STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365996	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Swan Creek	1650 Swan Creek Lane Toledo, OH 43614

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure the treatment of a suprapubic catheter was provided per physician order and failed to ensure the documentation of urine output was completed per physician order. This affected two (#20 and #22) of two residents reviewed for urinary catheters. The facility census was 37. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of the bladder, benign prostatic hyperplasia, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was moderately cognitively impaired, required substantial assistance from staff with toileting, had an indwelling catheter, and had occasional bowel incontinence. Review of the care plan revised on 03/08/24 revealed Resident #22 required a suprapubic catheter related to urinary retention and a history of meatus erosion. Interventions included for Resident #22 to wear clothing which does not constrict the catheter, avoid obstructions in drainage, position the drainage bag below the bladder, keep system closed as much as possible, catheter care each shift, documentation of output every shift and minimize manipulation of the tubing with catheter care. An additional care plan for Resident #22 included enhanced barrier precautions due to multiple drug resistant organism, interventions included gowns and gloves to be worn during high contact resident care activities including bathing, showering, providing hygiene, changing linens, toilet hygiene and urinary catheter care. Review of the current physician orders in place for Resident #22 revealed orders dated 03/14/24 for the nurse to complete suprapubic catheter care every shift with catheter site cleansed with soap and water, bacitracin ointment applied around catheter insertion site and covered with split gauze while wearing required personal protective equipment and for a graduated cylinder used for urine collection for suprapubic catheter to be changed each week. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of suprapubic catheter care on 04/29/24 at 8:12 A.M. by Registered Nurse (RN) #75 revealed hand hygiene completed prior to care, gloves donned, moistened two washcloths with water, both cloths were rung out, soap was applied to one of the washcloths, both washcloths were then placed on top of a towel sitting on the counter of the sink. RN #75 approached Resident #22 who was lying in bed, elevated the height of the bed, removed the covers, lower the pant waist band, and proceeded using the soap covered washcloth, cleansed around the suprapubic insertion site, using a different portion of the soap covered washcloth RN #75 cleaned the catheter insertion site and then the catheter, wiping down the catheter away from the insertion site. RN #75 then rinsed and then dried the catheter insertion site and the catheter in the same fashion. Observation of the insertion site revealed slight redness and a bump on the bottom left of the catheter. Interview with RN #75 stated the catheter site actually looked good in comparison to what it used to look like. Following care, RN #75 pulled up Resident #22's pants, ensured the catheter was not kinked and extended freely down the leg of right leg Resident #22. RN #75 washed hands and exited room. Follow up interview on 04/29/24 at 10:55 A.M. with RN #75 verified no split gauze was in place prior to catheter care and no bacitracin ointment or split gauze was applied during catheter care as physician ordered for Resident #22. RN #75 stated Resident #22 no longer required the bacitracin and split gauze treatment. Interview on 04/29/24 at 12:30 P.M. with Unit Manager #76 verified Resident #22 did have a current order for suprapubic catheter care once a shift to include cleansing, the application of bacitracin and a splint gauze and further verified the treatment order was being documented as completed. 2. Review of Resident #20's medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included dementia and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was severely cognitively impaired, was dependent on staff and family for activities of daily living, was incontinent of bowel and bladder, and Resident #20 was under the care of Hospice. Review of the progress notes dated 04/17/24 revealed at 6:37 A.M., the state tested nursing aide (STNA) reported to the nurse Resident #20 had not urinated. A bladder scan was completed. Resident #20 was noted to have 245 milliliters (ml) of urine in the bladder, was in no distress, and Hospice was notified. An additional note at 10:30 A.M. revealed Resident #20 still had not urinated and Hospice was talking with family about a catheter due to urinary retention. At 12:48 P.M., an indwelling catheter was placed by Hospice. Review of the physician orders for Resident #20 revealed an order written on 04/17/24 for catheter care and documentation of urine output to be completed every shift. Review of the vitals record from 04/17/24 to 04/28/24 revealed urine output was recorded and documented for Resident #20 on 04/17/24 at 7:04 P.M. as a small amount in the brief, on 04/19/24 at 1:35 P.M., 04/20/24 at 5:26 A.M., 2:26 P.M., and 8:42 P.M., on 04/21/24 at 5:17 A.M. and 2:29 P.M., on 04/22/24 at 6:19 A.M., 04/24/24 at 2:18 P.M. and 9:56 P.M., 04/26/24 at 5:34 A.M, and 04/27/24 at 1:47 P.M. documented as a small amount. There was no urine output recorded on 04/18/24, 04/23/24, and 04/25/24 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/29/24 at 12:30 P.M. with Unit Manager #76 verified urinary outputs for Resident #20 were not recorded each shift as physician ordered. Review of the facility policy titled Indwelling Catheter Care and Management, dated 12/22/23, revealed intake and output will be monitored per physician order and urinary output will be monitored for changes in the urine output, including volume and urine color with the urinary drainage bag emptied when one half to two thirds full to prevent undue traction on the urethra. Review of the facility policy titled Physician Orders, revised on 09/14/23, stated residents will receive care as ordered by the physician. This deficiency represents non-compliance investigated under Complaint Number OH00152129.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review, observations, staff interview, and review of the facility policies, the facility failed to implement enhanced barrier precautions when providing catheter care to the residents. This affected two (#20 and #22) of two residents observed for catheter care. The facility identified two residents (#20 and #22) with indwelling catheters. The facility census was 31. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of the bladder, benign prostatic hyperplasia, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was moderately cognitively impaired, required substantial assistance with toilet hygiene, had an indwelling catheter, and had occasional bowel incontinence. Review of the care plan revised on 03/08/24 revealed Resident #22 required a suprapubic catheter related to urinary retention and a history of meatus erosion. Interventions included enhanced barrier precautions due to multiple drug resistant organism, interventions included gowns and gloves to be worn during high contact resident care activities including bathing, showering, providing hygiene, changing linens, toilet hygiene and urinary catheter care. Review of the current physician orders in place for Resident #22 revealed an orders dated 03/14/24 for enhanced barrier precautions when providing supra-pubic catheter care and showers every shift, nurse to complete suprapubic catheter care every shift with catheter site cleansed with soap and water, bacitracin ointment applied around catheter insertion site and covered with split gauze while wearing required personal protective equipment. Observation of suprapubic catheter care on 04/29/24 at 8:12 A.M. by Registered Nurse (RN) #75 revealed hand hygiene was completed prior to care, gloves donned, and RN #75 did not don a gown. RN #75 approached Resident #22 who was lying in bed, elevated the height of the bed, removed the covers, lowered the pant waist band, and proceeded using the soap covered washcloth, cleansed around the suprapubic insertion site, using a different portion of the soap covered washcloth, RN #75 cleaned the catheter insertion site and then the catheter, wiping down the catheter away from the insertion site. RN #75 then rinsed and then dried the catheter insertion site and the catheter in the same fashion. Following care, RN #75 pulled up Resident #22's pants, ensured the catheter was not kinked and extended freely down the leg of right leg Resident #22. RN #75 washed hands and exited room. RN #75 never donned a gown during suprapubic catheter care for Resident #22. Follow up interview on 04/29/24 at 10:55 A.M. with RN #75 verified no gown was worn when suprapubic care. Interview with Unit Manager #76 on 04/29/24 at 3:30 P.M. verified enhanced barrier precautions were required with catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Based on medical record review revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included dementia and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was severely cognitively impaired, was dependent on staff and family for activities of daily living, was incontinent of bowel and bladder, and Resident #20 was under the care of Hospice. Review of the progress notes dated 04/17/24 revealed at 6:37 A.M., the state tested nursing aide (STNA) reported to the nurse Resident #20 had not urinated. A bladder scan was completed, Resident #20 was noted to have 245 milliliters (ml) of urine in the bladder. At 12:48 P.M., an indwelling catheter was placed by Hospice. Review of the physician orders for Resident #20 revealed an order written on 04/17/24 for catheter care, and documentation of urine output to be completed every shift. Observation of catheter care on 04/29/24 at 8:16 A.M. for Resident #20 completed by State tested Nursing Assistant (STNA) #77 revealed STNA #77 washed hands, donned gloves, and did not don a gown. STNA #77 used soap and water and a washcloth and cleansed the perineal area wiping front to back and away from the catheter insertion site and then down the catheter tubing. Using a second clean washcloth with water, the perineal area was rinsed wiping from front to back and then down the catheter tubing. The perineal area was then dried. Interview with STNA #77 on 04/29/24 at 8:20 A.M. verified gloves were the only the personal protective equipment worn during catheter care for Resident #20. Interview on 04/29/24 at 10:55 A.M. with Registered Nurse (RN) verified the personal protective equipment needed for catheter care included gloves and gown. Review of the facility policy titled Indwelling Urinary Catheter Care and Management, dated 12/11/23 stated when providing catheter care the staff is to perform hand hygiene, put on gloves and other personal protective equipment. Review of the facility policy titled Infection Control - Enhanced Barrier Precautions, revised 09/14/23 stated enhanced barrier precautions will be utilized for a resident known or suspected to be infected or colonized with epidemiologically important microorganisms transmitted by direct contact with the microorganism. Enhanced barrier precautions are to be used in the care and management of an indwelling catheter regardless of multi drug resistance and/or colonization and require the use of personal protective equipment to include gloves and a gown during care, with hand hygiene completed prior to and after care. This was an incidental finding discovered during the complaint investigation.