STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366156	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Crawford Care Center	1346 Lincoln Avenue Cincinnati, OH 45206

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record review, resident and staff interview the facility failed to treat one (#48) of three reviewed in a dignified manner. The facility census was 85. Findings Included: Review of the medical record revealed Resident #48 was admitted [DATE]. Diagnoses included vascular dementia, type two diabetes, and lumbago with sciatica. Review of the minimum data set (MDS) dated [DATE] revealed Resident #48 had a Brief Interview of Mental Status score of 08 that indicated the resident was cognitively impaired. Review of email dated 08/05/24 written by the Administrator revealed he had spoken to the Dietician #204 with the referencing an encounter with Resident #48. The Dietician stated she had realized what she had said, was very sorry and that the phrase was her common refrain when giving a banana to her grand kids. Dietician #204 was extremely remorseful, almost to the point of tears. Administrator stated that he comfortably says that she had no negative intention or connotation with her comment. Interview on 08/26/24 at 10:10 A.M. with Dietician #204 revealed Resident #48 who was sitting in gathering room off the elevator had stated he would like a snack. Dietician #204 stated she went to kitchen and got Resident # 48 a banana to give him. Dietician # 204 confirmed she approached Resident # 48 and said does the monkey wanted a banana and handed the banana to the resident. Dietician # 204 stated she meant nothing by this, and felt horrible, but this was something she had said to her grand kids and meant no harm from saying this. Dietician # 204 stated she had told the Administrator what had happened and explained she had not meant harm. Interview on 08/26/24 at 11:08 A.M. with Cooperate Administrator (CA) #277 who stated that she did speak with Administrator who was not at the facility on this day and verified Dietician #204 had come to him right away to explain the situation and felt bad. CA #277 stated that the Administrator revealed the Assistant Director of Nursing (ADON) #261 had investigated the incident and interview the staff. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility State tested Nursing Assistant (STNA) interview completed by the facility dated 08/26/24 revealed STNA #296 stated she was on the elevator on 08/05/24 around 11:30 A.M. when Dietician #204 had got on the elevator with a banana. Dietician #204 had asked STNA #296 if she had seen Resident #48, which STNA #296 had directed to location in dinning room. STNA #296 stated when elevator door open Dietician #204 had approached Resident #48 and peeled back the banana to hand Resident #48. STNA #296 stated Dietician #204 said to Resident #48 I have a banana for the monkey. STNA #296 stated Dietician #204 handed Resident #48 the banana. STNA #296 stated she told the ADON #261 right away of the concern. STNA #296 stated Resident #48 had a confused disappointed look on his face. Interview on 08/26/24 at 12:58 P.M. with Resident #48 the resident stated no staff call him names, or disrespect him in any manner at the facility. Resident #48 stated this included management and Dietician #204. Resident #48 stated he had no concerns related to allegation of abuse. Interview on 08/27/24 at 2:23 P.M. with ADON #261 stated that STNA #296 reported to her Dietician #204, make a comment to Resident #48 like hears the banana for my monkey. ADON #261 stated she had notified human resources and the Administrator who had then spoke to the Dietician #204. Dietician #204 had stated no harm was meant by the phrase. Interview on 08/27/24 at 3:02 P.M. with STNA #296 who stated she had seen Dietician #204 walk over to Resident #48, who was a black man, hears the banana for my monkey. STNA #296 no person should be called an animal. STNA #296 stated that the Dietician #204 was unprofessional when calling Resident #48 an animal. No staff should ever do this. STNA #296 stated the facility had lost her written statement that was given on 08/05/24. STNA #296 confirmed that facility had just got a written statement from her yesterday. STNA #296 stated the facility did not investigate this concern. Interview on 08/27/24 at 3:27 P.M. with the Administrator revealed he was told about the incident on 08/05/24 by the ADON and had a written statement regarding the incident on 08/05/24. Administrator stated he only had spoken to Dietician #204, and any other staff verbally. Review of the facility document titled Resident Rights undated revealed that the resident had rights by federal and state laws guarantee of certain basic rights to all residents of this facility. These rights included resident(s) to be treated with respect, kindness, and dignity. This deficiency represents non-compliance investigated under Complaint Number OH00156603.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, record review, interview, and facility policy review, the facility failed to ensure a wound treatment was completed as ordered. This affected one resident (#81) of three residents reviewed. The facility census was 85. Findings Included: Review of the medical record revealed Resident #81 admitted on [DATE]. Diagnoses included chronic osteomyelitis right ankle and foot, and diabetes mellitus. Review of the minimum data set assessment (MDS) dated [DATE] revealed Resident #81 was cognitively intact with a Brief Interview of Mental Status score of 15. Review of physician order dated 08/14/24 revealed right heel wound care was ordered as follows: cleanse with normal saline and pat dry. Apply betadine and let air dry, apply calcium alginate with silver to the wound bed, cover with abdominal dressing, then wrap with Kerlix and apply ace wrap to right foot every day. Interview on 08/26/24 at 9:50 A.M. with Resident #81 revealed his dressing to his right heel had not been changed in a couple of days. Observation of wound care for Resident #81 on 08/26/24 at 1:55 P.M. performed by Licensed Practical Nurse (LPN) #246 revealed the nurse removed the dressing on the resident which was observed to be a blue hydrofera sponge and not the ordered calcium alginate with silver to the wound bed, the dressing was covered with an abdominal dressing and Kerlix. The dressing that was removed was not dated. LPN #246 removed the old dressing and dressed Resident #81's wound as ordered. Interview with LPN #246 confirmed the wound treatment that was removed was the not the ordered treatment for Resident #81. Interview on 08/26/24 at 2:59 P.M. via telephone with LPN #339 revealed she had not completed the treatment to Resident #81's right heel on 08/25/24 as ordered. LPN #339 stated it was her first time working at the facility and she had a long medication pass and did not have time to perform the treatment. LPN #339 stated she was unable to perform Resident #81's treatment and but she did sign off the treatment in the treatment record as if it was completed. Interview on 08/26/24 at 3:15 P.M. with Director of Nursing (DON) verified it was not acceptable to not complete treatments as order by physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Wound Care dated 10/2010 revealed that the purpose of this procedure was to provide guidelines for the care of wounds by licensed nursing staff to promote healing. Verify that there was a physician's order for the procedure. Assemble the equipment and supplies as needed, dressing materials for wound, disposable clothes as indicated, antiseptic, and personal protective equipment that included gowns, gloves, and mask as needed. Wash and dry hands thoroughly. Place gloves on to remove tape and dressing. Pull gloves over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Put on gloves. Clean or irrigate the wound. Dress the wound and apply directly to wound area. [NAME] tape with initials, time, and date and apply to the dressing. This deficiency represents non-compliance investigated under Complaint Number OH00156403.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, interview, and facility policy review, the facility failed to ensure enhanced barrier precautions were implemented and the facility failed to complete hand hygiene during wound care. This affected one resident (#81) of three residents reviewed. The facility census was 85. Findings Included: Review of the medical record revealed Resident #81 admitted to the facility on [DATE]. Diagnoses included chronic osteomyelitis right ankle and foot, and diabetes mellitus. Review of the minimum data set assessment (MDS) dated [DATE] revealed that Resident #81 was cognitively intact with a Brief Interview of Mental Status score of 15. Review of physician order dated 08/14/24 revealed that Resident #81 treatment for the right heel was as follows: cleanse with normal saline and pat dry. Apply betadine, let air dry, apply calcium alginate with silver to wound bed, cover with an abdominal dressing, [NAME] with Kerlix and apply ace wrap to right foot every day. Interview on 08/26/24 at 9:50 A.M. with Resident #81 stated his dressing had not been changed to his right heel in a couple of days. Observation of wound care for Resident #81 on 08/26/24 at 1:55 P.M. performed by Licensed Practical Nurse (LPN) #246 who was wearing gloves as her only personal protective equipment (PPE), revealed the nurse removed the dressing on the resident which was observed to be a blue hydrofera sponge and not the ordered calcium alginate with silver to the wound bed, the dressing was covered with an abdominal dressing and Kerlix. The dressing that was removed was not dated. After LPN #246 removed the the old dressing the nurse was observed to doff her gloves which revealed another pair of gloves on her hands under the gloves she had just removed. The nurse proceeded to clean Resident #81's right heel then doffed the gloves on her hands and don new gloves without performing hand hygiene. LPN #246 completed the wound dressing as ordered. Interview with LPN #246 confirmed the wound dressing that was removed was the not the ordered treatment. LPN #246 confirmed she did not perform hand hygiene during the wound treatment, and the nurse confirmed gloves were the only PPE she wore while providing the wound care to Resident #81 and not the required personal protective equipment for a resident in enhanced barrier precautions. Interview on 08/26/24 at 3:15 P.M. with Director of Nursing (DON) verified it was not acceptable to not wear the correct personal protective equipment required during wound care and to not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Wound Care dated 10/2010 revealed that the purpose of this procedure was to provide guidelines for the care of wounds by licensed nursing staff to promote healing. Verify that there was a physician's order for the procedure. Assemble the equipment and supplies as needed including dressing materials for wound, disposable clothes as indicated, antiseptic, and personal protective equipment that included gowns, gloves, and mask as needed. Wash and dry hands thoroughly. Place gloves on to remove tape and dressing. Pull gloves over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Put on gloves. Clean or irrigate the wound. Dress the wound and apply directly to wound area. [NAME] tape with initials, time, and date and apply to the dressing. Review of the facility policy titled Enhanced Barrier Precautions dated 08/2022 revealed enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. Residents who were high contact resident care activities that required the use of gown and gloves for enhance barrier precautions include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use like central line, feeding tube, and wound care. Review of the facility policy titled Handwashing or Hand Hygiene dated 10/2023 revealed that indications for hand hygiene are as followed: for immediately before touching a resident, before performing an aseptic task, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal.