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	11/07/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on record review, observation, interview, and facility policy review, the facility failed to follow physician ordered oxygen settings for administration of oxygen to residents. This affected one resident (Resident #15) out of four residents reviewed for respiratory care. The facility census was 41. Findings Include: Review of Resident #15's medical record revealed Resident #15 was admitted on [DATE] with diagnoses including respiratory disorder, dementia, and breast cancer. Resident #15 required assistance from staff for activities of daily living (ADL) tasks. Review of Resident #15's physician orders revealed an order dated 10/11/24 to administer continuous oxygen 1 to 2 liters per minute (LPM) via nasal cannula to maintain oxygen saturation (SAT) above 90 percent (%) for dependence on supplemental oxygen. Review of Resident #15's Medication Administration Record (MAR) dated 10/01/24 to 11/06/24 revealed the order dated 10/11/24 to administer continuous oxygen 1 to 2 LPM via nasal cannula to maintain oxygen SAT's above 90% for dependence on supplemental oxygen was documented as being administered with oxygen SAT recordings ranging from 90% to 97%. Observation on 11/04/24 at 10:36 A.M. revealed an oxygen concentrator located in Resident #15's room. The oxygen concentrator had a small piece of bright yellow paper taped to the top of the concentrator next to the settings observation gauge. On the piece of bright yellow paper was written 1-2 Liters. The concentrator's setting was observed to be set at 0.5 LPM. There was clear oxygen tubing connected from the oxygen concentrator to Resident #15 via a nasal cannula. Interview on 11/04/24 at 4:44 P.M. with the Director of Nursing (DON) confirmed Resident #15's oxygen concentrator setting was on 0.5 LPM's even though the physicians order for the resident was for the oxygen setting to be 1 to 2 LPM. The DON stated the physician's orders were to be followed as written. Review of the facility's policy titled, Oxygen Administration, dated June 2019, revealed oxygen was to be administered under orders of a physician, except in the case of emergency.

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

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

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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. 47569 Based on observation, staff interviews, and facility policy review, the facility failed to complete hand hygiene during the dining room and room tray meal service. This affected two residents (Resident #25 and Resident #39) with the potential to affect all 13 residents on the skilled unit. The facility census was 41. Findings Include: 1. Observation on 11/04/24 at 12:04 P.M. revealed Certified Nursing Assistant (CNA) #356 was performing the lunch meal service in the skilled unit dining room for nine residents. CNA #356 had served the residents their drinks of choice prior to the tray cart being delivered from the kitchen. Upon receiving the tray cart in the dining room, CNA #356 began serving the trays to each resident, and assisting in preparing the food (such as removing lids to items and cutting up meat as needed) for ease of eating by the residents. After each resident was served, CNA #356 would return to the tray cart, open the cart door, remove a tray, and close the door without sanitizing or washing his hands. CNA #356 continued to serve the lunch trays until each resident in the dining room had received a lunch meal. CNA #356 then notified CNA #253 that the tray cart was ready for the room trays to be served to the residents who chose to stay in their rooms for lunch meal. Interview on 11/04/24 at 12:15 P.M. with CNA #356 revealed he did not wash his hands during lunch tray service in the dining room. CNA #356 stated washing or sanitizing his hands should have happened while the trays were being served to the residents. Review of the facility policy titled, Infection Prevention and Control, dated March 2020, revealed all staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after personal protective equipment (PPE) removal, before/after eating, before/after toileting, and before going off duty. 2. Observation on 11/04/24 at 12:23 P.M. revealed Certified Nursing Assistant (CNA) #253 retrieved the tray cart from the skilled unit's dining room. CNA #253 opened the cart door, removed a lunch tray for Resident #25, knocked on the door and entered Resident #25's room. CNA #253 removed several items off the bedside table, placed the lunch tray on the bedside table, removed the lids, and exited the room. CNA #253 returned to the tray cart, opened the door, removed Resident #39's tray, closed the cart door and served Resident #39's tray without washing or sanitizing her hands. Interview on 11/04/24 at 12:40 P.M. with CNA #253 confirmed she did not wash or sanitize her hands between serving Resident #25's lunch and Resident #39's tray. CNA #253 stated she should have washed or sanitized her hands between serving the two residents their lunch tray. Review of the facility policy titled, Infection Prevention and Control, dated March 2020, revealed all staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after personal protective equipment (PPE) removal, before/after eating, before/after toileting, and before going off duty.

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

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 34298 Based on record review and interview, the facility failed to completely and accurately report staff hours worked for the Payroll Based Journal (PBJ) report. This had the potential to affect all 41 residents residing in the facility. Findings include: Review of the PBJ report revealed the facility failed to have licensed nursing coverage 24 hours per day on 06/08/24, 06/09/24, 06/23/24, 06/29/24, and 06/30/24. Review of the staffing schedules for the nurses on 06/08/24, 06/09/24, 06/23/24, 06/29/24, and 06/30/24 revealed there was a licensed nurse in the facility. Interview on 11/07/24 at 9:45 A.M. with the Director of Nursing (DON) verified the corporate office stated they had trouble getting the invoices for agency staff and did not submit accurate staffing for nurses on 06/08/24, 06/09/24, 06/23/24, 06/29/24, and 06/30/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47569 Based on observation, record review, staff interview and facility policy review the facility failed to perform hand hygiene during medication administration. This deficient practice affected two residents (#10 and #16) out of six residents observed for infection control medication administration. The facility census was 41. Findings Include: Observation on 11/05/24 from 12:57 P.M. to 1:15 P.M. revealed Licensed Practical Nurse (LPN) #344 completing noon medications administration for residents residing on the skilled unit. LPN #344 sanitized hands prior to preparing Resident #16's narcotic medication for administration and locked the medication cart. LPN #344 then knocked on Resident #16's room door and entered the room. LPN #344 handed the medication cup to Resident #16 and Resident #16 took the medication with a drink of water. LPN #344 removed the medication and water cup from the room, returned to the medication cart and disposed of the cups in the trash can. LPN #344 then documented the administration of Resident #16's medication in Medication Administration Record (MAR). LPN #344 did not wash or sanitize hands. LPN #344 then began preparing Resident #10's medication for administration and locked the medication cart. LPN #344 then knocked on Resident #10's door and entered the room. LPN #344 handed the medication cup to Resident #10 and Resident #10 took the medication and handed the medication cup back to LPN #344. LPN #344 assisted Resident #10 with holding the water cup for Resident #10 to take a drink from. LPN #344 then left the room and returned to the medication cart and disposed of the used medication cup. LPN #344 then documented the administration of Resident #10's medication in the MAR. LPN #344 did not wash or sanitize her hands following the completion of medication administration. Review of Resident #16's medical record and physician orders revealed Resident #16 had an order dated 10/31/24 for pain medication Norco 5 milligrams (MG) - 325 MG tablet, one tablet by mouth three times per day for pain. Further review of Resident #16's MAR dated 11/04/24 revealed pain medication Norco had been administered by LPN #344. Review of Resident #10's medical record and physician orders revealed an order dated 09/05/24 for diuretic medication Lasix 40 MG, one tablet by mouth two times daily for heart failure. Further review of Resident #10's MAR dated 11/04/24 revealed diuretic medication Lasix had been administered by LPN #344. Interview on 11/05/24 at 1:20 P.M. with LPN #344 confirmed LPN #344 did not wash or sanitizer her hands before, during, or after administering medications to Resident #10 and #16. LPN #344 stated they should have washed or sanitized their hands during medication admiistration. Review of the facility policy titled, Infection Prevention and Control, dated 03/20 revealed, All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after PPE removal, before/after eating, before/after toileting, and before going off duty.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, staff interview, review of infection control logs, and policy review, the facility failed to update and implement their antibiotic stewardship program policy to ensure antibiotics were ordered appropriately. This affected one (Resident #30) out of one reviewed for antibiotic use. Findings include: Review of the medical record revealed Resident #30 was admitted on [DATE] with diagnoses that included heart failure and chronic kidney disease. A progress note dated 08/14/24 at 5:40 A.M. revealed Resident #30 voiced a complaint of pressure and discomfort to bladder. Resident #30 reported feeling the need to void but unable to do so. A urine culture reported 08/15/24 revealed mixed microbiota to urine sample for Resident #30 due to possible contamination. No antibiotic sensitivity was identified. Review of the McGeer Criteria for Infection Surveillance Checklist dated 08/16/24 revealed Resident #30 had dysuria, pain, swelling, and/or tenderness. The microbiologic criteria was not met due to mixed microbiota. The checklist was marked as urinary tract infection criteria was not met. Review of the monthly infection log revealed on 08/16/24 Resident #30 had a urinary tract infection on 08/16/24 and the culture results were negative and the criteria was not met. A progress note dated 08/16/24 at 6:52 A.M. revealed orders were received to start Resident #30 on Augmentin (antibiotic) twice a day for for seven days. The Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact and frequently incontinent of urine. Interview on 11/06/24 at 8:34 A.M. Director of Nursing (DON) revealed the facility no longer used the Loeb Criteria, but used McGeer Criteria to determine if an infection met the criteria for an antibiotic to be administered. DON verified there were no culture results for Resident #30 on 08/16/24 to identify what antibiotic the infection was susceptible to. Review of the Antibiotic Stewardship Policy dated 06/05/22 revealed the policy was not updated to use McGeer Criteria as it stated antibiotic use protocols included the Loeb Minimum Criteria to be used to determine whether to treat any infection with antibiotics.