STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366014	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Hills Rehabilitation and Nursing Center	416 Wooster Road Mount Vernon, OH 43050

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on observation, record review, and resident and staff interview, the facility failed to ensure Resident #141 was aware of the location and how to use the bathroom call light. This affected one (#141) of 19 residents reviewed in the initial sample of the annual survey. The facility census was 38. Findings include: Record review revealed Resident #141 was admitted to the facility on [DATE] with diagnoses including necrotizing fasciitis, Fournier gangrene, and diabetes mellitus. The admission Minimum Data Set (MDS) 3.0 assessment was in progress. Review of the care plan dated 11/12/24 revealed Resident #141 had a potential risk for falls related to weakness from hospital stay for necrotizing fasciitis labia majora and groin with Fournier gangrene with surgical debridement. Interventions included but not limited to call light within reach. An interview on 11/18/24 at 9:40 A.M. with Resident #141 revealed she felt unsafe in the bathroom because there was no call light in it. Observation and interview on 11/18/24 at 9:40 A.M. revealed there was no indication that a call light was available to Resident #141 in the bathroom. An interview with Maintenance Director (MD) #207 at the time of the observation stated there was a light switch next to the toilet tissue that was the call light but there was no red cord or label to indicate that it was a call light.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on resident, staff, and physician interview, record review, policy review, and Standard of Care by the American Diabetic Association, the facility failed to ensure Resident #39's representative was timely notified following a change in condition and failed to ensure Resident #21's physician was notified timely following a new diagnosis of diabetes mellitus. This affected two (Residents #21 and #39) of two residents reviewed for change of condition. The facility census was 38. Findings include: 1. Record review for Resident #39 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chromic obstructive pulmonary disease, chronic kidney disease, psychoactive substance abuse, and paranoid schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact and was independent for activities of daily living. Review of the progress note for Resident #39 dated 08/30/24 at 9:36 A.M. revealed Resident #39 was sitting on the side of her bed at 6:00 A.M. when the nurse came on duty this am. A short time later while passing medications, the front door alarm went off. Resident #39 was ambulating with wheeled walker on front porch. A woman friend in a blue four-door car was waiting for her. The nurse asked what she was doing. Resident #39 yelled, I am leaving, and I am not coming back. The nurse asked her what was wrong, and she replied that you do not want to know. Resident #39 was educated on consequences of leaving against medical advice (AMA). Resident #39 yelled to the nurse, I don't give a [expletive], and got in the vehicle. The nurse explained to the visitor that Resident #39 was not to leave the facility unsupervised. The visitor shook her head and drove away with Resident #39 in front seat of the vehicle. There was no documentation the emergency contact was notified of Resident #39 leaving AMA. An interview on 11/19/24 at 12:03 P.M. with Social Service Designee (SSD) #234 stated she was not at the facility the day that Resident #39 left AMA. She heard at the morning meeting that she had left. Resident #39 contacted her about getting her items that were left in the room. SSD #234 stated that different agencies put Resident #39 in hotels. SSD #234 verified the emergency contact was not called after Resident #39 went AMA in the electronic chart. Interview on 11/19/24 at 12:23 P.M. with the Administrator stated the daughter was called but there was no documentation that shows she was called. The Administrator stated the resident was her own person but left AMA. Review of the facility policy titled Change in Resident's Condition or Status revised December 2016 revealed the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and or status. 34298 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #21 was admitted on [DATE] and readmitted on [DATE] with diagnoses including post traumatic seizures, encephalopathy, traumatic brain injury, type II diabetes mellitus (DM), and acute respiratory failure. Review of the hospital notes dated 05/27/24 revealed Resident #21 had a history of traumatic brain injury in January 2022, intracerebral hemorrhage, seizure disorder, mood disorder, DM, and encephalopathy. The summary of hospitalization did not reveal diagnosis of DM or use of glycemic medication. A care plan dated 06/05/24 revealed Resident #21 had DM type II. Interventions included accuchecks as ordered, administer medications as ordered, labs as ordered, monitor blood sugar levels as ordered by physician. Abnormal blood glucose levels were to be covered per sliding scale as ordered by physician, and to monitor for hyperglycemia/hypoglycemia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact. The MDS assessment revealed Resident #21 did not receive any insulin injections or hypoglycemic medications. Review of the medication administration record (MAR) and physician orders from 06/05/24 through 10/29/24 revealed no blood glucose monitoring or antidiabetic medications or an A1C (blood test to measure the average blood glucose levels over the past three months). A progress note dated 10/29/24 at 10:47 A.M. revealed Resident #21 was sent to the hospital for evaluation due to history of seizures. Resident #21 appeared unsteady and short of breath. Emergency Department (ED) visit summary dated 10/29/24 revealed Resident #21 had blood glucose in the mid 500s with sodium of 124 milliequivalent's per liter (mEq/L). The low sodium level was likely from pseudohyponatremia from hyperglycemia. Resident #21 was given a dose of insulin in the ED. A recommendation for hospitalization was made but Resident #21 wanted to go back to the nursing home. It was discussed extensively with the nursing home a type II DM diagnosis on Resident #21's medical history, but the MAR did not show Resident #21 received any insulin. It was also discussed with the nursing home the importance of giving Resident #21 insulin. Review of the blood glucose monitoring on 10/30/24 at 1:01 P.M. revealed Resident #21's blood glucose level was 586 milligrams per deciliter (md/dL). On 10/30/24 at 4:32 P.M., Resident #21's blood glucose was 387 mg/dL, and at 9:31 P.M., it was 513 mg/dL. Physician orders dated 10/30/24 revealed Resident #21 was ordered Humalog (insulin) per sliding scale, Metformin (antidiabetic), and Lantus 10 units. Resident #21 was ordered a continuous glucose monitoring sensor. Resident #21's blood glucose levels from 10/31/24 to 11/19/24 ranged from 153 mg/dL (on 11/10/24) to 536 mg/dL. Interview on 11/18/24 at 9:39 A.M. with Resident #21 stated he was given the wrong medication or it was not administered correctly and he had to go to the hospital. Resident #21 stated his blood glucose was 500 at the hospital. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/19/24 at 11:59 A.M. with the Director of Nursing (DON) stated the diagnosis of type II DM for Resident #21 was added on 06/05/24. The DON stated Resident #21 returned to the facility from the hospital and the MDS nurse found in the diagnosis in the paperwork and added it the Resident #21's current diagnoses. The DON verified there was no monitoring of Resident #21's blood glucose levels or anti-diabetic medications ordered until 10/30/24. Interview on 11/20/24 at 8:15 A.M. with MDS Nurse #300 verified the diagnoses and care plan for type II DM was added when Resident #21 returned from the hospital in June. MDS Nurse #300 verified the doctor should be notified of any new diagnosis and the care plan had interventions that were not put in place. Interview on 11/20/24 at 12:32 P.M. with Medical Director (MD) #253 stated he was not aware a diagnosis of type II DM had been added in June for Resident #21. MD #253 stated the discharge summary and medication list of the hospital in June did not list any diagnosis or medication for DM and MD #253 did not look through all the paperwork sent from the hospital. MD #253 stated an A1C would have been ordered if MD #253 had been aware of a diagnosis of type II DM being added for Resident #21. MD #253 stated additional orders for blood glucose monitoring and medications would have been ordered depending on the results of the A1C. Review of the policy and procedure of Nursing Care of the Resident with DM revised December 2015 revealed the purpose of the guideline is to help the resident control his/her diabetes with diet, exercise and insulin (as ordered), prevent recurrent hyperglycemia/hypoglycemia, recognize, manage, and document the treatment of complications commonly associated with DM. The management of individuals with DM should follow relevant protocols and guidelines. The physician will order the frequency of glucose monitoring. Finger sticks (capillary blood sample) measure current blood glucose levels. The normal ranges are defined as 80-130 mg/dL before meals and less than 180 mg/dL after meals. Hyperglycemia is considered anything above the target reference ranges. Medication management of type II DM may include oral hypoglycemic agents with or without insulin. According to the Older Adults: Standard of Care in Diabetes-2024 by the American Diabetes Association dated January 2024 Treatment in skilled nursing facilities and nursing homes revealed management of diabetes in the long-term care (LTC) setting is unique. Individualization of health care is important for all people with diabetes; however, practical guidance is needed for health care professionals as well as the LTC staff and caregivers. Training should include diabetes detection and institutional quality assessment. LTC facilities should develop their own policies and procedures for prevention, recognition, and management of hypoglycemia.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on record review and interview the facility failed to ensure documentation was completed and physician notification occurred prior to a hospitalization for Resident #29. This affected one (#29) of two residents reviewed for hospitalization . The facility census was 38. Findings include: Record review for Resident #29 revealed an admitted [DATE]. diagnosed included diabetes mellitus, chronic kidney disease, and malignant neoplasm of duodenum. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact and required set up assistance for activities of daily living. Review of the progress note for Resident #29 dated 11/17/24 at 12:10 P.M. revealed Resident #29 requested to go to emergency room (ER) due to stomach being bloated. There were no signs and symptoms of clostridioides difficile (C-diff). Resident on Augmentin (antibiotic) for urinary tract infection (UTI). The husband was at bedside. Emergency services (911) called with report. Review of the progress note for Resident #29 dated 11/17/24 at 5:35 P.M. revealed Resident #29 returned from hospital at 5:00 P.M. by stretcher and two emergency medical technicians. No masses, bowel obstructions, or C-diff noted. Fluid and Zofran were given at the hospital. Resident #29 was alert and oriented. Review of Resident #29's medical record revealed no documentation that Resident #29 was assessed prior to going to the hospital. Interview on 11/21/24 at 10:47 A.M. with [NAME] President of Operations (VPO) # 250 verified that hospital transfer papers for Resident #29 were not in the medical chart to show the reason the resident was transferred and that the doctor was notified. Review of the facility policy titled Change in Resident's Condition or Status revised December 2016 revealed that prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, resident, staff, and physician interview, review of the Older Adults: Standard of Care in Diabetes-2024 by the American Diabetes Association, and policy and procedure for Nursing Care of the Resident with Diabetes Mellitus, the facility failed to provide diabetic care in accordance with professional standards after a diagnosis of type II diabetes mellitus was added to Resident #21's diagnoses. This affected one (#21) of 18 residents reviewed for standards of care. The facility census was 38. Findings include: Review of the medical record revealed Resident #21 was admitted on [DATE] and readmitted on [DATE] with diagnoses including traumatic brain injury, type II diabetes mellitus (DM), and acute respiratory failure. Review of the hospital notes dated 05/27/24 revealed Resident #21 had a history of traumatic brain injury in January 2022, intracerebral hemorrhage, seizure disorder, mood disorder, DM, and encephalopathy. The summary of hospitalization did not reveal diagnosis of DM or use of glycemic medication. A care plan dated 06/05/24 revealed Resident #21 had DM type II. Interventions included accuchecks as ordered, administer medications as ordered, labs as ordered, monitor blood sugar levels as ordered by physician. Abnormal blood glucose levels were to be covered per sliding scale as ordered by physician, and to monitor for hyperglycemia/hypoglycemia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact. The MDS assessment revealed Resident #21 did not receive any insulin injections or hypoglycemic medications. Review of the medication administration record (MAR) and physician orders from 06/05/24 through 10/29/24 revealed no blood glucose monitoring or antidiabetic medications or an A1C (blood test to measure the average blood glucose levels over the past three months). A progress note dated 10/29/24 at 10:47 A.M. revealed Resident #21 was sent to the hospital for evaluation due to history of seizures. Resident #21 appeared unsteady and short of breath. Emergency Department (ED) visit summary dated 10/29/24 revealed Resident #21 had blood glucose in the mid 500s with sodium of 124 milliequivalent's per liter (mEq/L). The low sodium level was likely from pseudohyponatremia from hyperglycemia. Resident #21 was given a dose of insulin in the ED. A recommendation for hospitalization was made but Resident #21 wanted to go back to the nursing home. It was discussed extensively with the nursing home a type II DM diagnosis on Resident #21's medical history, but the MAR did not show Resident #21 received any insulin. It was also discussed with the nursing home the importance of giving Resident #21 insulin. Review of the blood glucose monitoring on 10/30/24 at 1:01 P.M. revealed Resident #21's blood glucose level was 586 milligrams per deciliter (md/dL). On 10/30/24 at 4:32 P.M., Resident #21's blood glucose was 387 mg/dL, and at 9:31 P.M., it was 513 mg/dL. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 10/30/24 revealed Resident #21 was ordered Humalog (insulin) per sliding scale, Metformin (antidiabetic), and Lantus 10 units. Resident #21 was ordered a continuous glucose monitoring sensor. Resident #21's blood glucose levels from 10/31/24 to 11/19/24 ranged from 153 mg/dL (on 11/10/24) to 536 mg/dL. Interview on 11/18/24 at 9:39 A.M. with Resident #21 stated he was given the wrong medication or it was not administered correctly and he had to go to the hospital. Resident #21 stated his blood glucose was 500 at the hospital. Interview on 11/19/24 at 11:59 A.M. with the Director of Nursing (DON) stated the diagnosis of type II DM for Resident #21 was added on 06/05/24. The DON stated Resident #21 returned to the facility from the hospital and the MDS nurse found in the diagnosis in the paperwork and added it the Resident #21's current diagnoses. The DON verified there was no monitoring of Resident #21's blood glucose levels or anti-diabetic medications ordered until 10/30/24. Interview on 11/20/24 at 8:15 A.M. with MDS Nurse #300 verified the diagnoses and care plan for type II DM was added when Resident #21 returned from the hospital in June. MDS Nurse #300 verified the doctor should be notified of any new diagnosis and the care plan had interventions that were not put in place. Interview on 11/20/24 at 12:32 P.M. with Medical Director (MD) #253 stated he was not aware a diagnosis of type II DM had been added in June for Resident #21. MD #253 stated the discharge summary and medication list of the hospital in June did not list any diagnosis or medication for DM and MD #253 did not look through all the paperwork sent from the hospital. MD #253 stated an A1C would have been ordered if MD #253 had been aware of a diagnosis of type II DM being added for Resident #21. MD #253 stated additional orders for blood glucose monitoring and medications would have been ordered depending on the results of the A1C. Review of the policy and procedure of Nursing Care of the Resident with DM revised December 2015 revealed the purpose of the guideline is to help the resident control his/her diabetes with diet, exercise and insulin (as ordered), prevent recurrent hyperglycemia/hypoglycemia, recognize, manage, and document the treatment of complications commonly associated with DM. The management of individuals with DM should follow relevant protocols and guidelines. The physician will order the frequency of glucose monitoring. Finger sticks (capillary blood sample) measure current blood glucose levels. The normal ranges are defined as 80-130 mg/dL before meals and less than 180 mg/dL after meals. Hyperglycemia is considered anything above the target reference ranges. Medication management of type II DM may include oral hypoglycemic agents with or without insulin. According to the Older Adults: Standard of Care in Diabetes-2024 by the American Diabetes Association dated January 2024 Treatment in skilled nursing facilities and nursing homes revealed management of diabetes in the long-term care (LTC) setting is unique. Individualization of health care is important for all people with diabetes; however, practical guidance is needed for health care professionals as well as the LTC staff and caregivers. Training should include diabetes detection and institutional quality assessment. LTC facilities should develop their own policies and procedures for prevention, recognition, and management of hypoglycemia.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, policy review, and staff interview, the facility failed to identify if the pharmacy had any irregularities or recommendations from June 2024 through October 2024. This affected three (Resident #10, #29, and #33) of five residents reviewed for unnecessary medications. The facility census was 38. Findings include: 1. Review of the medical record revealed Resident #10 was admitted on [DATE] with diagnoses that included Fourier gangrene, paralytic, neuromuscular dysfunction, colostomy, bipolar disorder, convulsions, anxiety disorder, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact. Resident #10 received antianxiety, antidepressant, anticoagulant, and opioid medications. The physician orders included Effexor (antidepressant), Percocet (opioid pain medication) hydroxyzine (to treat anxiety), Keppra (anticonvulsant), apixaban (anticoagulant), amantadine (antidyskinetic), and paliperidone (antipsychotic) Review of the monthly pharmacy reviews revealed Resident #10's medications were reviewed in June 2024, July 2024, September 2024, and October 2024. (Resident #10 was at the hospital at the time of the August 2024 pharmacy review). The pharmacy reviews did not indicate if there were any irregularities or recommendations for Resident #10 when the monthly reviews were done. Interview on 11/21/24 at 1:57 P.M. with [NAME] President of Clinical Services #254 verified the monthly pharmacy reviews did not indicate if there were any irregularities or recommendations for Resident #10 during the months of June 2024, July 2024, September 2024, and October 2024. The facility contacted the pharmacy representative. The pharmacy representative stated they just sent individual recommendation via email to the Director of Nursing (DON) but did not provide a list of residents that had recommendations each month. [NAME] President of Clinical Services #254 verified there was nothing to ensure all the recommendations were received and addressed by the physician. 2. Review of the medical record revealed Resident #33 was readmitted on [DATE] with diagnoses including congestive heart failure, morbid obesity, hypoxemia, pain, presbyopia, macular degeneration, anxiety, depressive disorder, dysphagia, neuropathy, duodenal ulcer, hypertension, chronic kidney disease, and hyperlipidemia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 was cognitively intact. Resident #33 received antianxiety, antidepressant, diuretic, opioid, and antiplatelet medications. The physician orders included Tramadol (opioid pain medication) Lexapro (treats anxiety and depression), Prazosin (to treat post-traumatic stress disorder), Buspar (antianxiety), Lasix (diuretic), hydrozyzine (treats anxiety), and Bupropion (antidepressant). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the monthly pharmacy reviews revealed Resident #33's medications were reviewed in June 2024, July 2024, August 2024, September 2024, and October 2024. The pharmacy reviews did not indicate if there were any irregularities or recommendations for Resident #33 when the monthly reviews were done. Interview on 11/21/24 at 1:57 P.M. with [NAME] President of Clinical Services #254 verified the monthly pharmacy reviews did not idicate if there were any irregularities or recommendations for Resident #33 during the months of June 2024, July 2024, August 2024, September 2024, and October 2024. The facility contacted the pharmacy representative. The pharmacy representative stated they just sent individual recommendation via email to the Director of Nursing (DON) but did not provide a list of residents that had recommendations each month. [NAME] President of Clinical Services #254 verified there was nothing to ensure all the recommendations were received and addressed by the physician. 39333 3. Record review for Resident #29 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, chronic kidney disease, and malignant neoplasm of duodenum. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact and required set up for activities of daily living. Resident #29 received antipsychotics, antidepressants, diuretics, antiplatelets, and opioids during the seven-day look back period. Review of the current physician's orders revealed Resident #29 was ordered bupropion (antidepressant), lurasidone (antipsychotic), Oxycodone with acetaminophen (opioid pain medication) and Lasix (diuretic). Review of the monthly pharmacy reviews revealed Resident #29's medications were reviewed in June 2024, July 2024, August 2024, September 2024, and October 2024. The pharmacy reviews did not indicate if there were any irregularities or recommendations for Resident #29 when the monthly reviews were done. Interview on 11/21/24 at 1:57 P.M. with [NAME] President of Clinical Services #254 verified the monthly pharmacy reviews did not indicate if there were any irregularities or recommendations for Resident #29 during the months of June 2024, July 2024, August 2024, September 2024, and October 2024. The facility contacted the pharmacy representative. The pharmacy representative stated they just sent individual recommendation via email to the Director of Nursing (DON) but did not provide a list of residents that had recommendations each month. [NAME] President of Clinical Services #254 verified there was nothing to ensure all the recommendations were received and addressed by the physician. Review of the facility's Medication Regimen Reviews policy and procedure revised April 2007 revealed the primary purpose of the review is to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. The Consultant Pharmacist will document his/her findings and recommendations on the monthly drug/medication regimen review report. The Consultant Pharmacist will provide a written report to physicians for each resident with an identified irregularity. The Consultant Pharmacist will provide the DON and Medical Director with a written, signed and dated copy of the report, listing the irregularities found and recommendations for their solutions.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 39333 Based on observation, staff interview, test tray, and record review, the facility failed to serve pureed foods at a smooth consistency for residents on a mechanically altered diet. This had the potential to affect four residents (#4, #5, #23, and #30) identified by the facility who were prescribed pureed diets. The facility census was 38. Findings include: The observation of puree preparation on 11/18/24 at 10:50 A.M. revealed Dietary Manager (DM) #200 changed the puree vegetable for lunch to pureed peas. She stated the squash in the mixed vegetables sometimes does not puree correctly to a smooth consistency because of the rind. [NAME] #241 pureed the peas for several minutes and was tasting the peas as she was going. She took the pureed peas out of the robot coupe container, put the pureed peas into bowls for the residents, portioned a small amount into a five-ounce dessert dish with a plastic spoon. The taste test on 11/18/24 at 10:50 A.M. revealed the pureed peas were not of a smooth consistency and had pieces of the pea shells in it. The Regional Director of Culinary (RDC) #251 tasted the purees and verified the peas needed to be pureed more. RDC #251 recommended DM #200 to puree the menu item. [NAME] #241 pureed the mixed vegetables to the correct consistency for lunch service. The facility identified four residents, Residents #4, #5, #23, and #30, who were prescribed pureed diets Review of the undated facility's policy titled Pureed Food Preparation revealed the foods would be pureed to assure desire consistency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366014	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Hills Rehabilitation and Nursing Center	416 Wooster Road Mount Vernon, OH 43050

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 39333 Based on record review, review of the facility arbitration agreement, and staff interview, the facility failed to ensure their arbitration agreement had the required information that the signing resident or resident representative may communicate with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman as well as the agreement stated that the if the resident or resident representative would wish to cancel the arbitration agreement in within thirty (30) days, it does not have to be in writing. This affected 37 of 38 residents who signed the arbitration agreement. Resident #3 did not sign the arbitration agreement upon admission. The facility census was 38. Findings include: Review of the facility's admission packet revealed an arbitration agreement was within the admission packet. Review of resident medical records during the survey revealed arbitration agreements were signed by residents with the exception of the agreement for Resident #3, which was not signed upon admission. Review of the facility's arbitration agreement revealed the agreement did not state that the resident or resident representative may communicate with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman. The facility's arbitration agreement did not state the resident or resident representative has the right to cancel the arbitration agreement within thirty (30) days by providing written notice. Interview on 11/21/24 at 4:05 P.M. with the Administrator verified the facility's arbitration agreement that the residents sign upon admission did not include the resident or resident representative may communicate with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman and did not state the resident or resident representative has the right to cancel the arbitration agreement within thirty (30) days by providing written notice. The facility did not have a policy for arbitration agreements.

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	366014	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 39333 Based on staff interview, record review, and review of facility arbitration agreement, the facility failed to provide a neutral and fair arbitration process by ensuring both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator, and that the venue is convenient to both parties. This affected 37 of 38 residents who signed the arbitration agreement. Resident #3 did not sign the arbitration agreement upon admission. The facility census was 38. Findings include: Review of the facility's admission packet revealed an arbitration agreement was within the admission packet. Review of resident medical records during the survey revealed arbitration agreements were signed by residents with the exception of the agreement for Resident #3, which was not signed upon admission. Review of the facility's arbitration agreement revealed that by signing this Agreement, the Parties agree that, except as otherwise set forth herein, any action, claim, dispute or controversy of any kind, whether in contract, tort, statutory, common law, legal, equitable, or otherwise, during the term of the admissions agreement or hereafter arising between the parties in any way arising out of, pertaining to, or in connection with, the provision of health care services or any agreement between the parties including, but not limited to, the scope of this agreement with, and the arbitrability of, any claim or dispute, against whomever made (including, to the full extent permitted by applicable laws, third parties who are not signatories to this Agreement) shall be resolved by binding arbitration administered by the American Arbitrators Association (AAA). If the AAA does not enforce pre-dispute arbitration agreements, then any other reasonably comparable arbitration association chosen solely by the facility shall be an acceptable replacement. The agreement does not allow the resident or resident representative to seek other counsel except American Arbitrators Association (AAA) for binding arbitration disputes. This did not ensure both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator The facility's arbitration agreement revealed that in the event a court having jurisdiction finds any portion of the arbitration agreement or the admissions agreement unenforceable, that portion shall not be effective, and the remainder of the agreements shall remain effective. If a court finds that all of the provisions in this agreement providing for binding arbitration are unenforceable, then such provisions shall be replaced with a waiver of jury trial in accordance with the laws of Ohio without regards to its conflicts of law, and the venue shall be in the closest proper venue to the facility's principal place of business. This does not allow for the resident or resident representative to agree with the venue. An interview on 11/21/24 at 4:05 P.M. with the Administrator verified the facility's arbitration agreement did not provide a neutral and fair arbitration process by ensuring both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator, and that the venue is convenient to both parties. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366014	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Hills Rehabilitation and Nursing Center	416 Wooster Road Mount Vernon, OH 43050

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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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility did not have a policy for arbitration agreements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on review of the facility assessment, personnel record review, and staff interview, the facility failed to provide behavioral health education to all staff in orientation and annually thereafter. This had the potential to affect all 38 residents residing in the facility. Findings include: Review of the facility assessment dated [DATE] revealed the facility accepted residents with psychiatric disorders to include impaired cognition, mental disorder, bipolar, schizophrenia, post-traumatic stress disorder, anxiety disorder, and behaviors which required interventions. Review of the personnel file for Dietary Aide #500 revealed a hire date of 07/24/24 and no evidence the employee received training on mental health behaviors. Review of the personnel file for Housekeeper #209 revealed a hire date of 09/16/24 and no evidence the employee received training on mental health behaviors. Review of the personnel file for License Practical Nurse (LPN) #213 revealed a hire date of 07/24/24 and no evidence the employee received training on mental health behaviors. Review of the personnel file for Certified Nursing Assistant (CNA) #223 revealed a hire date of 08/21/20 and no evidence the employee received training on mental health behaviors. Review of the personnel file for CNA #203 revealed a hire date of 06/01/22 and no evidence the employee received training on mental health behaviors. Review of the personnel file for CNA #227 revealed a hire date of 11/08/21 and no evidence the employee received training on mental health behaviors. Review of the annual in-service for facility staff revealed that the in-service for behavior training was scheduled in December 2024. An interview with the Administrator on 11/21/24 at 9:30 A.M. revealed there was an annual in-service scheduled for behavioral training in December 2024. The Administrator stated she could not find any documentation that behavior training was provided to all staff at orientation or completed in the previous twelve months. The Administrator also verified the facility assessment included the facility accepted residents with psychiatric disorders to include impaired cognition, mental disorder, bipolar, schizophrenia, post-traumatic stress disorder, anxiety disorder, and behaviors which required interventions.