| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366080 | A. Building<br>B. Wing | 02/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Chesterwood Village | 8073 Tylersville Road<br>West Chester, OH 45069 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683<br><br>Based on staff interview, record review, and policy review, the facility failed to refer a resident to the appropriate state-designated mental health or intellectual disability authority when the resident had a new diagnosis of a mental disorder. This affected one (#34) of two residents reviewed for preadmission screening and resident review (PASARR) requirements. The facility census was 113.<br><br>Findings included:<br><br>Review of Resident #34's admission record indicated the facility admitted Resident #34 on 03/06/24. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified psychosis (onset 07/19/2024), major depressive disorder (onset 03/06/2024), post-traumatic stress disorder (PTSD) (onset 03/06/2024), conversion disorder with motor symptom or deficit (onset 03/06/2024), and disassociation and conversion disorder (onset 03/06/2024).<br><br>Review of Resident #34's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/11/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. According to the MDS, Resident #34 had active diagnoses of depression, psychotic disorder, and post traumatic stress disorder (PTSD).<br><br>Review of Resident #34's undated care plan included a problem area indicating the resident had major depressive disorder, PTSD, conversion disorder with motor symptom or deficit, and disassociation and conversion disorder. According to the care plan, the resident was diagnosed with the mental disorders over [AGE] years prior and received psychiatric services.<br><br>Review of Resident #34's Preadmission Screening and Resident Review Result Notice, dated 02/11/15, revealed the resident had no indications of serious mental illness and/or developmental disability.<br><br>Review of Resident #34's Preadmission Screening and Resident Review (PASARR) Identification Screen, dated 03/07/24 and signed by Licensed Social Worker (LSW) #26, revealed the resident had mental disorders including mood disorder and disassociation and conversion disorder. The PASARR did not indicate that the resident had psychotic disorder.<br><br>Review of Resident #34's Preadmission Screening and Resident Review Result Notice, dated 03/07/24, revealed the resident had no indications of serious mental illness and/or developmental disability.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366080 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/14/2025 |
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| NAME OF PROVIDER OR SUPPLIER Chesterwood Village | | STREET ADDRESS, CITY, STATE, ZIP CODE 8073 Tylersville Road West Chester, OH 45069 | |

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|---|---|
| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #34's Preadmission Screening and Resident Review (PASRR) Identification Screen, dated 02/11/25, and signed by LSW #26, revealed the resident had a significant change in condition. Per the screening, the resident had mental disorders including PTSD, mood disorder, and disassociation and conversion disorder. The PASARR did not indicate that the resident had psychotic disorder.<br><br>Interview on 02/14/25 at 11:22 A.M., with LSW #26 stated social services staff tracked PASARR screenings and ensured their accuracy. She stated a diagnosis of psychosis was added for the resident on 07/19/24, but when the facility completed the significant change PASARR screening, that diagnosis must have been overlooked.<br><br>Interview on 02/14/25 at 4:54 P.M., with the Director of Nursing stated she could not answer questions on PASARR screenings or how they were completed.<br><br>Interview on 02/14/2025 at 5:08 P.M., with the Administrator stated he did not know about PASARR screenings, and he deferred to the social worker.<br><br>Review of the policy titled, PASARR [PASRR] (MI [mental illness]/MR [mental retardation]) Identification Screen ([State]), revised November 2016, indicated, 5. A Resident Review is required for any individual who: exceeds the 30 day time limit for a hospital exemption; is transferring between nursing facilities without evidence of a prior PAS/RR being completed; experiences a significant change of condition; has exceeded the time limit for a previously issued categorical determination; or is exceeding the time frame for a previously issued resident review determination. 6. Social Services will initiate the Resident Review (PAS/RR-ID [intellectual disability] form 3622) when an individual meets the above circumstances. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366080 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/14/2025 |
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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683<br><br>Based on staff interview, record review, and policy review, the facility failed to ensure the accuracy of a Preadmission Screening and Resident Review (PASARR). This affected one (#34) of two residents reviewed for PASARR requirements. The facility census was 113.<br><br>Findings included:<br><br>Review of Resident #34's admission record indicated the facility admitted Resident #34 on 03/06/24. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified psychosis (onset 07/19/2024), major depressive disorder (onset 03/06/2024), post-traumatic stress disorder (PTSD) (onset 03/06/2024), conversion disorder with motor symptom or deficit (onset 03/06/2024), and disassociation and conversion disorder (onset 03/06/2024).<br><br>Review of Resident #34's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/11/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. According to the MDS, Resident #34 had active diagnoses of depression, psychotic disorder, and post traumatic stress disorder (PTSD).<br><br>Review of Resident #34's undated care plan included a problem area indicating the resident had major depressive disorder, PTSD, conversion disorder with motor symptom or deficit, and disassociation and conversion disorder. According to the care plan, the resident was diagnosed with the mental disorders over [AGE] years prior and received psychiatric services.<br><br>Review of Resident #34's Preadmission Screening and Resident Review (PASRR) Identification Screen, dated 02/11/25, and signed by LSW #26, revealed the resident had a significant change in condition. Per the screening, the resident had mental disorders including PTSD, mood disorder, and disassociation and conversion disorder. The PASARR did not indicate that the resident had psychotic disorder.<br><br>Review of Resident #34's Preadmission Screening and Resident Review (PASARR) Identification Screen, dated 03/07/24 and signed by Licensed Social Worker (LSW) #26, revealed the resident had mental disorders including mood disorder and disassociation and conversion disorder. The PASARR did not indicate that the resident had psychotic disorder.<br><br>Review of Resident #34's Preadmission Screening and Resident Review Result Notice, dated 03/07/24, revealed the resident had no indications of serious mental illness and/or developmental disability.<br><br>Interview on 02/14/25 at 11:22 A.M., with LSW #26 stated social services staff tracked PASARR screenings and ensured their accuracy. She stated the new PASARR for Resident #34 captured the resident's diagnosis of PTSD.<br><br>Interview on 02/14/25 at 4:54 P.M., with the Director of Nursing stated she could not answer questions on PASARR screenings or how they were completed.<br><br>(continued on next page) |

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| | 366080 | A. Building<br>B. Wing | 02/14/2025 |

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| Chesterwood Village | 8073 Tylersville Road<br>West Chester, OH 45069 |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/14/2025 at 5:08 P.M., with the Administrator stated he did not know about PASARR screenings, and he deferred to the social worker.<br><br>Review of the policy titled, PASARR [PASRR] (MI [mental illness]/MR [mental retardation]) Identification Screen ([State]), revised November 2016, indicated, 5. A Resident Review is required for any individual who: exceeds the 30 day time limit for a hospital exemption; is transferring between nursing facilities without evidence of a prior PAS/RR being completed; experiences a significant change of condition; has exceeded the time limit for a previously issued categorical determination; or is exceeding the time frame for a previously issued resident review determination. 6. Social Services will initiate the Resident Review (PAS/RR-ID [intellectual disability] form 3622) when an individual meets the above circumstances. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>46659<br><br>Based on observation, record review, resident interview, staff interview, facility document review, and policy review, the facility failed to ensure residents' fingernails were clean and trimmed. This affected two (#18 and #55) of four residents reviewed for activities of daily living (ADLs). The facility census was 113.<br><br>Findings included:<br><br>1. Review of Resident #18's admission record indicated the facility admitted Resident #18 on 12/26/21. The resident had a medical history that included diagnoses of type 2 diabetes mellitus, muscle weakness, Alzheimer's disease, and dementia.<br><br>Review of the annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/25/24, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #18 required substantial/maximal assistance from staff for personal hygiene.<br><br>Review of Resident #18's undated care plan included a focus area that indicated Resident #18 had an ADL self-care performance deficit related to dementia. Interventions directed staff to assist the resident with ADLs as needed.<br><br>Observation on 02/10/25 at 11:29 A.M., revealed Resident #18 had dirty fingernails.<br><br>Interview on 02/12/25 at 9:02 A.M., with Resident #18 stated they wanted the staff to keep their (Resident #18's) fingernails clean.<br><br>Interview on 02/12/25 at 9:08 A.M., with Nurse Aide (NA) #19 stated staff should keep residents' fingernails clean. NA #19 stated that Resident #18 did not refuse any personal hygiene care.<br><br>Interview on 02/12/25 at 9:25 A.M., with NA #3 stated that when giving a resident a shower or bath, the task also included cleaning their fingernails. NA #3 stated that NAs should make sure residents' nails were clean.<br><br>Interview on 02/12/25 at 9:15 A.M., with Registered Nurse (RN) #20 stated nurses or NAs could keep the residents' nails clean.<br><br>Observation on 02/13/25 at 10:42 A.M., revealed Resident #18' fingernails were dirty.<br><br>Interview on 02/13/25 at 11:03 A.M., with Licensed Practical Nurse (LPN) #13 stated the NAs were to offer to clean the residents' fingernails. LPN #13 stated she was unaware that Resident #18's fingernails were dirty.<br><br>Observation on 02/14/25 at 8:36 A.M., revealed Resident #18's fingernails were dirty.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/14/25 at 8:46 A.M., with LPN #18 observed Resident #18 and stated Resident #18's fingernails were dirty and needed to be cleaned. She stated that she was not aware of the resident refusing nail care, and if they did refuse, the staff would notify a nurse.<br><br>Interview on 02/14/25 at 8:48 A.M., with NA #25 stated that residents' nails were cleaned when they received their showers. NA #25 stated that Resident #18 had not refused to have their nails cleaned in the past.<br><br>Interview on 02/14/25 at 9:03 A.M., with NA #25 observed Resident #18's nails and stated Resident #18's fingernails were not clean. She stated that the resident may eat with their hands and that it was important to keep their hands and nails clean. NA #25 stated Resident #18's fingernails would need to be soaked to get them clean.<br><br>Interview on 02/14/25 at 9:05 A.M., with LPN #18 observed Resident #18's nails and stated that Resident #18's fingernails needed to be cleaned. LPN #18 stated that staff were to make sure the resident's fingernails stayed clean. She stated that Resident #18 did sometimes eat with their hands, so it was important that they keep the resident's hands clean. She stated that it looked like the resident's hands had not been cleaned for a few days.<br><br>Interview on 02/14/25 at 4:46 P.M., with the Director of Nursing (DON) stated she expected the staff to provide nail care on shower days or daily to make sure they were clean. She stated they should be clean for infection control purposes. The DON stated the nurses and NAs were trained to complete those tasks as part of their daily duties<br><br>Interview on 02/14/25 at 4:12 P.M., with the Administrator stated he expected staff to clean, file, and trim fingernails as needed. He stated having clean nails was important for infection control purposes.<br><br>40141<br><br>2. Review of the admission record indicated the facility admitted Resident #55 on 04/20/24. The resident had a medical history that included diagnoses of atherosclerotic heart disease, type 2 diabetes mellitus, and muscle weakness.<br><br>Review of the quarterly Minimum Data Set (MDS) assesment, with an Assessment Reference Date (ARD) of 11/23/24, revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required total assistance with personal hygiene, substantial assistance for bathing, and setup assistance with eating.<br><br>Review of Resident #55's undated care plan included a focus area that indicated the resident had an ADL self-care performance deficit related to impaired mobility and musculoskeletal impairment. Interventions directed staff to trim/clean the resident's fingernails on bath day and as necessary.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 02/10/25 at 10:42 P.M., with Resident #55 had long fingernails on all fingers, with a brown substance visible under most of the fingernails. The resident stated their fingernails had not been cut in a long time and that they were dirty. The resident stated they had asked for their fingernails to be cut, and a staff member wrote it down, but they did not do it. Resident #55 stated the fingernails were too long for them to be able to clean them independently. Resident #55 stated they had a shower the other day and thought staff might do it (clean and trim their nails) then, but they did not.<br><br>Observation and interview on 02/12/25 at 7:51 P.M., with Resident #55's fingernails remained long with a brown substance underneath them. The resident stated they really wanted their fingernails cleaned and cut.<br><br>Interview on 02/12/25 at 7:55 P.M., with Certified Nurse Aide (CNA) #1 stated nurse aides were responsible for providing fingernail care. STNA #1 stated she always checked with the nurse before cutting fingernails. She stated fingernails should be cleaned during a resident's bath or as needed. She stated residents received two baths per week, on a rotation schedule to be provided every two to three days.<br><br>Observation and interview on 02/14/25 at 9:00 P.M., with Resident #55 was in bed and said to Nurse Aide (NA) #2 that they wanted their nails cut, as the NA was observing the fingernails. The resident stated their hands were too weak to cut them and that the nails were too long for the resident to clean. The resident stated the fingernails needed to be cut and cleaned. NA #2 stated Resident #55's fingernails were not clean. NA #2 stated the resident ate finger foods, so their fingernails needed to be clean for hygiene purposes.<br><br>Interview on 02/14/25 at 9:17 P.M., with NA #3 stated that she was the preceptor for the NA class that was currently in the facility. NA #3 stated nail care was provided as needed. NA #3 observed Resident #55's fingernails and stated they were long and dirty with a brown substance. NA #3 stated that it was an infection control issue, especially since the resident ate a lot of finger foods.<br><br>Interview on 02/14/25 at 4:46 P.M., with the Director of Nursing (DON) stated she expected the staff to provide nail care on shower days or daily to make sure they were clean. She stated they should be clean for infection control purposes. The DON stated the nurses and NAs were trained to complete those tasks as part of their daily duties<br><br>Interview on 02/14/25 at 4:12 P.M., with the Administrator stated he expected staff to clean, file, and trim fingernails as needed. He stated having clean nails was important for infection control purposes. The Administrator stated Resident #55's fingernails should have been clean.<br><br>Review of the policy titled, Activities of Daily Living (ADL Care), revised August 2024, indicated, Staff will ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The policy specified ADLs included, Hygiene - bathing, dressing, grooming, and oral care.<br><br>Review of a facility document titled, Nurse Aide and Nurse Aide in Training (NAT) Job Description, revised January 2025, revealed the Responsibilities included, 1. Provides/assists as needed with personal hygiene care daily, such as shampoos, general grooming, shaves male residents, and sees that nails are clean and manicured. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>52066<br><br>Based on staff interview, resident interview, record review, and policy review, the facility failed to ensure pain medication was administered promptly. This affected one (#325) of six residents reviewed for pain management. The facility census was 113.<br><br>Findings included:<br><br>Review of the admission record indicated the facility admitted Resident #325 on 02/01/25. The resident had a medical history that included diagnoses of other osteomyelitis (bone infection) in ankle and foot; osteomyelitis, unspecified; and peripheral vascular disease (narrowing or blockage of blood vessels that carry blood from the heart to other parts of the body), unspecified.<br><br>Review of the admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/07/25, revealed Resident #325 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received scheduled pain medication and received or was offered and declined as needed (PRN) pain medication during a five-day look back period. Per the MDS, the resident experienced pain frequently. The MDS indicated the resident rated their pain level during the five-day look back period at an 8, on a scale of 0-10, with 10 being the worst possible pain.<br><br>Review of Resident #325's undated care plan included a focus area that indicated the resident was at risk for alteration in comfort related to wounds and osteomyelitis of the ankle and foot. Interventions directed staff to administer pain medication and other non-pharmacological interventions as indicated, encourage the resident to ask for pain medication before the pain became more severe, and evaluate the effectiveness of pain interventions.<br><br>Interview on 02/10/25 at 11:38 A.M., with Resident #325 stated their pain medications were not administered as ordered during the evening of 02/08/25.<br><br>Review of Resident #325's medication administration record (MAR), for the timeframe from 02/01/25 through 02/13/25, revealed transcription of an order for oxycodone hydrochloride (HCl) (an opioid) oral tablet 10 milligrams (mg), one tablet every four hours PRN for severe pain, with an order date of 02/02/25. The MAR also included transcription of an order for acetaminophen (an analgesic) 325 mg, two tablets every six hours PRN for pain related to osteomyelitis of the foot and ankle. The MAR revealed staff documented on 02/08/25 that Resident #325 was given acetaminophen one time, at 11:18 A.M. for a pain level of 5, with effective results. The MAR revealed staff documented on 02/08/25, that Resident #325 was given oxycodone at 4:45 P.M. for a pain level of 7, with effective results. The next dose was documented to have been administered on 02/09/25 at 12:03 A.M. (seven hours and 18 minutes after the previous dose) for a pain level of 2, with effective results.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/13/25 at 2:50 P.M., with Licensed Practical Nurse (LPN) #13 stated she worked on 02/08/25, clocking in at 7:00 A.M. and clocking out at 1:30 A.M. on 02/09/25. She stated she was the person administering narcotic medications that night. She stated that the staffing over the weekend was terrible. She stated a nurse did not show up for her shift. Per LPN #13, the night shift had been struggling with staffing problems for the rehabilitation unit (100 Hall), where Resident #325 resided. She stated she was all over the building in all the units trying to help. LPN #13 stated that she remembered a nurse responsible for 100 Hall telling her that there were residents who needed pain medication. She stated she responded within 15 minutes after she was notified and that the residents did not have to wait long.<br><br>Interview on 02/14/25 at 7:18 P.M., with Nurse Aide (NA) #14 stated there was not enough nursing staff for the night shift on 02/08/25. She stated there was a nurse who did not show up for work and the other nurse had been in training for two days and left after deciding she should not be working. NA #14 stated when she arrived for her shift at 7:00 P.M., Resident #325 was asking for pain medications, but one nurse did not show up and the other nurse did not provide the medication. NA #14 stated she tried to calm and comfort the resident, but the resident was upset. She stated she remembered the resident waited a long time for their medication. (Based on review of the MAR referenced above, the resident, who was asking for pain medication at 7:00 P.M., did not receive the medication until 12:03 A.M )<br><br>Interview on 02/14/25 at 5:22 P.M., with the Assistant Director of Nursing (ADON) stated the biggest concern she had from the previous weekend was a nurse not showing up for work, which made it hard. She stated the staff were to work together to get their tasks completed. She stated nurses were still responsible to administer PRN medications.<br><br>Interview on 02/14/25 at 4:54 P.M., with the Administrator stated his expectation was for staff to follow the physician orders and ensure the effectiveness of the medication and to contact the physician as needed.<br><br>Review of the policy titled, Pain Management, revised June 2015, indicated, The facility will evaluate, identify and put interventions in place for patients with pain based on nursing and clinician assessments. The policy specified that the procedures included, 6. Administer pain medication as prescribed by the physician/clinician. 7. Patient will be assessed for relief of pain after administration of pain medication. (Documentation in EMR [electronic medical record]) 8. If relief is determined to be inadequate, the physician may need to be contacted for changes in treatment. The physician/clinician can evaluate treatment plan or create a new treatment plan.<br><br>This deficiency represents the noncompliance investigated under Complaint Number OH00161332. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683<br><br>Based on staff interview, resident interview, record review, agreement review, and policy review, the facility failed to maintain ongoing communication with a dialysis center. This affected one (#92) of one resident reviewed for dialysis. The facility census was 113.<br><br>Findings included:<br><br>Review of Resident #92's admission record revealed the facility admitted Resident #92 on 05/31/24. The resident had a medical history that included diagnoses of end stage renal disease (ESRD), major depressive disorder, and essential hypertension.<br><br>Review of Resident #92's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/06/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received hemodialysis while a resident.<br><br>Review of Resident #92's undated care plan revealed a focus area that indicated the resident needed hemodialysis and had a potential for complications/infection related to ESRD. The care plan indicated the resident received dialysis at the corporation operating outpatient dialysis clinics on Mondays, Wednesdays, and Fridays.<br><br>Review of Resident #92's Order Summary Report, with active orders as of 02/12/25, revealed an order dated 07/19/24 regarding the resident being transported by their family on Mondays, Wednesdays, and Fridays for dialysis.<br><br>Interview on 02/13/25 at 9:53 A.M., with Resident #92 stated the facility staff had never sent them to the dialysis center with a communication form.<br><br>Review of Resident #92's medical record revealed no communication sheet from the dialysis center for the following timeframes:<br><br>- Between 07/19/24 and 07/24/24.<br><br>- Between 07/24/24 and 07/31/24.<br><br>- Between 07/31/24 and 08/05/24.<br><br>- Between 08/09/24 and 08/14/24.<br><br>- Between 08/16/24 and 08/28/24.<br><br>- Between 08/28/24 and 09/11/24.<br><br>- Between 09/13/24 and 09/20/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366080 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/14/2025 |
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| NAME OF PROVIDER OR SUPPLIER Chesterwood Village | | STREET ADDRESS, CITY, STATE, ZIP CODE 8073 Tylersville Road West Chester, OH 45069 | |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Between 09/20/24 and 09/25/24.<br><br>- Between 10/09/24 and 10/25/24.<br><br>- Between 10/25/24 and 11/01/24.<br><br>- Between 11/01/24 and 11/06/24.<br><br>- Between 11/08/24 and 11/29/24.<br><br>- Between 11/29/24 and 12/22/24.<br><br>- Between 12/24/24 and 01/08/25.<br><br>- Between 01/10/25 and 01/15/25.<br><br>- Between 01/15/25 and 01/22/25.<br><br>- Between 01/24/25 and 01/29/25.<br><br>- Between 01/29/25 and 02/07/25 .<br><br>Review of the Patient Communication Sheet from the dialysis center, dated 02/07/25, indicated information on the form included date of treatment, an assessment of the resident's vital signs pre-and post-treatment, medications administered, and a treatment summary indicating stable/unstable condition, narrative of the treatment, and any new orders.<br><br>Interview on 02/13/25 at 8:53 A.M., with Licensed Social Worker #26 stated the most recent dialysis communication form she could find in the resident's record was from 02/07/25.<br><br>Interview on 02/13/25 at 9:24 A.M., with the Director of Nursing (DON) stated the dialysis center usually sent to the facility via facsimile (fax) or sent back their patient communication form to the facility. She stated that she did not know if the facility staff sent a form to the dialysis center for communication. She stated the clinic where Resident #92 received dialysis sent dialysis information back as a fax, which would then go in the hard copy health record. She stated if, for whatever reason, the facility did not receive this fax, staff could call the dialysis center and request it. The DON stated she did not know what happened to the previous two dialysis communication forms, which were not in the resident's hard copy health record. She stated she would have to investigate to see if the facility staff failed to contact to the dialysis center about the forms.<br><br>Review of the Resident #92's [the corporation operating outpatient dialysis clinics] Patient Communication Sheet, dated 02/12/25, indicated that it was faxed to the facility on [DATE] at 9:24 P.M<br><br>Review of the Resident #92's [the corporation operating outpatient dialysis clinics] Patient Communication Sheet, dated 02/10/25, indicated that it was faxed to the facility on [DATE] at 9:26 P.M<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 02/13/25 at 10:28 A.M., with Licensed Practical Nurse (LPN) #16 stated Resident #92 did not go out to the dialysis center with communication forms or return with communication forms. She stated the facility was not faxed by the dialysis center, and she did not know she was to follow up with the dialysis center, so she did not do so.<br><br>Interview on 02/13/25 at 11:08 A.M., with the Administrator stated he had provided all the dialysis communication forms that were found in Resident #92's chart. He stated that some communication forms were missing, but he stated the facility policy indicated they only needed to communicate with the dialysis center as needed.<br><br>Interview on 02/14/25 at 4:54 P.M., with the Director of Nursing (DON) stated the facility expectation was to send out dialysis patients with their paperwork and they would return with paperwork. She stated Resident #92 was provided paperwork to be taken with them to dialysis and the dialysis center faxed communication forms back. She stated if they did not receive a fax back, then the nurse should reach out to the dialysis center. She stated nursing staff knew to do this. She stated that a nurse who did not know, Licensed Practical Nurse (LPN) #16, was new to the unit when she worked. She stated she should have been informed of that practice when she reported into work that day.<br><br>Review of the undated policy titled, Hemodialysis Coordination and Resident Monitoring, indicated, Residents ordered to receive hemodialysis will be monitored on-going for signs and symptoms of adverse effects. The coordination of the program. will be maintained by facility staff in conjunction with the dialysis center and the Physician(s) involved. The policy revealed the Procedure included 8. The Hemodialysis Center, Nursing Facility, Dietician, and Physician will consult and [sic] needed, and 10. The facility will maintain a written agreement with the specific dialysis center.<br><br>Review of a Memorandum of Agreement, dated 01/21/25, indicated an agreement between the facility and [a corporation operating outpatient dialysis clinics]. The document revealed, 1. Responsibilities of LTCF [long-term care facility], included c. If is a skilled nursing facility ('SNF') or a sub-acute unit, appropriate LTCF healthcare staff will make an assessment of each patient's physical condition and determine whether the patient is stable enough to be dialyzed on an outpatient basis. If it is determined that a patient is sufficiently stable, this assessment will be communicated to the Facilities' nurse manager or his or her designee. This assessment and communication will occur prior to each and every transfer of a patient to [the corporation operating outpatient dialysis clinics] for hemodialysis on an outpatient basis regardless of the number of times any particular patient may be transferred and dialyzed . Additionally, a patient's nephrologist or attending physician at LTCF will make an assessment of the patient's physical condition on a routine, medically appropriate basis (but no less than every thirty (30) days). The results of this assessment will be communicated with [the corporation operating outpatient dialysis clinics]'s nurse or his or her designee. The agreement revealed, 2. Responsibilities of [The corporation operating outpatient dialysis clinics], included b. [The corporation operating outpatient dialysis clinics] shall provide relevant information regarding each patients' dialysis treatment which may require follow-up care or observation by LTCF's staff, and d. [The corporation operating outpatient dialysis clinics] shall provide to LTCF: i. information which may be utilized in the development and maintenance of LTCF patient care plans; and ii. Information about how care should be rendered to a patient in emergency and non-emergency situation. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>37683<br><br>Based on resident interview, staff interview, record review, and policy review, the facility failed to ensure complete and accurate records for dialysis assessments marking the incorrect access site for those assessments. This affected one( #92) of one resident reviewed for dialysis. The facility census was 113.<br><br>Findings included:<br><br>Review of Resident #92's admission record revealed the facility admitted Resident #92 on 05/31/24. The resident had a medical history that included diagnoses of end stage renal disease (ESRD), major depressive disorder, and essential hypertension.<br><br>Review of Resident #92's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/06/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received hemodialysis while a resident.<br><br>Review of Resident #92's undated care plan revealed a focus area that indicated the resident needed hemodialysis and had a potential for complications/infection related to ESRD. The care plan indicated the resident received dialysis at the corporation operating outpatient dialysis clinics on Mondays, Wednesdays, and Fridays.<br><br>Review of Resident #92's [facility's corporation's name] Dialysis assessment, dated 01/28/25, indicated the resident had a hemodialysis port. The assessment indicated the port was in the resident's right lower quadrant.<br><br>Review of Resident #92's [facility's corporation's name] Dialysis assessment, dated 01/29/25 at 2:54 P.M., indicated the resident had a hemodialysis port. The assessment indicated the port was in the right upper quadrant.<br><br>Review of Resident #92's [facility's corporation's name] Dialysis assessment, dated 01/29/25 at 7:45 P.M., indicated the resident had a hemodialysis shunt. The assessment indicated the shunt was in the left upper extremity.<br><br>Review of Resident #92's [facility's corporation's name] Dialysis assessment, dated 02/02/25, indicated the resident had a hemodialysis port. The assessment indicated the port was in the right upper quadrant.<br><br>Review of Resident #92's [facility's corporation's name] Dialysis assessment, dated 02/06/25, indicated the resident had a hemodialysis port. The assessment indicated the port was in the right upper quadrant.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #92's [facility's corporation's name] Dialysis assessment, dated 02/07/25, indicated the resident had a hemodialysis port. The assessment indicated the port was in the right upper quadrant.<br><br>Review of Resident #92's [facility's corporation's name] Dialysis assessment, dated 02/11/25, indicated the resident had a hemodialysis port. The assessment indicated the port was in the right upper quadrant.<br><br>Interview on 02/12/25 at 9:20 A.M., with Resident #92 stated a dialysis access site on their chest was removed a month prior and their current access site was in their arm.<br><br>Interview on 02/14/25 at 2:57 P.M., with Licensed Practical Nurse (LPN) #17 stated Resident #92's access site was on the resident's left arm.<br><br>Interview on 02/14/25 at 4:54 P.M., with the Director of Nursing (DON) stated nursing staff should document their assessments on the dialysis access sites. The DON stated she was unfamiliar with Resident #92's access site.<br><br>Review of the policy titled, Medical Record System, revised October 2023, indicated It is the policy of the facility that medical/clinical records are maintained on each resident, in accordance with accepted professional standards and practices, that are complete, accurately documented, readily accessible, and systemically organized. The policy also specified the Procedure included, 1. A complete medical record contains an accurate and functional representation of the actual experience of the resident in the health care center. The medical record should contain enough information to show that the health care center knows the status of the resident; has adequate plans of care; and provides sufficient evidence of the effects of the care provided. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>40141<br><br>Based on observation, staff interview, local health department staff interview, record review, facility document review, and policy review, the facility failed to consistently implement policies and procedures related to infection control when they failed to ensure COVID-19 outbreak signage was posted at facility entrances during an outbreak, failed to ensure the county health department was promptly notified of a positive COVID-19 test result, and failed to ensure all staff were fit-tested for N95 masks. The failed practices had the potential to affect all 113 residents. The facility census was 113.<br><br>Findings included:<br><br>1. Review of Resident #100's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/13/24, revealed the facility admitted Resident #100 on 12/07/24.<br><br>Review of an undated facility document titled, Resident Testing - For the Month, indicated, A single positive employee or resident triggers the initiation of Outbreak Investigation Protocol. The document indicated Resident #100 was symptomatic and tested positive for COVID-19 on 02/03/25.<br><br>Observation on 02/10/25 at 9:00 A.M., revealed signage referencing COVID-19 symptoms and recommending visitors to not enter if symptoms were present was visible to visitors upon entrance to the facility. There was no signage at either facility entrance to alert visitors of the presence of COVID-positive residents residing in the facility.<br><br>Interview on 02/11/25 at 2:24 P.M., with the Director of Nursing (DON) stated that on 02/10/25 there were two COVID-19 positive residents in the facility, and as of 02/11/25, there were two more COVID-positive residents.<br><br>Interview on 02/11/25 at 4:05 P.M., with the DON stated she had received a call from the local health department, and it was recommended for staff to wear masks. The DON stated the facility reported to the local health department, and all staff were to wear masks until the outbreak area was determined. The DON stated outbreak status was when someone tested positive and stated that signage indicating an outbreak would be posted at the entrances.<br><br>Interview on 02/12/25 at 11:09 A.M., with the Assistant DON (ADON), who was the Infection Preventionist, stated the facility's outbreak investigation started on 02/03/25 when a resident tested positive for COVID-19. The ADON stated she was not sure when the local health department was notified of the positive COVID-19 test result.<br><br>Interview on 02/12/25 at 11:55 A.M., with the ADON stated a corporate staff member notified the local health department of the positive COVID test results.<br><br>Interview on 02/12/25 at 11:59 A.M., with the Regional COVID Coordinator (RCC) stated she was the one who notified the National Healthcare Safety Network (NHSN) and the local health department.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a telephone interview on 02/13/25 at 2:50 P.M., with the Director of Epidemiology (DOE) for the local county district stated the DON had sent an email on 02/11/25 regarding COVID-19 positive residents in the building. The DOE stated that when he was notified, he told the DON to place outbreak signs at entrances and make masks available, and that staff needed to start wearing masks. The DOE stated the required notification timeframe of a positive test was by the end of the following business day. The DOE stated he had no record of notification prior to 02/11/25 for the COVID-19 positive results on 02/03/24.<br><br>Interview on 02/14/25 at 1:35 P.M., with the Assistant Director of Nursing (ADON), who was the Infection Preventionist, stated she had been reporting positive cases of COVID-19 to the RCC and the RCC had been reporting to the health department, but she would be reporting the cases to the health department moving forward. She stated she knew COVID-19 positive residents should be reported to the health department within 24 hours. The ADON stated she did not know if the health department had been notified within 24 hours of the first COVID-19 positive resident.<br><br>Interview on 02/14/25 at 4:12 P.M., with the Administrator stated he expected the health department to be notified of a COVID-19 outbreak as soon as the facility became aware.<br><br>Interview on 02/14/25 at 4:45 P.M., with the DON stated that she had been educated that week that after one positive COVID-19 case, the health department had to be notified. The DON stated she expected timely notification to the health department moving forward. The DON stated she first spoke with the DOE on 02/11/25 about the positive test result from 02/03/25.<br><br>Interview on 02/14/25 at 6:20 P.M., with the Administrator stated that if one COVID-19 positive test result was considered an outbreak, then the signage should have been placed in the entrances upon knowledge of the positive test.<br><br>2. Interview on 02/13/25 at 3:51 P.M., with the Administrator stated the facility only used one type of N95 mask.<br><br>Interview on 02/13/25 at 4:14 P.M., with Pre-Trained Nurse Aide (Pre-T NA) #4 stated she started working at the facility in January of 2025 and she had not been fit tested for an N95 mask.<br><br>Interview on 02/13/25 at 4:15 P.M., with Nurse Aide (NA) #5 stated she had not been fit tested for a N95 mask. NA #5 stated no one had asked her to be fit tested .<br><br>Interview on 02/13/25 at 4:15 P.M., with Registered Nurse (RN) #6 stated she had not been fitted for a mask but did wear an N95 the facility provided.<br><br>Interview on 02/13/25 at 4:17 P.M., with Licensed Practical Nurse (LPN) #7 stated she had not been fit tested .<br><br>Interview on 02/13/25 at 4:17 P.M., with NA #2 stated she had been hired one month prior and had not been fit tested for a N95 mask. NA #2 also stated she had not been fit tested for an N95.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 02/13/25 at 4:23 P.M., with NA #8 stated she had been working at the facility for four months. STNA #8 she was not fit tested for an N95 when she was hired. NA #8 stated she worked with one of the COVID-19 positive residents on 02/12/25 and had used an N95 mask but stated she had not been fit tested for that mask.<br><br>During a follow-up interview on 02/13/25 at 5:50 P.M., with NA #8 stated she had not been fit tested at a different facility prior to her current employment. NA #8 stated she did not know what fit testing was and thought fit testing involved measuring the face.<br><br>Interview on 02/14/25 at 1:35 P.M., with the Assistant Director of Nursing (ADON), who was the Infection Preventionist, stated N95 fit testing was last completed at the end of September 24. She stated fit testing was also completed at the time of hire. The ADON stated she believed that staff who were not fit tested for a N95 mask were not supposed to work. The ADON stated NA #8 should have been fit tested , and she assumed she had been. The ADON stated they never knew when they might need to start wearing N95 masks to prevent the spread of COVID-19 through the building.<br><br>Interview on 02/14/25 at 4:12 P.M., with the Administrator stated he expected N95 fit testing to be completed upon hire and annually. The Administrator stated N95 fit testing was important to protect the employees and the residents. The Administrator stated he was not aware that the facility had staff who had not been N95 fit tested .<br><br>Interview on 02/14/25 at 4:45 P.M., with the DON stated she expected N95 fit testing to be completed upon hire and annually. The DON stated N95 fit testing was important to help protect the residents. She stated she did not know the facility had staff who had not been fit tested .<br><br>Interview on 02/14/25 at 6:20 P.M., with the Administrator stated the facility had three regional nurse educators who were certified and had done N95 fit testing for staff. The Administrator stated the nurse educators should be notified once the medical evaluation for the staff was completed. The Administrator stated he did not know why the N95 fit testing was not completed.<br><br>Review of policy titled, COVID-19 Facility Staff and Resident Testing, revised September 2024, indicated, Facility will educate staff and post signs to make sure everyone entering the facility is aware recommended actions to prevent transmission to others if they have any of the following three criteria: 1) A positive viral test for SARS-CoV-2. The policy indicated, An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. The policy revealed, [State] Reporting Process: included 2. Reporting of All Positive Cases- Positive COVID-19 results for all types of COVID tests performed on [State] residents should be reported to the local health department where the person resides within 24 hours of case identification.<br><br>Review of policy titled, Infection Control Transmission Based Precautions, revised September 2024, indicated, Basic PPE [personal protective equipment] Requirements for Droplet Precautions revealed COVID-19- requires N95 mask. |