STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366268	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Hills Nursing Home	4748 Olde Pump Street Walnut Creek, OH 44687

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on medical record review, job description review, and interview the facility failed to ensure a medication assistant did not perform duties outside her scope of practice. This affected four residents (#25, #32, #35 and #38) of nine residents reviewed for care and service. The facility census was 50. Findings included: 1. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE]. Diagnoses included low back pain, diabetes, hypertension, chronic kidney disease, osteoarthritis, osteoporosis, anxiety disorder, depression, thyroid nodule, seasonal allergies, gout, malignant neoplasm of large intestines, cataracts, cerebral infarction, and traumatic brain injury. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #25 had intact cognition. Review of the April physician's orders revealed Resident #25 had an order for tramadol (a narcotic pain medication) 50 milligrams (mg) once daily. Review of the February 2024 medication administration records (MAR) revealed Medication Assistant (MA-C) #101 documented pain levels for Resident #25 on 02/03/24, 02/04/24, 02/12/24, 02/17/24, 02/18/24, 02/21/24, 02/22/24, and 02/23/24. Review of the March 2024 MAR revealed MA-C #101 documented pain levels for Resident #25 on 03/02/24, 03/03/24, 03/06/24, 03/07/24, 03/08/24, 03/16/24, 03/17/24, 03/20/24, 03/21/24, 03/25/24, 03/26/24, 03/30/24, and 03/31/24. Review of the progress note dated 03/11/24 at 9:30 A.M. revealed MA-C #101 had documented details about Resident #25 sliding out of her chair under the nursing section of the progress notes. The details documented included Resident #25 told the medication assistant she had slid out of her recliner chair yesterday around 3:00 P.M. She said when the nurse helped her up, she hit her knee off the floor and it was bleeding. It was not bleeding now but the resident asked her to clean it and put a bandage on it. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the progress note dated 03/17/24 at 3:28 P.M. revealed MA-C #101 documented details about a fall for Resident #25 under the nursing section of the progress notes. The details documented included Resident #25 was found on the floor at 2:30 P.M. Resident #25 stated she was messing around with her stuff. Her vital signs were okay. The Nurse Practitioner (NP) and family were aware. There was no follow-up documentation from a licensed nurse regarding the details of this note. On 04/03/24 at 12:45 P.M. MA-C #101 verified she had notified the NP of Resident #25's fall, had cleaned and bandaged the knee of Resident #25 and she had assessed and documented the resident's pain level because other nursing staff told her she could. MA-C #101 did not provide evidence the resident was assessed by a licensed nurse related to this incident. 2. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. Diagnoses included diabetes, atherosclerotic heart disease, chronic kidney disease, bipolar disorder, fractured upper tibia, insomnia, and anxiety disorder. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #32 had intact cognition. Review of the February 2024 MAR revealed MA-C #101 documented pain levels for Resident #32 on 02/03/24, 02/04/24, 02/12/24, 02/17/24, 02/18/24, 02/21/24, 02/22/24, and 02/23/24. Review of the progress notes dated 03/03/24 at 11:25 A.M. revealed MA-C #101 documented the following in the nursing section of the progress notes: Resident #32 was very agitated and uncooperative when taking her medications. She was having to ask her numerous times to take it before she would take anything. She took her as needed Ativan. She refused to wear her brace, it was explained to her that she needs to wear it per therapy and she still refused. Review of the March 2024 MAR revealed MA-C #101 documented pain levels for Resident #32 on 03/02/24, 03/03/24, 03/06/24, 03/07/24, 03/08/24, 03/11/24, 03/16/24, 03/17/24, 03/20/24, 03/21/24, 03/25/24, 03/26/24, 03/30/24, and 03/31/24. On 04/03/24 at 6:45 A.M. an interview with MA-C #101 revealed she documented behaviors she witnessed while attempting to give the resident medications. She stated she was told by the Director of Nursing she could. On 04/03/24 at 12:45 P.M. an interview with MA-C #101 revealed she had assessed the resident for pain and documented the pain level because other nursing staff told her she could. 3. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, hemiplegia of the left side, thyrotoxicosis with goiter, glaucoma, insomnia, and dementia. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #38 had moderately impaired cognition. Review of the February 2024 MAR revealed MA-C #101 documented pain levels for Resident #38 on 02/03/24, 02/04/24, 02/12/24, 02/17/24, 02/18/24, 02/21/24, 02/22/24, and 02/23/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the March 2024 MAR revealed MA-C #101 documented pain levels for Resident #38 on 03/02/24, 03/03/24, 03/06/24, 03/07/24, 03/08/24, 03/11/24, 03/16/24, 03/17/24, 03/20/24, 03/21/24, 03/25/24, 03/26/24, 03/30/24, and 03/31/24. Review of the progress note dated 03/20/24 at 10:22 A.M. revealed MA-C #101 documented the following under the nursing section of the progress notes: Resident #38 went out for a swallowing test this morning and she was allowed to eat regular food. There was no documentation regarding whether or not an official order for a regular diet had been obtained by a nurse or if a copy of the swallowing evaluation was received from the hospital and in the resident's chart for verification of the diet change. Further review of the medical record revealed no evidence of swallowing test results present in the medical record for Resident #38, however, there was no evidence Resident #38 had been adversely affected by eating a regular diet after MA-C #101 charted Resident #38 was allowed a regular diet on 03/20/22. On 04/03/24 at 12:15 P.M. an interview with the Director of Nursing revealed the facility never received the swallowing evaluation from the hospital for Resident #38. She stated they had been trying to get it from the hospital but the hospital had not sent it yet to them. On 04/03/24 at 12:45 P.M. an interview with MA-C #101 revealed Resident #38 had told her about her diet change. She stated the unit manager called the hospital to verify the order and she charted on it. MA-C #101 revealed she had assessed and documented pain levels because other nursing staff told her she could. 4.Review of the medical record revealed Resident #35 was admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of the colon, intestinal obstruction, malignant neoplasm of the peritoneum, mal neoplasm of small intestine, heart failure, hypothyroidism, hypertension, chronic obstructive pulmonary disease, bipolar disorder, epilepsy, anxiety disorder, depression, mental disorder, and alcohol dependence. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #35 had intact cognition. Review of the February 2024 MAR revealed MA-C #101 documented pain levels for Resident #35 on 02/03/24, 02/04/24, 02/12/24, 02/17/24, 02/18/24, 02/21/24, 02/22/24, and 02/23/24. Review of the March 2024 MAR revealed MA-C #101 documented pain levels for Resident #35 on 03/02/24, 03/03/24, 03/06/24, 03/07/24, 03/08/24, 03/11/24, 03/16/24, 03/17/24, 03/20/24, 03/21/24, 03/25/24, 03/26/24, 03/30/24, and 03/31/24. On 04/03/24 at 12:45 P.M. an interview with MA-C #101 revealed she had assessed and documented pain levels because other nursing staff told her she could. 5. Review of the personnel file for MA-C #101 revealed she had been working at the facility as a Medication Assistant since January 2024 and had been working as a State tested Nursing Assistant (STNA) prior to the current position with the facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Ohio Nurse Aide Registry revealed MA-C #101 held a current certification as an STNA in Ohio with an expiration date of 03/19/2026 and was in good standing. Additional interview on 04/03/24 at 10:10 A.M. with MA-C #101 revealed she does give report to the next nurse and received report from the off going nurse for the hall she was working, she did call physicians and NPs to updated them on resident status, falls and concerns. She stated she would put them on hold and get a nurse if they had an order to give. MA-C #101 verified she was completing resident assessments instead of a nurse doing the assessment in order to administer as needed (prn) medications to residents. MA-C #101 revealed she would get a nurse if a resident required insulin or narcotic administration. On 04/03/24 at 1:00 P.M. interview with the Director of Nursing revealed she had provided education to MA-C 3101 when the employee started as a medication assistant on what she could chart and not chart on. During the interview, the DON stated what was the sense of having medication assistants if they could only administer medications. She verified the nurse giving the narcotic pain medication should be documenting the pain level not MA-C #101. Review of the facility job description for a medication aide dated 07/2023 revealed the scope of responsibility of a medication aide would be for providing routine daily nursing care and activities of daily living to the residents in accordance with Ohio federal and state regulation and standards and the polices and procedures of the corporation. The medication aide could not administer the first dose of medications, could not split pills, could not remove medication from the emergency drug kit. They can prepare and administer oral medications, nasal drops, eye drops, ear drops, topical, rectal and vaginal medication and transdermal patches, as needed medications, they can stock the medication cart, apply treatments and test only after being signed off for diabetic testing, both urine and finger sticks, fecal and urine specimens, hemoccult testing, emptying an changing colostomy bags, instilling commercially prepared enema, apply lotions, creams and protectants to the skin except those used for debridement, apply cold dry compressed, administered a sitz bath and obtain vital signs. They are able to document medication given to the resident, notify staff nursing of any changes in the resident's condition, assist with feeding the residents, assist the licensed nurse and nursing assistants with care and direct family concerns to the staff nurse. This job description does not mention a medication aide could document behaviors, complete assessments for administering as needed medications, complete pain level assessments, notify the physician or put a dressing on a wound in place of a licensed nurse. This deficiency represents non-compliance investigated under Complaint Number OH00OH00151914.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on record review, observation, and interview, the facility failed to maintain a medication error rate of less than five percent. Three errors occurred within 27 opportunities for error resulting in a medication error rate of 11.0 %. This affected two residents (Resident #45 and #49) of four reviewed for medication administration. The facility census was 50. Findings included: 1. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, hemiplegia to the right side, dysphagia, atherosclerotic heart disease, rheumatoid arthritis, hypertension, congestive heart failure, Sjogren's syndrome nontraumatic intracranial hemorrhage, pacemaker, and depression. Review of the quarterly [NAME] Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #45 had moderately impaired cognition. Review of the [DATE] physician's orders revealed Resident #45 had an order for Refresh tears 0.5 percent one drops in both eyes three times daily and lactulose (stool softner) 30 milliliters (ml) once daily. Observation of medication administration on [DATE] at 7:15 A.M. revealed Medication Assistant (MA-C) #101 prepared medication for Resident #45. MA-C#101 only poured 15 milliliters (ml) of lactulose syrup into the medication cup (the order was for 30 ml) and the bottle of refresh tears had an expiration date of , d+[DATE]. MA-C#101 started to walk away from the medication cart to go administer these medications to Resident #45 when the surveyor stopped her and verified the medications errors. She verified at this time the lactulose was the wrong dosage and the bottle of Refresh tears had expired on ,d+[DATE]. She indicated that was the only bottle of refresh tears in the medication cart to be administered to Resident #45 and she had been receiving them daily. 2. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. Diagnoses included dementia, asthma. shortness of breath, hypertension, edema, anxiety disorder, depression, osteoporosis, hypothyroidism, allergic rhinitis, and chronic respiratory failure. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #49 had intact cognition. Review of the [DATE] physician's orders revealed Resident #49 had an order for Fluticasone propionate diskus (asthma medication)100 micrograms one inhalation twice daily. Observation of medication administration on [DATE] at 7:10 A.M. revealed MA-C #101 prepared medication for Resident #49. MA-C #101 did not have Resident #49 rinse her mouth out after administering her Fluticasone propionate diskus inhalation. Resident #49 even asked if she had to rinse her mouth out and MA-C #101 stated to her no she did not. MC-A #101 verified at this time she had not had Resident #49 rinse her mouth out after administering the inhaler. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacture's instruction for Fluticasone propionate diskus revealed after inhalation the patient should rinse their mouth out with water without swallowing to help reduce the risk of oropharyngeal candidiasis. This deficiency represents non-compliance investigated under Master Complaint Number OH00152435 and Complaint Numbers OH00152010 and OH00151914.