STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366175	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at the Meadows	11760 Pellston Court Cincinnati, OH 45240

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on observation, medical record review, resident and staff interview, and review of service invoices, the facility failed to maintain a homelike environment. This affected one (#329) of six residents reviewed for the physical environment. The facility census was 77. Findings include: Review of the medical record for Resident #329 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, atherosclerotic heart disease of native coronary artery, and bipolar disorder. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #329 had intact cognition and required supervision with toileting. Observation on 05/05/24 at 10:29 A.M. of Resident #329's bathroom revealed an area below the sink where there was no drywall and the pipes in the wall were exposed. The area measured approximately two feet long by one and one-half feet wide Interview on 05/05/24 at 10:29 A.M., with Resident #329 stated the dry wall below the sink had been missing since she was admitted . Resident #329 further stated she talked with someone about having it repaired and was told it would be addressed, however nothing more happened with the repair. Interview on 05/07/24 at 1:00 P.M., with Maintenance Director (MD) #330 verified the dry wall was missing below the sink in front of the pipes in Resident #329's bathroom. MD #330 stated he had a plumber out to repair the pipes and had not had a chance to repair the dry wall after that was completed. MD #330 estimated the dry wall had been missing for a few weeks. Review of an invoice from the plumber revealed the pipes were repaired 01/23/24. Follow-up interview on 05/08/24 at 9:50 A.M., with MD #330 verified the invoice was dated 01/23/24, indicating the dry wall had not been replaced over three months.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review and staff interview, the facility failed to ensure resident assessments were accurately completed. This affected three (#4, #13, and #68) of 23 residents reviewed for assessments. The facility census was 77. Findings include: 1. Review of the medical record of Resident #68 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, psychosis, psychotic disorder, psychoactive substance abuse, unspecified convulsions, unspecified mood disorder, anxiety, history of sudden cardiac arrest, and unspecified bilateral hearing loss. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed section J1800, for any falls since the prior MDS assessment (11/08/23), was checked, no, indicating there had not been any falls since 11/08/23. Review of a progress note dated 12/19/23 revealed the resident had a fall in the shower room. Review of the quarterly MDS assessment dated [DATE] revealed Resident #68 had severely impaired cognition and was assessed as having adequate hearing. Review of the plan of care dated 02/28/23 revealed Resident #68 had the potential for altered communication and hearing deficit related to her cognitive deficit and hearing loss. Review of an audiology progress note dated 12/27/23 revealed Resident #68 had severe hearing loss in both ears. Interview on 05/08/24 at 1:10 P.M., Corporate MDS #606 verified Resident #68's MDS assessment from 01/17/24 did not accurately capture the fall which occurred on 12/19/23, and verified the MDS dated [DATE] did not accurately code the resident's hearing ability. 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] and had diagnoses including unspecified polyneuropathy, type II diabetes, chronic multifocal osteomyelitis of the left ankle and foot, and morbid obesity. Review of the most recent annual MDS assessment completed on 04/17/24 revealed Resident #4 was cognitively intact, had no behaviors, did not wander, and did not reject care. Further review revealed the resident had no obviously broken teeth, had adequate vision, and did not use corrective lenses. During an interview on 05/05/24 at 3:55 P.M. with Resident #4 the resident stated he needed to see the dentist regarding broken teeth and needed to see the ophthalmologist regarding glasses needing adjustment. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/24 at 1:40 P.M. with Corporate MDS #606 verified Resident #4 had broken teeth and wore prescription glasses and stated the annual MDS assessment dated [DATE] was coded wrong. 3. Review of the medical record of Resident #13 revealed an admitted [DATE]. Diagnoses included cerebral infarction, nontraumatic subarachnoid hemorrhage, other abnormalities of gait and mobility, muscle weakness, vascular dementia, and restlessness and agitation. Review of the MDS dated [DATE] revealed there were no issues with teeth including no broken teeth assessed for Resident #13. Observation on 05/06/24 at 2:14 P.M. revealed broken and missing teeth on the bottom jaw and missing teeth on the top jaw of Resident 13's mouth. Interview on 05/08/24 at 1:10 P.M. with Corporate MDS #606 confirmed Resident #13's MDS assessment dated [DATE] did not accurately reflect her dental status. 42492 50007

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50007 Based on medical record review and staff interview, the facility failed to ensure a baseline care plan was completed within 48 hours of admission. This affected two (#13 and #329) of nine residents reviewed for baseline care plans. The facility census was 77. Findings include: 1. Review of the medical record for Resident #329 revealed an admitted [DATE]. Diagnoses included diabetes mellitus with diabetic neuropathy, atherosclerosis of coronary artery, unstable angina, pure hypercholesterolemia, and bipolar disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #329 had intact cognition. Review of the medical record revealed no evidence of a baseline care plan being completed within 48 hours of Resident #329's admission as required. Interview on 05/08/24 at 2:14 P.M. with Regional Director of Clinical Operations (RDCO) #600 verified Resident #329 did not have a baseline care plan completed as required. 2. Review of the medical record of Resident #13 revealed an admitted [DATE]. Diagnoses included cerebral infarction, nontraumatic subarachnoid hemorrhage, other abnormalities of gait and mobility, muscle weakness, vascular dementia, and restlessness and agitation. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #13 had moderately impaired cognition. Review of the medical record revealed no evidence of a baseline care plan being completed within 48 hours of Resident #13's admission as required. Interview on 05/07/24 at 3:54 P.M. with Regional Business Office Manager (RBOM) #601 verified Resident #13 did not have a baseline care plan completed as required.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on medical record review, resident and resident representative interview, staff interview, and policy review, the facility failed to conduct care conferences and failed to update care plan interventions in a timely manner. This affected seven (#4, #19, #22, #34, #40, #51, and #68) out of eight residents reviewed for care planning. The facility census was 77. Findings include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, major depressive disorder, unspecified dementia with unspecified severity, other behavioral disturbance, and other recurrent depressive disorders. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had severely impaired cognition. Resident #51 was assessed to require supervision for eating, bed mobility, and transfer, moderate assistance for oral hygiene, bathing, and upper body dressing, maximal assistance for lower body dressing and personal hygiene, and was dependent on staff for toileting. Review of the plan of care dated 02/27/20 revealed Resident #51 was at risk for falls related to balance deficit, cognitive deficits, disease progression, not waiting for assistance, impulsiveness, wandering, and history of falls. Interventions included to assist in position for comfort as needed, encourage non-skid footwear at all times, maintain an uncluttered environment, night light to room, non-skid strips to the bathroom floor, provide activities that minimize the potential for falls while providing diversion and distraction, and refer to therapy as needed. Review of a fall risk evaluation dated 12/03/23 revealed Resident #51 was at risk for falls. Review of the progress note dated 12/03/23 revealed Resident #51 was found on the floor near her bed. Review of the fall investigation dated 12/03/23 revealed Resident #51 had a fall and the intervention was non-skid strips to the floor. Review of the progress note dated 12/04/23 revealed the interdisciplinary team reviewed Resident #51's fall on 12/03/23 and added an intervention of non-slip strips to floor at bedside. Review of the progress note dated 03/17/24 revealed Resident #51 was found on the floor in front of her bed. Review of the fall investigation dated 03/17/24 revealed Resident #51 had a fall and the intervention was non-skid strips in front of the bed. Review of the progress note dated 03/27/24 revealed the interdisciplinary team reviewed Resident #51's fall on 03/17/24 and no new interventions were documented. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/07/24 at 5:30 P.M. with Regional Business Office Manager #601 confirmed the fall interventions for non-skid strips to the flooring Resident #51's room were not added to the care plan following the falls on 12/03/23 and 03/17/24. 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] and had diagnoses including unspecified polyneuropathy, type II diabetes, chronic multifocal osteomyelitis of the left ankle and foot, and morbid obesity. Review of the most recent MDS assessment completed on 04/17/24 revealed Resident #4 was cognitively intact, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #4 had one documented care conference held on 06/12/23 attended by the resident and social services. During an interview on 05/05/24 at 3:52 P.M., Resident #4 stated he had not had any care conferences since admission. During an interview on 05/07/24 at 3:48 P.M. Social Worker (SW) #316 verified Resident #4 had an initial care conference in June 2023 and had not had any quarterly care conferences since. 3. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] and had diagnoses including unspecified anxiety disorder, unspecified schizoaffective disorder, unspecified depression, unspecified hallucinations, and unspecified chronic obstructive pulmonary disease. Review of the most recent MDS assessment completed 02/02/24 revealed Resident #34 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #34 had one care conference on 10/26/23. During an interview on 05/05/24 at 1:42 P.M. Resident #34 stated she did not receive routine care conferences. During an interview on 05/08/24 at 9:32 A.M. SW #316 verified she had no additional documentation of care conferences for Resident #34. 4. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] and had diagnoses including unspecified affective mood disorder, type II diabetes, and mild major depressive disorder. Review of the most recent MDS assessment completed 01/27/24 revealed Resident #40 was cognitively intact, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #40 had two documented care conferences dated 10/27/23 and 04/27/24. During an interview on 05/05/24 at 10:10 A.M. Resident #40 stated staff talked to her individually about her care, but could not recall any formal care conferences with the interdisciplinary team. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/24 at 9:30 A.M. SW #316 verified Resident #40 had no other care conferences documented in the past twelve months except on 10/27/23 and 04/27/24. 5. Review of the medical record of Resident #22 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus, atherosclerotic heart disease of native coronary artery, schizoaffective disorder, bipolar type, bipolar disorder, adjustment disorder with mixed disturbance of emotions and conduct, anxiety disorder, congestive heart failure, hyperlipidemia, essential hypertension, major depressive disorder, gastro-esophageal reflux disease, and dysphagia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #22 had intact cognition. The resident was assessed as having fluctuating inattention and disorganized thinking and delusions during the assessment period. Interview on 05/05/24 at 10:07 A.M., Resident #22 stated he had not had a recent care conference. Review of the medical record of Resident #22 revealed the resident had care conferences on 12/22/22, 06/28/23, and 12/20/23. Interview on 05/07/24 at 12:34 P.M. SW #316 verified Resident #22's last care conference was 12/20/23. SW #316 stated care conferences were supposed to be completed on a quarterly basis. 6. Review of the medical record of Resident #68 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, psychosis, psychotic disorder, psychoactive substance abuse, unspecified convulsions, unspecified mood disorder, anxiety, history of sudden cardiac arrest, and unspecified bilateral hearing loss. Review of the quarterly MDS assessment dated [DATE] revealed Resident #68 had severely impaired cognition. Interview on 05/05/24 at 4:48 P.M. Resident #68's responsible party stated she only had two care conferences since admission and had not had any recent care conferences. Review of the medical record revealed care conferences were held for Resident #68 on 06/27/23, 09/11/23, and 10/23/23. Interview on 05/07/24 at 12:34 P.M. with SW #316 verified Resident #68's last care conference was 10/23/23. SW #316 stated care conferences were supposed to be held quarterly. 7. Review of Resident #19's medical record revealed an admitted [DATE] and diagnoses of cerebral vascular disease and dementia. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #19 had severely impaired cognition. Review of the medical record revealed Resident #19 had a care conference on 03/28/24 which was the only care conference held during the past year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/06/24 at 10:09 A.M. with Resident #19's responsible party revealed he had not had any care conferences in the past two to three years. Interview on 05/08/24 at 9:31 A.M. with SW #316 verified there were no other care conference held in the past year for Resident #19. Review of a policy titled, Care Conference Procedure, dated 02/01/18, revealed care conferences were held quarterly to discuss diagnosis, condition, ancillary services, activities of daily living, rehabilitation, mood/behavior, falls/safety, nutrition, skin, medication issues, risks, discharge potential, review of code status, and additional topics as applicable. This deficiency represents non-compliance investigated under Complaint Number OH00152456. 42492 42731 50007

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure residents utilized safe smoking practice while using electronic smoking devices and failed to thoroughly investigate resident falls. This affected one (#72) of one resident reviewed for smoking and one (#51) of three residents reviewed for falls. The facility census was 77. Findings include: 1. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, chronic pulmonary embolism, chronic combined heart failure, and morbid obesity. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 had severely impaired cognition, had no behaviors, did not wander, and did not reject care. Review of a progress note dated 05/01/24 at 4:40 P.M. revealed Licensed Practical Nurse (LPN) #302 observed Resident #72 using a vaping device (a type of electronic device used to inhale an aerosol containing a substance) next to the nursing station. Resident #72 was told that vaping was not permitted inside the building, and the resident indicated he understood. Observation on 05/07/24 at 2:36 P.M. revealed Resident #72 used a pink vaping device and exhaled a [NAME] of white smoke near LPN #603's face as she searched for the bed remote control and asked the resident to consent to perform a dressing change. LPN #603 was observed to shake her head but did not say anything to Resident #72 and continued to gather supplies for a dressing change. During an interview on 05/07/24 at 2:37 P.M., when asked about Resident #72's vaping device at the bedside, LPN #603 stated she wondered what the device was. During an interview on 05/07/24 at 3:42 P.M. Regional Business Office Manager (RBOM) #601 confirmed a vaping device was the same as an electronic cigarette (e-cigarette) and residents should not be using them unsupervised in the room. During an interview on 05/08/24 at 8:57 A.M. LPN #302 stated on 05/01/24 Resident #72 was sitting in his wheelchair by the nursing station using his vaping device. LPN #302 stated she told the resident he was not allowed to use it inside the building. LPN #302 stated she did not take his vaping device away from him. LPN #302 stated Resident #72 was only allowed to use the vaping device outside, and he usually kept the device in his room or carried it with him when he was out of the room. Review of policy titled, Smoking Policy - Residents, dated June 2018, revealed electronic cigarettes were labeled with resident's name and kept locked up by facility staff. Residents were permitted to use their electronic cigarettes unsupervised outside in designated smoking areas during designated smoking times. This was noted on the resident's care plan and all personnel caring for the resident were aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, major depressive disorder, unspecified dementia, unspecified severity, with other behavioral disturbance, and other recurrent depressive disorders. Review of the quarterly MDS assessment dated [DATE] revealed Resident #51 had severely impaired cognition. Resident #51 was assessed to require supervision for eating, bed mobility, and transfer, moderate assistance for oral hygiene, bathing, and upper body dressing, maximal assistance for lower body dressing and personal hygiene, and was dependent on staff for toileting. Review of the plan of care dated 02/27/20 revealed Resident #51 was at risk for falls related to balance deficit, cognitive deficits, disease progression, not waiting for assistance, impulsiveness, wandering, and history of falls. Interventions included to assist in position for comfort as needed, encourage non-skid footwear at all times, maintain an uncluttered environment, night light to room, non-skid strips to the bathroom floor, provide activities that minimize the potential for falls while providing diversion and distraction, and refer to therapy as needed. Review of a fall risk evaluation, dated 12/03/23, revealed Resident #51 was at risk for falls. Review of the progress note dated 12/03/23 revealed Resident #51 was found on the floor near her bed. Review of the fall investigation dated 12/03/23 revealed no root cause analysis for Resident #51's fall. Review of the progress note dated 12/04/23 revealed the interdisciplinary team reviewed Resident #51's fall on 12/03/23 and added an intervention of non-slip strips to the floor at bedside. Review of the progress note dated 03/07/24 revealed Resident #51 was found on the floor. Review of the fall investigation dated 03/07/24 revealed no root cause analysis for Resident #51's fall. Review of the progress note dated 03/12/24 revealed the interdisciplinary team reviewed Resident #51's fall on 03/07/24 and added an intervention of non-skid strips to the bathroom floor. Review of the progress note dated 03/17/24 revealed Resident #51 was found on the floor in front of her bed. Review of the fall investigation dated 03/17/24 revealed no root cause analysis for Resident #51's fall. Review of the progress note dated 03/27/24 revealed the interdisciplinary team reviewed Resident #51's fall on 03/17/24 and no new interventions were documented. Interview on 05/07/24 at 5:30 P.M. with Regional Business Office Manager (RBOM) #601 verified Resident #51's falls on 12/03/23, 03/12/24, and 03/17/24 the falls were not thoroughly investigated and a root cause of analysis of the falls was not completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Falls - Clinical Protocol, revised 03/2018, revealed staff would begin to try to identify possible causes within 24 hours of the fall. 42492 44069

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure medications were stored appropriately. This had the potential to affect all 77 residents residing in the facility. The facility census was 77. Findings Include: 1. During medication storage observation on [DATE] at 11:15 A.M. revealed the facility stock medication room was observed to contain expired stock medications. There were three bottles of mucus relief medication that expired on [DATE] (,d+[DATE]) and two bottles of an oral laxative (Bisacodyl) expired on February 2024 (,d+[DATE]). Interview with Registered Nurse (RN) #605 on [DATE] at 11:25 A.M. confirmed the medications were expired. 2. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] and had diagnoses including unspecified affective mood disorder, type II diabetes, and mild major depressive disorder. Review of the most recent Minimum Data Set (MDS) assessment completed [DATE] revealed Resident #40 was cognitively intact, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #40 had current physician orders for medications including the pain medication aspirin 81 milligrams (mg) by mouth once daily, the supplement cyanocobalamin 1000 micrograms (mcg) by mouth once daily, the heart medication isosorbide mononitrate extended release (ER) 30 mg by mouth once daily, the blood pressure medications losartan potassium 25 mg by mouth once daily and Norvasc five (5) mg by mouth once daily, the psychoactive medication sertraline 50 mg by mouth once daily, the thyroid medication Synthroid 50 mcg by mouth once daily, the diabetic medication metformin 1000 mg by mouth twice daily, the blood pressure medication metoprolol tartrate 25 mg by mouth twice daily, and the narcotic pain medication Tylenol with codeine by mouth three times daily. Observation on [DATE] at 10:20 A.M. revealed Resident #40 had crushed medication mixed in chocolate pudding in a plastic medication cup with a spoon on her bedside table. During an interview on [DATE] at 10:20 A.M. Resident #40 stated the mediation cup had all of her morning medications in it including her Tylenol with codeine. The resident stated the staff leave her medications at bedside all the time. (continued on next page)

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	366175	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at the Meadows	11760 Pellston Court Cincinnati, OH 45240

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:28 A.M. Licensed Practical Nurse (LPN) #400 asked Resident #40 why she had not taken her medication. LPN #400 verified she handed the medications to Resident #40 and had not watched her swallow the medications at the time of administration before leaving the room. LPN #400 confirmed the medications in the pill cup included all of Resident #40's morning medications. 3. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] and had diagnoses including type II diabetes, unspecified heart failure, stage II chronic kidney disease, unspecified anxiety disorder, and major depressive disorder. Review of the most recent MDS assessment completed [DATE] revealed Resident #11 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Review of the medical record revealed Resident #11 had physician orders for metformin 500 mg two tablets by mouth once daily, the supplement potassium chloride ER 20 milliequivalents (mEq) by mouth once daily, therapeutic multivitamin with minerals by mouth once daily, the blood pressure medication lisinopril 10 mg by mouth once daily, the anti-inflammatory medication diclofenac 50 mg by mouth once daily, aspirin 81 mg by mouth once daily, and urinary retention medication tamsulosin 0.4 mg by mouth once daily. During an observation on [DATE] at 8:02 A.M. LPN #603 exited Resident #11's room with a plastic cup containing medications and placed the medications in the top drawer of the medication cart. During an interview on [DATE] at 8:02 A.M. LPN # 603 stated Resident #11 did not want to take her medicine right now and she would re-attempt to administration them later. LPN #603 stated the medication cup contained Resident #11's medications and stated she could leave the medications in the drawer until the resident was ready to take them as long as the medication cart was locked at all times. During an additional interview on [DATE] at 8:37 A.M. LPN #603 stated she did not know you could not store medications in the cart after the resident refused to take them. Review of the facility policy titled, Storage of Medications, revised February 2023, revealed drugs and biological's used in the facility are stored in locked compartments under proper temperature, light and humidity controls; discontinued, outdated, or deteriorated drugs or biological's are returned to the dispensing pharmacy or destroyed; compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's are locked when not in use; and medications are stored separately from food and are labeled accordingly. The nursing staff was responsible for maintaining medication storage and preparation area in a safe, clean, and sanitary manner. Medications and biologicals were stored in the packing or containers in which they were received. 25908

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42731 Based on observation, staff interview, and policy review, the facility failed to ensure food was stored and served in a safe and sanitary manner and failed to ensure clean dishes and eating utensils with handled in a manner to prevent contamination. This had the potential to affect 76 residents in the facility. The facility identified one resident (#63) who did not receive food from the kitchen. The facility census was 77. Findings include: 1. Observation on 05/05/24 at between 8:57 A.M. and approximately 9:10 A.M., of the facility kitchen, revealed the walk-in cooler had a large bag of brown salad, not wrapped, not sealed, and not labeled; a pan of an unidentified white substance, covered with plastic wrap, and dated 04/28/24; a large pan with unidentified food, covered loosely in foil, not labeled, and not dated; a pan of hot dogs in liquid, covered in plastic wrap, not labeled, and not dated; and a pan of macaroni and cheese, covered with plastic wrap, not labeled, and not dated. Observation of the dry storage area revealed a box of brownie mix, a box of fruit cocktail, and a box of stuffing mix all stored directly on the floor. Further observation revealed a box of rice on a shelf with a blue plastic bag sticking out of the top that was not sealed or dated. Observation of the general kitchen area revealed a ceiling ventilator, located directly above the pan storage area, was covered in a gray, fuzzy material. The gray, fuzzy material also surrounded the ventilator in an approximate three feet radius around the ventilator. A camera was also observed in the ceiling which was also covered in the gray, fuzzy material. Interview at the time of the observation of the kitchen with Dietary Cook (DC) #333 stated the white substance was butter, and verified the food items in the walk-in cooler were not properly stored as indicated. DC #333 verified all foods should be wrapped, sealed, labeled, and dated. DC #333 verified the boxes of food that were stored directly on the floor in the dry storage area and stated they should not be stored on the floor. DC #333 also verified the bag of rice was not sealed or dated. DC #333 verified the gray fuzzy material on the ventilator and ceiling surrounding the ventilator and stated the material was dust. 2. Observation on 05/05/24 at 9:10 A.M. revealed Dietary Aid (DA) #322 utilized the dishwasher to wash dishes from breakfast. DA #322 wore gloves as she cleaned off the plates, arranged the dishes and silverware in a rack, pushed the rack into the dishwasher, and retrieved and unloaded the clean dishes on the other end of the dishwasher wearing the same gloves she had used to clean off the dirty plates and handle the dirty dishes and silverware. DA #322 was observed over a period of approximately five minutes to repeat the process several times. Interview on 05/05/24 at 9:15 A.M. with DA #322 verified she handled the dirty dishes with gloves and unloaded the clean dishes without changing her gloves. DA #322 stated sometimes she changed her gloves between handling the dirty and clean dishes and sometimes she does not. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 05/05/24 at 9:10 A.M. revealed an approximate three feet long by six inch wide area directly above the counter of the loading side of the dishwasher with a black speckled substance. Further observation at 12:12 P.M. revealed the substance remained in place. Interview on 05/07/24 at 12:12 P.M., with Dietary Manager (DM) #346 verified the speckled black substance on the wall by the dish machine. 4. Observation on 05/07/24 at 10:13 A.M. revealed DM #346 prepared food for the lunch meal. Further observation revealed DM #346 had a beard which was not covered with any restraint. Interview at the time of the observation with DM #346 verified he was not wearing a restraint over his facial hair and stated the facility had just run out of beard restraints. Observations on 05/07/24 at 10:18 A.M., 11:12 A.M., 12:06 P.M., and 12:19 P.M., revealed DM #346 continued preparation of food without a beard restraint. Review of the facility policy titled, Food Receiving and Storage, dated 11/2022, revealed food in the dry storage area was kept at least six inches off the floor, dry foods are stored in a manner that maintains the integrity of the foods until they are ready to use, all foods stored in the refrigerator are covered, labeled and dated with a use by date, refrigerated foods are labeled, dated, and monitored so they are used by their use-by date. Review of the facility policy titled, Food Preparation and Service, dated 11/2022, revealed cross-contamination can occur when disease-causing microorganisms are transferred to food by hands (including gloved hands), and staff were to wear hair restraints (hair net, beard restraint, etc.) so that hair does not contact food.

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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** 42492 Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure nursing staff used appropriate hand hygiene when performing blood glucose monitoring. This affected one (#329) of two residents reviewed for blood glucose monitoring. The facility census was 77. Findings include: Review of the medical record revealed Resident #329 was admitted to the facility on [DATE] and had a primary diagnosis of type II diabetes with diabetic neuropathy. Review of the admission Minimum Data Set (MDS) assessment completed on 04/23/24 revealed Resident #329 was cognitively intact. Observation on 05/06/24 at 8:15 A.M. revealed Licensed Practical Nurse (LPN) #603 obtained Resident #329's blood glucose level and left the room without washing her hands with soap and water. During an interview on 05/06/24 at 8:22 A.M. LPN #603 verified she did not wash her hands after obtaining Resident #329's blood glucose level. Review of a policy titled, Obtaining a Fingerstick Glucose Level, dated October 2011, revealed after the procedure was completed, nurses disinfected the reusable blood glucose monitoring equipment, doffed gloves, and washed hands with soap and water.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 42731 Based on observation, staff interview, and review of equipment manuals, the facility failed to ensure kitchen equipment was maintained in working order. This had the potential to affect 76 residents in the facility. The facility identified one resident (#63) who did not receive food from the kitchen. The facility census was 77. Findings include: 1. Observation on 05/07/24 at 10:17 A.M. revealed the steamer in the kitchen was leaking water into a small reservoir connected to the steamer which was then leaking into a large bin. The bin measured approximately one foot long by two feet wide and had approximately four inches of white cloudy water inside. Interview at the time of the observation with Dietary Manager (DM) #346 verified water from the steamer was dripping into an overflowing reservoir and into a bin. DM #346 stated the steamer had been malfunctioning since he started working at the facility in October 2023. DM #346 stated someone came out to repair the steamer a few months prior and the steamer worked appropriately for a few days but then started leaking again. Review of the operation manual for the steamer, dated 09/18/19, revealed no mention of the need for a bin to collect water below the steamer. 2. Observation on 05/07/24 at 10:55 A.M., revealed DM #346 began the process of preparing pureed food for the upcoming meal. DM #346 scooped creamed corn into the food processor, placed the lid on top, stuck the prong of a thermometer into a hole on the food processor, and started to puree the creamed corn. Interview at the time of the observation with DM #346 stated he had to place the thermometer into the hole to get the food processor to work. DM #346 stated the food processor had been that way for approximately two weeks and would not work unless the thermometer prong was in the hole. Review of the undated food processor operation manual revealed no mention of the need to insert a thermometer prong into the machine for it to function. 3. Observation on 05/07/24 at 12:19 P.M., revealed the plate warmer sitting next to the counter. DM #346 was removing plates from the plate warmer and preparing plates for the lunch meal. The plate warmer was not observed to be hot nor warm to the touch. Further observation revealed the plate warmer was not plugged into any electrical source. Interview on 05/07/24 at 12:06 P.M., with DM #346 stated the plate warmer had not worked since he started working at the facility in October 2023. DM #346 stated he filled out a maintenance request form a while ago and filled another form out last week.