

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>28704</p> <p>Based on observation, medicare health inspection report review, survey inspection review and interview, the facility failed to ensure state survey results were readily accessible for review including the most recent survey of the facility. This had the potential to affect all 45 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the Medicare website: Facility Health and Complaint Inspection Data revealed the facility's most recent health inspection was completed on 09/23/22 and complaint inspections were completed on 03/13/23, 05/04/23, 02/06/24, and 04/04/24.</p> <p>On 06/25/24 at 3:35 P.M., observation of the facility posting corkboard located across from the activity room leading towards the 100 and 200 halls revealed required postings including resident right information and the most recent federal Statement of Deficiencies and Plan of Correction survey results. The most recent posted health inspection (annual) survey results dated 09/23/22 did not include the facility's plan of correction. Other survey type results posted were dated 12/05/19 through 05/04/23. No other survey results were posted for review after the survey completed 05/04/23.</p> <p>On 06/26/24 at 10:50 A.M., observation of the main office/receptionist area with Scheduling Coordinator #94 revealed a table against the wall which included an unlabeled green binder and a clipboard standing upright between two bookends. Review of the unlabeled binder revealed survey results dated 09/23/22 without the written facility plan of correction. No survey results after 09/23/22 were available for review in the green binder.</p> <p>On 06/26/24 at 10:59 A.M., observation with Business Office Manager (BOM) #166 revealed the most recent survey results posted in the leading to the 100 and 200 halls was dated 05/04/23 and the most recent survey results for review in the receptionist area was dated 09/23/22. BOM #166 verified the facility had not posted the survey results for the complaint investigations completed on 03/13/23, 02/06/24 or 04/04/24.</p> <p>This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number OH00154718, Complaint Number OH00154465 and Complaint Number OH00154365.</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, medical record review, resident right posting review, and interview, the facility failed to ensure resident mail was delivered unopened. This affected two residents (#79 and #91) of five sampled residents. The census was 45.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #79 was admitted on [DATE] and Resident #91 was admitted on [DATE].</p> <p>Review of Resident #79's quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] and Resident #91's quarterly MDS assessment dated [DATE] revealed the residents were cognitively intact for daily decision-making.</p> <p>On 06/25/24 at 3:35 P.M., observation of the facility required postings revealed residents had the right to have mail delivered unopened.</p> <p>On 06/26/24 between 9:53 A.M. and 10:05 A.M., interview with Resident #79 revealed her mail was opened in May 2024 by staff without her permission. Resident #79 stated her opened mail included a retail store package, her wireless service provider bill and an advertisement. The mail was delivered to her opened and paperclipped to a facility stamped envelope. Resident #79 stated she asked Charge Nurse #108 why her mail was opened and Charge Nurse #108 stated she was told to open both her mail and the retail package. Resident #79 stated this was a violation of her rights and it made her very upset. The resident stated she does have terrible arthritis (severe hand/finger contractions) but she could still open her own mail or at least it should be delivered unopened and if she chooses to have staff assist her with opening her mail, she would be okay with that.</p> <p>On 06/27/24 at 9:47 A.M., interview with Resident #91 revealed staff has delivered her mail opened and she has not given the facility permission to do this. Resident #91 stated it was not their business what she gets in the mail. She has also been waiting on a package that her daughter ordered for her over two weeks ago that she has not received.</p> <p>On 06/27/24 at 9:55 A.M., interview with Life Enrichment Director (LED) #126 stated Resident #91's daughter had sent her a package but it was addressed to the daughter; therefore, the package was returned to sender per the Director of Nursing. LED #126 stated the facility had not informed Resident #91 or her daughter of this but would notify her today. LED #126 verified residents had the right to receive unopened mail and resident mail should only be opened when permission was given.</p> <p>On 06/27/24 at 10:03 A.M., interview with Charge Nurse #108 stated she has delivered mail to residents when needed and verified she had opened Resident #79's mail and retail store package. Charge Nurse #108 stated she was instructed to do so because the box sounded like there was a bottle of pills in it. Charge Nurse #108 verified she opened the package without the resident's permission. Charge Nurse #108 would not say who instructed her to open the package but verified she should have had permission before opening the resident's mail. Charge Nurse #108 stated Resident #79 was upset when this happened and the resident was very particular with her things including her mail.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/27/24 at 10:42 A.M., interview with Business Office Manager #166 stated she does not open resident mail or packages.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154718, Complaint Number OH00154465.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to provide adequate care and services to prevent the development and decline of pressure ulcers. This affected three residents (#37, #87 and #91) of four residents reviewed for pressure ulcers. The facility identified three residents with pressure ulcers and the facility census was 45.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #87 was admitted on [DATE] with diagnoses including post-polio syndrome, hip fracture, hypertension and depression.</p> <p>Review of the Braden Scale for Predicting Pressure Ulcer Risk dated 01/06/24 revealed Resident #87 was at high risk for pressure ulcer/injury development. There was no risk assessment completed between 01/06/24 and 06/25/24.</p> <p>Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #87 was cognitively intact and was not at risk for pressure ulcers.</p> <p>Review of the Wound Progress Report dated 05/29/24 revealed Resident #87 developed a facility acquired Stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) left mid-buttock pressure ulcer that was healed on 06/12/24.</p> <p>Review of the Treatment Record (TAR) dated June 2024 revealed the following treatments were not completed as ordered: Barrier cream and foam dressing to left buttock daily was not completed on 06/24/24, the left buttock and left lateral ankle pressure ulcer treatment was not completed on 06/26/24.</p> <p>On 06/25/24 at 3:27 P.M., observation revealed Resident #87 was laying in bed on his back on a standard mattress at a 45 degree angle. The resident was partially covered with a sheet.</p> <p>Review of the Wound Progress Report dated 06/25/24 revealed Resident #87 had developed two facility acquired pressure ulcers including: an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left midline buttock measuring 5.22 centimeters (cm) in length (l) by 2.8 (cm) in width (w) and the wound bed was covered with slough. The resident also had a Stage II fluid filled blister measuring 2.5 (cm) in (l) by 1.8 (cm) in (w) to the left lateral ankle. New order was received to pad and protect wound physician recommended an air mattress.</p> <p>On 06/26/24 at 11:55 A.M., observation revealed no evidence of a low air loss mattress on Resident #87's bed.</p> <p>On 06/27/24 at 12:18 P.M., observation of Resident #87's left midline buttock dressing change revealed an unstageable left midline buttock pressure ulcer approximately 6.0 (cm) in (l) by 3.0 (c) in (w). The wound was covered with necrotic (dead) tissue and the outer left buttock was dark purple in appearance.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/27/24 at 1:24 P.M., interview with Charge Nurse #108 verified Resident #87 did not have a Braden Risk assessment completed since 01/06/24 and these should be done every three months and with any change in skin or condition.</p> <p>On 06/27/24 between 2:00 P.M. and 2:11 P.M., interview with the Director of Nursing (DON) stated Resident #87 had a low air loss mattress from hospice on his bed. Observation with staff revealed no low air loss mattress on Resident #87's bed and resident was laying on his back on a regular mattress. DON asked Licensed Practical Nurse (LPN) #108 about having the specialty mattress and she stated one had been ordered two days ago but he did not have one yet. DON instructed LPN #108 to call hospice and if an air mattress could not be obtained to let her know so she can rent one for him.</p> <p>On 07/01/24 at 2:20 P.M., interview with the DON verified there was no evidence treatments were completed on 06/26/24, the resident did not have a low air loss mattress as recommended and was at high risk for skin breakdown.</p> <p>2. Review of the record revealed Resident #37 was admitted on [DATE] with diagnoses included cerebral infarction, [NAME]-barre syndrome, arthritis, multiple myeloma, barrette's esophagus, paroxysmal atrial fibrillation and severe sepsis with septic shock.</p> <p>Review of the Skin Evaluation Form dated 03/28/24 revealed a pressure ulcer to the lateral left leg measuring 10.0 (cm) in (l) by 4.5 (cm) in (w) by <0.1 (cm) in depth (d). The wound edges were blackened, there was a moderate amount of serosanguinous drainage. The ulcer was not staged, no interventions were documented and the assessment did not have a signature of the person completing the assessment.</p> <p>Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #37's cognition was moderately impaired for daily decision-making, was at risk for pressure ulcer and had no unhealed pressure, venous or arterial ulcers.</p> <p>Review of the Braden Scale for Predicting Pressure Ulcer Risk dated 04/18/24 revealed Resident #37 was at risk for pressure ulcer/injury development. No other risk assessments were available for review after 04/18/24.</p> <p>Review of the left lateral leg (LLL) Wound Progress Reports and Treatment Record (TAR) dated June 2024 revealed the following:</p> <p>Dated 06/05/24, the wound measured 1.26 centimeters (cm) in width (w) by 3.14 (cm) in length (l) by 0.11 (cm) in depth (d). Treatment orders included to cleanse the wound with saline solution and pat dry with gauze. Apply Tetracyte to the wound bed, followed by oil emulsion gauze and alginate. Cover with ABD pad and wrap with Kerlix followed by ACE bandage 3 times weekly and as needed (PRN) and apply silver nitrate to hypergranulated tissue. Follow up in one week.</p> <p>Review of Resident #37's TAR revealed the wound treatment was not completed on 06/07/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dated 06/12/24, the wound was covered in 100% granulation (healthy) tissue and measured 2.59 (cm) in (w) by 2.49 (cm) in (l) by 0.11 (cm) in (d). The debridement area was cleansed with saline solution then dressed with a non-adherent dressing. The clinician reviewed the importance of off loading, turning, repositioning and dressing change and frequency to help achieve wound healing. Treatment orders included to cleanse the wound with saline solution and pat dry with gauze. Apply oil emulsion gauze and alginate. Cover with ABD pad and wrap with Kerlix followed by ACE bandage 3 times weekly and PRN. Apply silver nitrate to hypergranulated tissue.</p> <p>Review of Resident #37's TAR revealed the wound treatment was not completed on 06/17/24.</p> <p>Dated 06/18/24, the wound appearance was 51.01% granulation tissue and 48.99% necrotic (dead) tissue and measured 6.28 (cm) in (w) by 6.42 (cm) in (l) by 0.2 (cm) in (d). The debridement area was cleansed with wound cleanser then dressed with a non-adherent dressing, fluff and conforming gauze. The clinician reviewed the importance of off loading, turning, and repositioning and dressing change and frequency to help achieve wound healing. The clinician referred the patient to the primary care physician for further intervention to aid in cessation. Treatment order to cleanse with wound cleanser, apply Mupirocin (topical antibiotic that's used to treat small areas of bacterial skin infections), cover with a non-stick and absorbent dressing. Wrap toes to above left knee with rolled gauze and light compression bandage daily. Start Keflex (antibiotic) 250 mg per tablet daily for one week.</p> <p>Review of Resident #37's Physician Orders and Medication Administration Record revealed Keflex was not ordered or administered until 06/19/24.</p> <p>Review of Resident #37's TAR revealed the new wound order given on 06/18/24 was not written until 06/20/24 and the LLL treatment was not completed on 06/20/24, 06/22/24, 06/24/24 or 06/25/24.</p> <p>Dated 06/25/24, wound measured 5.68 (cm) in (l) by 5.76 (cm) in (w) by 0.1 (cm) in (d) with 100% granulation. Treatment orders included to cleanse with wound cleanser, stop Mupirocin, and cover with nonstick dressing and absorbent pad dressing daily for one week. Finish Keflex until gone.</p> <p>Review of Resident #37's TAR revealed LLL treatments were not completed every three days as ordered on 06/07/24 or 06/17/24. Daily LLL wound treatments were not completed daily as ordered on 06/20/24, 06/22/24, 06/24/24, 06/25/24, 06/26/24, 06/27/24 or 06/28/24.</p> <p>Review of the care plan: Actual Skin Breakdown LLL wound dated 04/10/24 revealed a goal for the wound to decrease in size and show improvement and interventions included to administer treatments as ordered.</p> <p>On 07/01/24 at 1:40 P.M., interview with Charge Nurse #124 verified the above and confirmed a decline in Resident #37's LLL wound between 06/12/24 and 06/18/24. Charge Nurse #124 stated physician orders were to be completed as ordered and any new orders were to be started that day.</p> <p>On 07/09/24 at 12:12 P.M., electronic mail correspondence with LPN #138 would not confirm nor deny the accuracy of the MDS information or the unsigned assessments.</p> <p>3. Medical record review revealed Resident #91 was admitted on [DATE] with diagnoses including diabetes mellitus, hip fracture and manic depression.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Braden Scale for Predicting Pressure Ulcer Risk dated 01/03/24 revealed Resident #91 was at risk for pressure ulcer/injury development. There was no other risk assessment completed after 01/03/24.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making and had one unstageable pressure ulcer.</p> <p>Review of Resident #91's Skin Evaluation Forms revealed the following:</p> <p>Dated 01/26/24, development of a suspected deep tissue injury (SDTI), soft mushy heel and area was light purple in color. Interventions included to pad and protect, float heels and bilateral foot pillows. The SDTI measured 4.5 (cm) in (l) by 5.0 (cm) in (w).</p> <p>Dated 01/30/24, SDTI declined to an unstageable pressure ulcer of the left heel with eschar (black, dead) noted measuring 4.0 (cm) in (l) by 5.5 (cm) in (w) by 0.1 (cm) in (d). The assessment indicated edema was present and did not indicate the amount of eschar covering the wound. Treatment was to pad and protect with ABD and Kerlix three times a week.</p> <p>Review of the TAR dated February 2024 revealed a left heel treatment to pad and protect with ABD and Kerlix three times a week was not completed between 02/09/24 and 02/12/24 and bilateral foot pillows and float heels at all times was not documented as being done on 02/03/24, 02/09/24 to 02/12/24, 02/19/24 or 02/27/24.</p> <p>Review of the record revealed no evidence of vitamins or nutritional supplements were ordered for Resident #91's unstageable left heel pressure ulcer between 01/26/24 and 03/31/24.</p> <p>On 06/26/24 at 5:00 P.M., interview with the DON verified if there was not initials on the electronic MAR/TAR it meant it was not done.</p> <p>On 07/09/24 at 12:42 P.M., electronic interview with the Administrator would not confirm or deny the above information.</p> <p>Review of the policy: Pressure Injury Prevention and Management (revised 02/26/24) revealed the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154465.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, medical record review and interview, the facility failed to ensure ostomy supplies were available as ordered. This affected one of one resident (#9) residing in the facility with an ostomy. The facility census was 45.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #9 was admitted on [DATE] with diagnoses including hip fracture, weakness, atrial fibrillation, constipation and colostomy.</p> <p>Review of the electronic Physician Orders dated 06/26/24 revealed Resident #9 was ordered to use the following ostomy supplies: [NAME] Wafer #11402 and [NAME] Bag #18182. Resident #9's ostomy wafer and ostomy bag was to be changed every three days and as needed.</p> <p>On 07/03/24 at 9:29 A.M., observation of Resident #9's ostomy supplies located in her closet and top dresser drawer were labeled [NAME] Wafer #11402 and Ostomy Bag #18373. Charge Nurse #138 asked Resident #9 if she could see what ostomy supplies were in use at the time of the observation, and Resident #9 raised her shirt revealing an ostomy bag #18373 attached to the wafer. Interview with Resident #9 at the time of the observation stated those are the only ones for staff to use. Resident #9 further stated that she had not had a bowel movement for two days and had not had any incontinence issues.</p> <p>Review of the care plan: Potential for bowel incontinence related to weakness dated 06/26/24 revealed a goal to have fewer incontinence episodes as evidence by STNA documentation. There was no mention of the resident's ostomy and no interventions related to what supplies to use or how often to care for the site.</p> <p>Review of the record revealed no evidence of a care plan related to Resident #9's colostomy.</p> <p>On 07/03/24 at 9:27 A.M. and 9:34 A.M., observation with Charge Nurse #138 verified the resident was not using the physician ordered size ostomy bag and stated the facility did not have the size ordered. Charge Nurse #138 stated the resident had been discharged home and returned the same day and did not bring back her ostomy supplies. Charge Nurse #138 verified the resident was readmitted on [DATE] and had been using ostomy bag #18373 since readmission.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154465.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review, policy review and interview, the facility failed to obtain weights as ordered. This affected one resident (#37) of six sampled residents. The census was 45.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #37 was admitted on [DATE] with diagnoses included cerebral infarction, [NAME]-barre syndrome, arthritis, multiple myeloma, barrett's esophagus paroxysmal atrial fibrillation, severe protein calorie malnutrition, and severe sepsis with septic shock.</p> <p>Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #37's cognition was moderately impaired for daily decision-making, was at risk for pressure ulcer development, and had no unhealed pressure, venous or arterial ulcers.</p> <p>Review of the Nutritional assessment dated [DATE] revealed Resident #37 had a clinically significant weight loss of 18% prior to admission to the facility with severe protein calorie malnutrition. Weights were to be monitored.</p> <p>Review of the electronic Physician Orders dated 04/04/24 revealed daily weights were ordered and Dietitian #186's Interdisciplinary Notes dated 05/09/24 revealed Resident #37's weight was stable at 151.9 pounds (lbs) with a body mass index of 23.</p> <p>Review of the Vital Stats dated 06/01/24 Thru 07/01/24 revealed Resident #37's weight on 06/15/24 was 148 lbs. and on 07/01/24 his weight was 149.1 lbs.</p> <p>Review of Resident #37's Treatment Record and Weight Tracker dated 06/01/24 through 07/01/24 revealed daily weights were not completed as ordered except on 06/09/24, 06/15/24, 06/17/24, 06/23/24, 06/24/24, 06/30/24 and 07/01/24.</p> <p>Review of the care plan: Vital Parameters dated 04/18/24 revealed to obtain weights as ordered.</p> <p>On 07/03/24 at 10:14 A.M., interview with Dietitian #186 verified Resident #37 was ordered daily weights, weights were to be documented in the electronic record and it was her expectation for physician orders to be followed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154465.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>28704</p> <p>Based on observation, and interview, the facility failed to post nursing staff data in a place that was readily visible. This had the potential to affect all 45 residents residing in the facility.</p> <p>Findings include:</p> <p>On 06/25/24 at 3:16 P.M., observation of the facility revealed no evidence the daily nurse staffing data was posted in a visible area.</p> <p>On 06/26/24 at 7:47 A.M., 7:56 A.M. and 10:50 A.M., observations of the facility revealed no evidence the nurse staffing data was posted in a visible area.</p> <p>On 06/26/24 at 10:50 A.M., interview with Scheduling Coordinator #94 revealed the nurse staffing data was kept on a clipboard across from the receptionist. At that time, she proceeded to a table located against the wall across from the receptionist, and removed a clipboard positioned on its side facing the wall that was wedged between a set of bookends and an unlabeled green binder. Observation of the clipboard revealed the daily nurse staffing posting dated 06/26/24.</p> <p>On 06/26/24 at 11:04 A.M., interview with Scheduling Coordinator #94 verified the posting was not readily visible to residents, visitors or staff and stated she was unaware it had to be visible at all times.</p> <p>On 06/27/24 at 9:33 A.M., observation of the receptionist area revealed the nurse staffing data posted was laying on top of a table attached to a clipboard. The posted nurse staffing data was dated Wednesday, 06/26/24. At the time of the observation, Business Office Manager #166 verified the nurse staffing data had not yet been posted for 06/27/24.</p> <p>On 07/02/24 at 9:45 A.M., observation revealed the nurse staffing data posted was dated 07/01/24. Social Work Designee #119 verified the current nurse staffing data for 07/02/24 was not posted at the time of the observation.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00154465.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and staff and resident interviews, the facility failed to ensure their pharmacy services provided resident intravenous medication in a timely manner. This affected one resident (#45) of two residents reviewed for intravenous medication administration. The census was 45.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #45 was admitted on [DATE] with diagnoses including cerebral infarction, bacteremia and sepsis.</p> <p>Review of the Physician Orders dated 05/27/24 revealed to administer Ceftriaxone (antibiotic) 2 grams (g) intravenous (IV) every 12 hours for infection through 06/28/24.</p> <p>Review of the Medication Administration Record (MAR) dated June 2024 revealed the following IV antibiotics were not administered as ordered:</p> <p>Ceftriaxone 2 g IV was not administered upon rising on 06/08/24, 06/10/24, 06/19/24, 06/23/24 and 06/24/24.</p> <p>Ampicillin 2 g IV for bacteremia was not administered at 12 noon on 06/19/24 and 06/20/24.</p> <p>Ceftriaxone 2 g IV was not administered in the evening on 06/19/24.</p> <p>Review of Resident #45's Interdisciplinary Notes dated 06/24/24 at 4:32 P.M. revealed the certified nurse practitioner (CNP) was notified of four missed doses of Ceftriaxone intravenous and ordered to extend the order by four doses due to the same.</p> <p>Review of the Medication Incident Reporting (MIR) dated 06/24/24 revealed Ceftriaxone 2 g IV was not administered as ordered due to pharmacy did not deliver medication on 06/21/24, 06/22/24, 06/23/24 or 06/24/24.</p> <p>Review of the electronic mail dated 06/24/24 revealed the Director of Nursing informed pharmacy of concerns related to inability to receive needed supplies and medications. This weekend we experienced not being able to get hold of pharmacy. Numerous phone calls were made all weekend. When someone did answer we were told that the antibiotic would be in the next PM run. Never came. When they called about it, the tech said it looks like it was never received but it was suppose to go out. He has missed 4 doses of his Ceftriaxone but it was suppose to go out. The resident has missed four doses of his Ceftriaxone and one dose of Ampicillin either due to no drug or no tubing.</p> <p>Review of the Pharmacy POD After Hours Daily Summaries revealed the following IV antibiotics were dispensed/in progress:</p> <p>On 06/13/24, 16 Ampicillin 2g/100ml NS and eight Ceftriaxone 2g/100ml NS were dispensed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/17/24, 12 Ampicillin 2g/100ml NS and six Ceftriaxone 2g/100ml NS were in progress.</p> <p>On 06/19/24, 14 IV tubing sets were dispensed.</p> <p>On 06/20/24, 16 ampicillin 2g/100ml NS and eight Ceftriaxone 2g/100ml NS were dispensed.</p> <p>Review of the signed pharmacy Packaging Slips revealed the following:</p> <p>On 06/10/24, 12 Ampicillin 2g/100ml NS, six Ceftriaxone 2g/100ml NS and six IV tubing sets were received by facility staff.</p> <p>On 06/13/24, IV supplies including 14 IV tubing sets were received by facility staff.</p> <p>On 06/17/24, 12 Ampicillin 2g/100ml NS and six Ceftriaxone 2g/100ml NS were received by facility staff.</p> <p>On 07/01/24 at 9:04 A.M., interview with the Director of Nursing stated the facility was not able to administer IV medications as ordered due to not having adequate supply of the IV antibiotics and/or IV tubing. The DON stated she has reached out to pharmacy to address the issue but continues to have issues with timely delivery of medications.</p> <p>On 07/01/24 at 2:45 P.M., electronic interview with Pharmacy #202 revealed the pharmacy did not have signed manifests that were linked in our system for every delivery but provided the above. Typically IV medications were sent out twice per week on Monday and Thursday for refills and a weeks worth of supplies was sent out every Wednesday for refills; however, it looks like there is a record of them running out of tubing prematurely on multiple occasions. The facility should also have six vials of Ampicillin and six vials of Ceftriaxone 1gm in their IV emergency kit. This kit is replenished on request from the facility.</p> <p>On 07/10/24 at 10:02 A.M., electronic interview with the Administrator revealed the facility did not have a policy for pharmacy.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154465.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review, observation, and interview, the facility failed to maintain an accurate medical record. This affected three residents (#45, #87 and #99) of six sampled residents. The census was 45.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #99 was admitted on [DATE] with diagnoses including chronic atrial fibrillation, congestive heart failure and edema.</p> <p>Review of the hospital Discharge Instructions dated 10/18/23 revealed Resident #99 was prescribed Torsemide (diuretic) 40 mg once a day.</p> <p>Review of the electronic Physician's Orders dated 10/17/23 revealed to administer two tablets of Torsemide 20 mg daily.</p> <p>Review of the electronic Medication Administration Record (MAR) dated October 2023 revealed two different doses to administer for Torsemide. The order was transcribed on the electronic MAR as follows: 'Torsemide 20 mg by mouth once daily. Give two tablets to equal 40 mg for Essential Hypertension. 20 mg po (orally) QD (everyday)'.</p> <p>On 07/03/24 at 12:40 P.M., interview with the Director of Nursing verified the order for Torsemide was not clearly written as it indicated two different doses to be administered (20 mg or 40 mg) between 10/18/23 and 11/07/23.</p> <p>2. Medical record review revealed Resident #45 was admitted on [DATE] with diagnoses including cerebral infarction and sepsis.</p> <p>Review of the Physician Orders dated 05/27/24 revealed to administer Ceftriaxone (antibiotic) 2 grams (g) intravenous (IV) every 12 hours for infection through 06/28/24.</p> <p>Review of the resident's Interdisciplinary Notes revealed Resident #45's antibiotic infused without difficulty at 6:20 A.M. and a second dose was documented at 5:23 P.M. as being administered.</p> <p>Review of the MAR dated June 2024 revealed no evidence Ceftriaxone 2 g IV was administered on 06/22/24.</p> <p>On 07/01/24 at 12:30 P.M., interview with the Director of Nursing verified the medication record did not indicate Ceftriaxone 2 g was administered on 06/22/24.</p> <p>3. Medical record review revealed Resident #87 was admitted on [DATE] with diagnoses including post-polio syndrome, hip fracture, hypertension and depression.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Interdisciplinary Notes dated 06/17/24 revealed an air mattress with bolsters from hospice was requested and a low-air loss mattress was placed on the residents bed on 06/19/24. On 06/21/24, the resident's care conference indicated a foam mattress with foam overlay was ordered in case he wanted to lay in his bed since he preferred sleeping in recliner.</p> <p>On 06/25/24 at 3:27 P.M., observation revealed Resident #87's was laying in bed on his back on a standard mattress at a 45 degree angle. The resident was partially covered with a sheet.</p> <p>Review of the Wound Progress Report dated 06/25/24 revealed Resident #87 had developed two facility acquired pressure ulcers and new orders received included a recommendation of an air mattress.</p> <p>On 06/27/24 between 2:00 P.M. and 2:11 P.M., interview with the DON stated Resident #87 had a low air loss mattress from hospice on his bed. Observation with staff revealed no low air loss mattress on Resident #87's bed and the resident was laying on his back on a regular mattress. DON stated she was not aware this had not been done. The DON asked LPN #108 why the specialty mattress was not in place and she stated one had been ordered two days ago but he did not have one yet. DON verified the medical record was not accurate related to the use of a specialty pressure relieving mattress.</p> <p>This deficiency represents incidental non-compliance investigated under Complaint Number OH00154465 and Complaint Number OH00154365.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review, observation, policy review, and interview, the facility failed to maintain adequate infection control practices. This affected one resident (#87) of three residents observed for pressure ulcer treatments and one resident (#25) resident observed for incontinence care. The census was 45.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #87 was admitted on [DATE] with diagnoses including post-polio syndrome, hip fracture, hypertension and depression.</p> <p>Review of the Wound Progress Report dated 06/25/24 revealed Resident #87 had developed two facility acquired pressure ulcers including an unstageable pressure ulcer to the left midline buttock measuring 5.22 centimeters (cm) in length by 2.8 (cm) in width. The wound bed was covered with slough.</p> <p>On 06/27/24 at 12:18 P.M., observation of Resident #87's left midline buttock pressure ulcer treatment revealed Licensed Practical Nurse (LPN) #60 gathered her supplies, washed her hands at the sink and Hospice Aide #204 rolled Resident #87 onto his right side revealing an unstageable left midline buttock pressure ulcer approximately 6.0 (cm) in (l) by 3.0 (c) in (w). The wound was covered with necrotic (dead) tissue and the outer left buttock was dark purple in appearance. LPN #60 cleansed the wound with normal saline, applied collagenese santyl with a sterile q-tip to the necrotic area of the wound, applied a 6 (cm) by 6 (cm) comfort foam border to the area, dated the dressing once and then removed her gloves. LPN #60 washed her hands at the sink and assisted Hospice Aide #204 with positioning Resident #87 up in bed laying on his back.</p> <p>On 06/27/24 at 12:30 P.M., interview with LPN #60 verified she did not change her gloves after cleansing the wound or during the dressing change. LPN #60 stated she thought about it but the resident just had a bath so didn't think she needed to.</p> <p>Review of the policy: Clean Dressing Change (revised 01/29/24) revealed it was the policy of this campus to provide wound care in a manner to decrease potential for infection and/ or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Procedure included to perform hand hygiene and put on clean gloves. Cleanse the wound as ordered, pat dry with gauze, measure wound using disposable measuring guide, perform hand hygiene and put on clean gloves. Apply topical ointments or creams and dress the wound as ordered, protect surrounding skin as indicated with skin protectant, secure dressing and mark with initials and date. Discard disposable items and gloves into appropriate trash receptacle and perform hand hygiene.</p> <p>2. Medical record review revealed Resident #25 was admitted on [DATE] with diagnoses including dementia, anxiety and depression. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed the resident was always incontinent of bowel and bladder and dependent on staff for assistance with toileting.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/02/24 at 10:52 A.M., observation of incontinence care revealed State tested Nurse Aide (STNA) #46 gathered supplies including disposable incontinence wipes and an incontinence product, washed hands at the sink and applied gloves. STNA #46 assisted Resident #25 from her recliner chair to a standing position with a sit-to-stand mechanical lift, placed a bedside commode behind the resident, untabbed the resident's product and allowed it to fall into the bedside commode beneath the resident. The brief was saturated with urine and loose bowel movement. STNA #46 proceeded to use multiple incontinence wipes to cleanse the resident of bowel and urine dropping them into the bedside commode. STNA #46 then grasped the clean incontinence product, applied the new incontinence product, grasped the resident's dress, pushed the bedside commode away from the resident, maneuvered the sit-to-stand lift over the resident's wheelchair, lowered the resident into the wheelchair, applied the foot pedals to the wheelchair and then removed the soiled gloves.</p> <p>On 07/02/24 at 11:00 A.M., interview with STNA #46 verified gloves were not changed during incontinence care.</p> <p>Review of the policy: Perineal Care (revised 04/14/23) revealed it is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Procedures included setting up supplies, place waterproof pad underneath resident, cleanse, thoroughly dry, re-position resident in supine position, change gloves if soiled and continue with perineal care.</p> <p>This deficiency identifies non-compliance investigated at Complaint Number OH00154465.</p>