's undated assistance with meals policy revealed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. This deficiency represents non-compliance investigated under Complaint Number OH00159910.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, staff interviews and record review, the facility failed to maintain adequate staff levels to ensure the residents who required feeding assistance were timely provided with meals. This affected five (#35, #42 #47, #48, and #67) of the nine residents identified by the facility who required assistance with eating. The facility census was 62. Findings include: Review of Resident #42's medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included cachexia, mass and lump in the neck, chronic obstructive pulmonary disease, heart failure, insomnia, male erectile dysfunction, hypertensive heart disease with heart and diverticulosis of large intestine without perforation or abscess without bleeding. Review of Resident #42 admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was severely cognitively impaired and dependent on staff for eating. Observation of the third floor on 11/18/24 at 11:59 A.M. revealed the meal trays arrived on the floor. Certified Nursing Assistant (CNA) #47 and CNA #57 started to pass trays. Observation of the third floor on 11/18/24 at 12:34 P.M. revealed five residents (#35, #42 #47, #48, and #67) had not received their room meal trays. Interview with CNA #47 on 11/18/24 at 12:34 P.M. revealed the third floor had seven Residents (#35, #42 #47, #48, #55, #56, and #67) who were dependent on staff for assistance with eating and reported that the facility had two CNAs on the third floor to assist with feeding the seven residents. CNA #47 reported the scheduler, medical records staff member and two nurses were supposed to assist with feeding residents on the third floor. Observation of the third floor on 11/18/24 at 12:51 P.M. revealed Resident #42's meal tray was still sitting on the meal cart. Interview with Licensed Practical Nurse (LPN) #37 and LPN #501 on 11/18/24 at 12:51 P.M. verified CAN #47 and CAN #57 were assigned to the floor. LPN #37 and LPN #501 stated they had not assisted any residents with eating. Both LPN #37 and LPN #501 reported that they were busy with medication administration and other nursing duties and were not able to feed the residents. LPN #501 reported the scheduler and medical records staff member were also unavailable to feed residents. LPN #501 verified Resident #42 had not received his meal or assistance with eating because the facility only had two CNAs to feed eight residents. Review of the daily staffing for 11/24/24, revealed CNA #47 and CNA #57 were the only CNAs assigned to the third floor. Review of the facility's undated assistance with meals policy revealed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Complaint Number OH00159910.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, staff interviews and record review, the facility failed to ensure a handwashing sink with flowing water had a filter in place to prevent the spread of Legionella. This affected all 34 residents (#34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54. #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66 and #67) on the third floor but had the potential to affect all 62 residents who resided in the facility. The facility also failed to ensure there were handwashing stations in resident rooms who were in Enhanced Barrier Precautions (EBPs). This affected 24 residents (01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, #12, #13, #14, #16, #19, #22, #23, #27, #29, #32, #33, #48, and #66) of the 24 residents who the facility identified as being in EBPs, but had the potential to affect all 62 residents who resided in the facility. The facility also failed to ensure outside a Laboratory Phlebotomist wore the appropriate personal protective equipment (PPE) when caring for a resident in EBPs related to Candida Auris (C. Auris) to prevent the spread of C. Auris. This affected one (#67) of the 24 residents reviewed for infection control. The facility census was 62. Findings include: 1) Review of Resident #11's medical record revealed the resident admitted to the facility on [DATE]. Diagnoses included respiratory failure with hypoxia, chronic embolism and thrombosis of unspecified vein, mild protein calorie malnutrition, anxiety disorder, other seizures, paraplegia, major depressive disorder, personal history of traumatic brain injury, tracheostomy status and chronic obstructive pulmonary disease. Review of Resident #11 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was severely cognitively impaired. Review of Resident #11's progress note dated 10/19/24 revealed the resident was ordered a midline catheter (a thin, flexible tube inserted in a vein in the upper arm and ends near the shoulder to administer fluids or medications) be placed for intravenous (IV) antibiotics to treat C. Auris. A midline catheter could not be placed in house and the on-call nurse practitioner (NP) ordered Resident 11 to be sent to the hospital to receive treatment. Resident #11's responsible party was contacted. Resident #11 left the facility with no skin issues. Review of Resident #11's hospital records dated 10/28/24 revealed Resident #11 was admitted to the facility on [DATE]. Resident #11 tested positive for Legionella (type of serious pneumonia caused by a type of bacteria) on 10/20/24 and negative for Legionella five hours later on 10/21/24. The significance of the discordant serial Legionella urinary antigenic testing was listed as uncertain. Review of Resident #11's progress note dated 10/29/24 revealed Resident #11 returned to the facility at 2:55 P.M. by ambulance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's water sampling dated 10/30/24 revealed there was one positive Legionella water sample collected from Resident #02's room. The sample resulted on 11/11/24 and the positive water sample was on the same floor, but a different wing of Resident #11's room. The facility completed a second water sampling for Legionella on 11/11/24 and there were no new cases identified when the sampling was reported on 11/21/24. Review of an email correspondence from the Local Health Department (LHD) #600 to the Director of Nursing (DON), Administrator, Licensed Practical Nurse (LPN) #96 and Maintenance Director #55 on 11/05/24, revealed LHD #600 was in contact with the facility regarding a presumptive Legionella healthcare associated case in the facility. LHD #600 requested the facility follow steps including implementing water use restrictions throughout the facility or by using point of use filters. The filters should be installed within two to three days after the receipt of the email. The facility should communicate to staff and residents about the water restrictions and post signage near each fixture with a filter for people to contact maintenance if a filter is damaged or removed. Observation of the facility on 11/18/24 at 8:48 A.M., revealed there was a handwashing sink in the third-floor shower room without a filter in place. Further observation of the handwashing sink revealed the handwashing sink had running, unfiltered water with no sign indicating the water should not be used due to the Legionella case. Interview with Maintenance Assistant #79 on 11/18/24 at 8:48 A.M., verified the handwashing sink in the third-floor shower room was turned on, did not have a filter in place and did not have a sign indicating the water should not be used. Maintenance Assistant #79 stated the water to the handwashing sink in the third-floor shower room should have been turned off or had the appropriate filter for Legionella installed on it. Telephone interview with State Health Department Environmental Specialist (SHDES) #700 on 11/18/24 at 2:46 P.M., revealed the facility had a presumptive positive healthcare associated case of Legionella and the facility was informed that they should restrict water or use filters on the water sources. SHDES #700 stated he was not aware the facility had a handwashing sink with running water that did not have a filter on it in the third-floor shower room. 2) Review of the facility's undated list of 24 residents (01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, #12, #13, #14, #16, #19, #22, #23, #27, #29, #32, #33, #48, and #66) who were in EBPs. Review of the facility's undated list of 12 residents (#01, #02, #03, #04, #05, #08, #11, #12, #14, #15, #19 and #13) with C. Auris and in EBPs located on the second floor of the facility. Observation of the facility on 11/18/24 at 8:48 A.M. revealed the water supply to the handwashing sinks in all of the resident's rooms were turned off. There was a gallon jug of water located on each of the resident's sink. Further observation of the facility revealed the all of the resident's toilets had running water to them. There was a filter for Legionella on a handwashing sink in the employee bathroom located on the second floor. There was a filter for Legionella on a handwashing sink in the employee bathroom located on the third floor and a handwashing sink with running water that did not have a filter located in the shower room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Maintenance Assistant #79 on 11/18/24 at 8:48 A.M., verified the facility had disconnected the water supply to all of the resident's handwashing sinks in rooms due to a Legionella case. Maintenance Assistant #79 stated the facility provided a gallon jug of water in each resident's room. Maintenance Assistant #79 stated the handwashing sink in the third-floor shower room was not supposed to be turned on because it did not have a filter on it. Maintenance Assistant #79 reported the facility only had one approved handwashing station on the second and third floors, which was located in the employee bathrooms on each floor. Interview with Regional Director of Operations (RDO) #800 on 11/18/24 at 11:04 A.M. revealed the facility only had two handwashing sinks with filters in place that were available for use for all residents and staff because the facility was told to restrict water or put filters on water sources by the local Health Department after the facility had a presumptive positive Legionella case. Telephone interview with LHD #650 on 11/18/24 at 2:24 P.M. revealed LHD #650 became involved with the facility after the facility had a positive C. Auris case on 09/21/24. LHD #650 stated the facility had four additional residents test positive for C. Auris on 10/09/24 and one additional resident test positive for C. Auris on 10/31/24 during point prevalence screening. LHD #650 reported she was aware of the presumptive positive Legionella case but stated that she believed the facility had installed point of use filters on all faucets. LHD #650 stated she was not aware that the facility had only one filtered handwashing station located in the employee bathroom on second floor and one filtered handwashing station located in the employee bathroom on the third floor. LHD #650 reported it was not appropriate for the facility to only have two handwashing stations with running water especially with the increased C. Auris cases. LHD #650 reported that gallon jugs of water being used in resident rooms would also not be appropriate for handwashing after caring for residents with C. Auris and it was not appropriate to only have one handwashing station on the same floor as 12 residents that were positive for C. Auris and in EBPs. Review of email correspondence from LHD #650 to LPN #96 dated 10/01/24, revealed LHD #650 sent documentation regarding implementation of personal protective equipment use in the nursing home to prevent the spread of Multi Drug Resistant Organisms (MDROs). LHD #650 also recommended the facility review their handwashing for the containment of C. Auris. Review of the Centers for Disease Control and Prevention (CDC) article titled preventing the spread of C Auris (https://www.cdc.gov/candidaauris/prevention/index.html#:~:text=auris%20can%20spread%20easily%20from,or%20ABHS%20is%20not%20available) dated 04/24/24 revealed C. Auris can spread easily from patients who are colonized or infected. Healthcare providers can help stop it from spreading with frequent hand cleaning with alcohol-based hand sanitizer and the use of soap and water if hands are soiled or alcohol-based hand sanitizer is not available. 3) Review of Resident #67's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included vascular dementia, major depressive disorder, epilepsy, chronic kidney disease, type two diabetes mellitus without complications, aphasia, insomnia. The resident was moderately cognitively impaired. Review of Resident #67's medical chart from 09/19/23 to 11/09/24 revealed no documented evidence that the resident was positive for C. Auris or on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #02's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses including anoxic brain damage, non-pressure chronic ulcer of right heel and midfoot with other specified severity, resistance to multiple antibiotics, acute respiratory failure, anxiety disorder and epilepsy. Resident #02 was severely cognitively impaired. Review of Resident #02's hospital records dated 02/29/24, revealed Resident #02 had a diagnosis of C. Auris with an onset date of 02/14/24. Review of Resident #02's physician order dated 11/06/24 revealed Resident #02 was ordered EBP related to C. Auris of the skin. Observation of Resident #02's room on 11/19/24 at 12:07 P.M. revealed Phlebotomist #500 was in Resident #02's room leaning over Resident #02 without a gown in place and drawing blood. Phlebotomist #500 was wearing gloves, but Phlebotomist #500's clothing was making direct contact with Resident #02, the resident's linen and bed as she was leaning over him. Resident #02's door had signs indicating EBP precautions and to see the nurse before entering. Further observation of Phlebotomist #500 revealed Phlebotomist #500 finished drawing Resident #02's blood, exited the room, removed her gloves and placed them in her bag. Phlebotomist #500 then put Resident #500's vial of blood in a plastic bag and placed it in the side of her bag. Phlebotomist #500 did not complete any hand hygiene. Phlebotomist #500 proceeded to the elevator, pressed the call button, and once inside, she entered the code to the elevator and pressed the third-floor button. Phlebotomist #500 got off on the third floor where there were no cases of C. Auris. Phlebotomist #500 walked to Resident # 67's room, donned gloves, leaned over Resident #67 to draw her blood while making contact with Resident #67, her linens and the bed. Interview with Phlebotomist #500 on 11/19/24 at 12:10 P.M. verified she saw the signage on Resident #02's door about being in EBP. Phlebotomist #500 verified she entered Resident 02's room, completed her lab procedure without wearing a gown. Phlebotomist #500 verified she then went to Resident #67's room and completed a lab procedure and without completing any hand hygiene after leaving Resident #02's room. Phlebotomist #500 stated she was aware that Resident #02 was in EBP but thought it would be fine to not wear a gown since she was only drawing the resident's blood. Review of the facility's enhanced barrier precautions policy dated August 2022 revealed Enhanced Barrier Precautions were utilized to prevent the spread of MDROs to residents. Enhanced barrier precautions employ targeted gown and glove use during home contact resident care activities. Gloves and a gown are applied prior to performing the high contact resident care activity. The PPE is changed before caring for another resident. Face protection may be used if there is also a risk of splashes or sprays. Examples of high contact resident care activities requiring gown and glove use for EBPs include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use which includes care of central lines, feeding tubes, tracheostomy and ventilator and wound care or any skin opening requiring a dressing. EBPs may be indicated for residents infected or colonized with C. Auris. Signs are posted on the door or wall outside the resident's room indicating the type of precautions and PPE required and PPE is available outside of the resident's room. This deficiency represents non-compliance investigated under Complaint Number OH00159925, OH00159910 and OH00159811.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39967 Based on observation, staff interviews and record review, the facility failed to ensure water temperatures were maintained within an appropriate range. This affected all 62 residents who resided in the facility. Findings include: Observation of the facility on 11/18/24 at 8:48 A.M., revealed the water temperature of the only operational handwashing sink located in the third floor shower room was 84 degrees Fahrenheit. The water temperature of the only operational handwashing sink located in the second floor shower room was 91.6 degrees Fahrenheit. Interview with Maintenance Assistant #79 on 11/18/24 at 8:48 A.M. verified the water temperature of the handwashing sink in the third floor shower room was 84 degrees Fahrenheit and the water temperature of the handwashing sink in the second floor shower room was 91.6 degrees Fahrenheit. Review of the facility's safety of water temperatures policy dated December 2009 revealed water heaters that service resident rooms, bathrooms, common areas and shower areas shall be set to temperatures between 105 and 120 degrees Fahrenheit.