

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Heritagespring Healthcare Center of West Chester		STREET ADDRESS, CITY, STATE, ZIP CODE 7235 Heritagespring Drive West Chester, OH 45069	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, staff interviews, review of the facility policy, and review of the electronic monitoring device recording, the facility failed to ensure residents were free from verbal abuse. This affected one (#60) of the three residents reviewed for abuse. The facility census was 111.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #60 revealed an admitted [DATE]. Diagnoses included major depressive disorder, emphysema, peripheral vascular disease (PVD), and hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was dependent on staff for all activities of daily living (ADLs).</p> <p>Review of the care plan dated 08/01/23 revealed Resident #60 had behavior problems including combative with staff, resistive to care, using racial slurs, and swearing at staff. Interventions included administering medications as ordered, staff to anticipate and meet the resident's needs. staff to provide opportunities for positive interaction and attention, and staff to intervene as necessary to protect the rights and safety of others.</p> <p>(continued on next page)</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the electronic video recording in Resident #60's room dated 09/09/24 at 3:50 P.M. revealed Certified Nursing Assistant (CNA) #14 was providing incontinent care to Resident #60. CNA #15 was also present to assist as needed with care. CNA #14 was very rough with the resident during repositioning and the resident became agitated and stated expletive you to CNA #14. CNA #14 responded and said expletive you back to Resident #60. CNA #14 then extended her middle finger up to the resident's face asked Resident #60 if he saw it and said expletive you again. Throughout the video, CNA #14 continued to handle Resident #60 roughly during care. Resident #60 became agitated again and raised his arm up in a possible attempt to hit CNA #14. CNA #14 told Resident #60 she would call the police on him if he hit her. Resident #60 yelled call the police multiple times. CNA #14 stated she would call the police if he hit her and would tell them to come and get him. CNA #14 told Resident #60 to do it. CNA #14 continued to taunt Resident #60, and he stated expletive you again as CNA #14 repeated it back. CNA #14 stated she would bust his expletive. CNA#15 was observed standing at the bedside and did not intervene during the verbal abuse by CNA #14. CNA #14 and CNA #15 finished providing care and lowered Resident #60's bed to the floor and covered him up. The Director of Nursing (DON) arrived in the room and asked who had just provided care. The DON asked CNA #14 and CNA #15 to wait in the hallway.</p> <p>Review of the Self-Reported Incident (SRI) dated 09/09/24 at 5:35 P.M. revealed at approximately 5:20 P.M., the DON notified the Administrator regarding a message left with the receptionist. Resident sister called the facility and felt staff handled Resident #60 roughly by CNA #14 during care. Resident #60 had a history of being verbally aggressive and combative with staff. CNA #14 was immediately removed from the facility. A head-to-toe assessment was completed on Resident #60 with no negative findings. The local Police Department were called to the facility. According to Police Department, no physical assault occurred. CNA #14 admitted to using profanity toward Resident #60. CNA #14 was terminated. Education on abuse with all staff was completed. Other residents were assessed and interviewed with no negative findings.</p> <p>Review of the progress note dated 09/10/24 at 12:00 A.M. revealed Resident #60 was seen for a physical exam. Resident #60 was at baseline and reported he was not in any pain. Resident #60 was free from bruising, rashes, or lesions and vital signs were stable.</p> <p>Review of the police report dated 09/10/24 at 7:10 A.M. revealed the videos were observed of CNA #14 and CNA #15 providing care to Resident #60. In the video, Resident #60 cursed at CNA #14 several times. CNA #14 was heard saying expletive you to Resident #60 and continued changing him. CNA #14 was heard saying she would call the cops on Resident #60. The videos revealed no sign that CNA #14 physically assaulted Resident #60.</p> <p>Interview on 10/30/24 at 3:17 P.M. with interim Administrator revealed Resident #60's sister called the facility, while watching the live feed of the electronic monitoring device in the resident's room related to concerns during care to Resident #60. The interim Administrator reported she had notified the police of the alleged abuse. A head-to-toe assessment was completed on Resident #60 with no negative findings. The interim Administrator stated CNA #14 was immediately suspending pending investigation. Abuse education was completed with all staff and all residents were assessed or interviewed with no negative findings. The interim Administrator stated verified CNA #15 should have intervened during care to prevent further abuse from occurring.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/30/24 at 3:52 P.M. with the Director of Nursing (DON) verified she had seen the videos regarding the incident on 09/09/24. The DON verified CNA #15 should have intervened during care to protect Resident #60 from the abuse.</p> <p>Review of the facility policy titled, Abuse/Neglect/Misappropriation of Property, dated September 2022 revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. The facility staff should immediately report all such allegations to the Administrator and the respective State Survey Agency. Verbal abuse was the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but were not limited to threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.</p> <p>The deficient practice was corrected on 09/10/24 when the facility implemented the following corrective actions:</p> <p>On 09/09/24, immediately following the allegations of abuse, the DON separated CNA #14 and CNA #15 from Resident #60's room, notified the Administrator, physician, and the resident's responsible party.</p> <p>On 09/09/24, Resident #60 had a head-to-toe assessment completed with no negative findings related to abuse</p> <p>On 09/09/24, the interim Administrator filed an SRI with the state agency, filed a police report, and initiated an investigation for the allegations of abuse towards Resident #60.</p> <p>On 09/09/24, the DON educated all staff on the facility abuse policy.</p> <p>On 09/09/24 and 09/10/24, Social services (SS) #70 and nursing staff conducted body audits and interviews on all residents in house to ensure no evidence of abuse was present. No abnormal findings were discovered.</p> <p>Interviews with RN #30, LPN #22, CNA #10, and STNA #11 confirmed they had received education on the facility abuse policy on 09/09/24.</p> <p>Beginning on 09/11/24, audits for abuse were conducted by DON of random residents for concerns of abuse. Audits were conducted every day for a week, and then weekly for eight weeks. No negative findings were identified during the audits.</p> <p>On 09/09/24, CNA #14 was terminated from employment with the facility.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00158336.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on open and closed medical record review, staff interviews, review of Emergency Medical Services (EMS) report, review of electronic monitoring device video footage, review of witness statements, review of the facility's timeline, and review of facility policy, the facility failed to ensure Resident #60 received appropriate treatment and care and medical intervention to timely treat a change in condition. This resulted in Immediate Jeopardy and serious life-threatening harm which ultimately resulted in death beginning on [DATE] at 7:40 A.M. when Resident #60, who was dependent on staff for oral intake, was being fed breakfast by Certified Nursing Assistant (CNA) #13, started coughing, became congested and eventually had white secretions from his nose and mouth impairing his airway. Subsequently, Resident #60 coded on [DATE] around 9:36 A.M. and expired in the facility after failed attempts of resuscitation. This affected one (#60) of five residents reviewed for assessing a change in condition. The facility census was 111.</p> <p>On [DATE] at 12:52 P.M., the Administrator, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #45, [NAME] President of Nursing (VPN) #112 and Administrator #02 via phone, were notified Immediate Jeopardy began on [DATE] at 7:40 A.M. when CNA #13 entered Resident #60's room and began feeding him breakfast. Resident #60 suddenly started coughing, sounded congested and refused to eat anymore. CNA #13 left the resident's room to inform Licensed Practical Nurse (LPN) #22 of the sudden onset of coughing, congestion, the resident may vomit, and the resident ate less than his normal 75 to 100 Percent (%) oral intake. At 8:17 A.M. (via review of the electronic monitoring equipment inside the resident's room) LPN #22 entered the room, administered Resident #60's routine morning medications along with a routine ordered blood pressure and pulse, but failed to perform an assessment to address the resident's change in condition. At 8:59 A.M., CNA #12 entered Resident #60's room and noticed white phlegm-like secretions draining from the resident's nose, wiped his nose, left the room, and informed LPN #22 of the findings. At 9:14 A.M., Unit Manager (UM)/LPN #21, was doing routine morning rounds, entered Resident #60's room, noticed the white secretions from Resident #60's nose and wiped his nose. UM/LPN #21 retrieved a blanket, covered the resident up, left the room without completing an assessment and reported her findings to LPN #22. At 9:34 A.M., CNA #11 and CNA #12 entered the resident's room to give Resident #60 a bed bath and noticed white frothy secretions coming from Resident #60's nose and mouth. At 9:37 A.M., Resident #60 stopped breathing, cardiopulmonary resuscitation (CPR) was started, EMS was summoned and worked on the resident until he was pronounced dead at 10:14 A.M. after failed attempts at resuscitation.</p> <p>The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions:</p> <p>On [DATE] at 7:39 A.M., according to the facility's timeline, CNA #13 entered Resident #60's room, repositioned the resident to eat, fed the resident, left room at 8:08 A.M. and went to notify LPN #22 that the resident was congested.</p> <p>On [DATE] at 8:18 A.M., according to the facility's timeline, LPN #22 assessed Resident's #60 blood pressure and heart rate.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 8:58 A.M., according to the witness statement, CNA #12 entered Resident #60's room and noted the resident was trying to blow his nose. CNA #12 looked in the back of the resident's throat, did not observe anything, and kept the resident sitting upright.</p> <p>On [DATE] around 9:10 A.M., LPN #22 notified Nurse Practitioner (NP) #80 of her respiratory observation. New orders were received for a stat (immediately) chest X-ray (CXR).</p> <p>On [DATE] at 9:14 A.M., according to the documentation in the medical record, UM/LPN #21 was conducting routine rounds and entered Resident #60's room to check on the resident and nasal drainage was noted. UM/LPN #21 assisted the resident as he blew his nose. No other complaints were voiced, or signs and symptoms of distress were noted at that time.</p> <p>On [DATE] at 9:31 A.M., according to the facility's timeline, CNA #12 entered Resident #60's room to prepare the resident for a bed bath.</p> <p>On [DATE] at 9:39 A.M., per the facility's timeline, CNA #11 entered Resident #60's room to assist with the bed bath. The CNAs in the room noted the resident had vomited as they were gathering supplies and noted the resident appeared to not be breathing. CNA #12 ran to get the nurse.</p> <p>On [DATE] at 9:41 A.M., according to the facility's timeline, multiple licensed nurses entered Resident #60's room due to the resident not breathing.</p> <p>On [DATE] at 9:49 A.M., according to the medical record, EMS entered Resident #60's room and took over care of the resident. EMS called the time of death at 10:14 A.M.</p> <p>On [DATE] at 11:00 A.M., Resident #60's progress notes, orders, and care plans were reviewed by Corporate Registered Nurse (CRN)/Nurse Educator #111. No concerns were noted.</p> <p>On [DATE] at 11:00 A.M., the DON and UM/LPN #21 interviewed LPN #22, CNAs #12, #11 and #13 in regard to Resident #60's condition prior to the resident coding. Interviews were completed on [DATE] at 5:15 P.M.</p> <p>On [DATE] at 9:00 A.M., ADON #45 reviewed all current residents with any new progress notes during the past 24 hours to review for a possible change of condition. No concerns were identified.</p> <p>On [DATE] at 8:30 A.M., the DON reviewed all current residents with any new progress notes during the past 24 hours to review for a possible change of condition. No concerns were identified.</p> <p>On [DATE] at 3:00 P.M., the DON was provided in-service education by VPN #112 on the Change of Condition policy and conducting assessments including, but not limited to, vital signs and pulmonary assessment.</p> <p>On [DATE] at 3:54 P.M., a Quality Assurance (QA) meeting was held with the Administrator, Medical Director #90 (Via Phone), the DON, ADON #45, CRN/Nurse Educator #111, and VPN #112 to review findings. The QA committee developed, reviewed and approved the plan of action. This QA meeting included a review of the Change of Condition policy. No changes were made to the Change of Condition policy. A determination was made for a plan of action including, but not limited to, plan to assess all residents' vitals and lungs in house.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Starting on [DATE] at 4:15 P.M., all 107 current residents' vital signs were obtained by the DON, ADON #45, LPN #21, RNs #32, #30, #33, #28, Physical Therapist (PT) #110, Director of Therapy #100 and all vital signs were completed at 5:43 P.M. Resident #05 refused vital signs.</p> <p>Beginning on [DATE] at 4:15 P.M., all 107 current residents' pulmonary status were assessed by the DON, ADON #45, UM/LPN #21, RNs #32, #30, #33 and #28. All assessments were completed on [DATE] at 10:00 P.M. Resident #05 and Resident #42 refused assessments. Resident #32 was assessed with left lung rhonchi and right lung with diminished breath sounds. NP #80 was notified, and a new order for chest x-ray and albuterol (bronchodilator for difficulty breathing) was obtained. Resident #30 was assessed with coughing and diminished bilateral lung sounds. NP #80 was notified, and guaifenesin (expectorant) and a chest x-ray were ordered.</p> <p>On [DATE] at 4:39 P.M., the DON and CRN/Nurse Educator #111 started an additional in-service education to the current 37 licensed nurses. This education was sent electronically, verified it was delivered, then reached out to every nurse for verification. The education included, but was not limited to, ensuring a nurse assesses residents for potential change in condition. A resident assessment for a change in condition assessment includes, but not limited to, vital signs and cardiopulmonary assessment. On [DATE], the DON and CRN/Nurse Educator #111 provided the 37 licensed nursing staff with one-on-one (1:1) additional in-service education. This additional in-service education included, but was not limited to, ensuring a nurse assesses residents for potential change in condition. A resident assessment for a change in condition assessment includes, but not limited to, vital signs and cardiopulmonary assessment. Any licensed nurse not on-site was provided education via telephone by the DON. The education onsite and via telephone were completed for all licensed nursing staff on [DATE] at 7:30 P.M. All licensed nurses were able to verbalize understanding of the educational content.</p> <p>On [DATE] at 9:00 A.M, the DON reviewed all current residents with any new progress notes during the past 24 hours to review for a possible change of condition. No concerns were identified.</p> <p>On [DATE], to monitor ongoing compliance, the DON or designee will review current residents progress notes daily from the past 24 hours to review for a possible change of condition. This will be completed daily for 30 days.</p> <p>Beginning on [DATE] at 7:00 A.M., a Performance Improvement Audit Worksheet is being completed for 10 random residents to ensure the residents are assessed for potential changes in condition using a general physical assessment and obtaining vital signs. The Performance Improvement Audit Worksheet is being completed by the DON or designee daily for seven days, then three times per week for four weeks, then weekly for four weeks, then monthly. If any issues are noted, the DON will take appropriate action at the time the concern is noted. Results of the Performance Improvement Audit Worksheet will be reported to the QA committee for a determination of the need for further ongoing formal monitoring.</p> <p>On [DATE] at 12:00 P.M., a QA meeting was held with the Administrator, Medical Director #90 (Via Phone), DON, ADON #45, CRN/Nurse Educator #111, and VPN #112 to review education and the audit findings. The QA committee reviewed the plan and no concerns were identified. The QA committee will monitor weekly for four weeks.</p> <p>On [DATE] at 2:33 P.M., Medical Director #90 was notified of Immediate Jeopardy by the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], interviews with LPN #23 at 4:30 P.M., LPN #27 at 4:32 P.M., LPN #24 at 4:34 P.M., LPN #21 at 4:35 P.M., and ADON #45 at 4:37 P.M., revealed the staff had received education and in-service training on change in condition, physician notification, documentation and were knowledgeable about the facility's procedures and processes.</p> <p>Review of the medical records for five additional residents (#30, #32, #75, #112, and #113) related to a change in condition, revealed no concerns were noted.</p> <p>Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #60 revealed an original admitted [DATE] and the resident expired in the facility on [DATE]. Medical diagnoses included Alzheimer's disease, dementia, hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side, major depressive disorder, chronic obstructive pulmonary disease (COPD) and peripheral vascular disease (PVD).</p> <p>Review of the care plan revised [DATE] revealed Resident #60 had a nutritional problem and was at risk for malnutrition related to Alzheimer's, heart disease, cerebrovascular accident, self-feeding deficit, and COPD. Interventions included providing and serving diet as ordered and monitor, document, and report any signs and symptoms of dysphagia (pocketing, choking, coughing, drooling, holding food in mouth, and refusing to eat), administer medications as ordered, monitor weight and provide recommendations as needed.</p> <p>Review of the nutritional assessment, dated [DATE], authored by Registered Dietitian (RD) #60 revealed Resident #60 was on a regular diet with regular texture, thin consistency and dependent on staff for meals. The oral and swallowing status revealed Resident #60 had no concerns with coughing or choking during meals or when swallowing medications. The meal intakes were approximately 75 to 100 %.</p> <p>Review of physician orders for Resident #60 dated [DATE], revealed the resident was ordered a soft touch call light with brightly colored tape to the call light.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. Resident #60 was dependent on staff with eating, toileting, bathing, dressing, and transfers.</p> <p>Review of the facilities timeline of staff entering Resident #60's room dated [DATE], revealed at 7:39 A.M., CNA #13 entered Resident #60's room with a tray and at 8:08 A.M., CNA #13 exited the resident's room. At 8:18 A.M., LPN #22 entered the resident's room. At 8:35 A.M., RD #60 entered the resident's doorway to check on the resident. At 8:58 A.M., CNA #12 entered the resident's room for three minutes. At 9:14 A.M., LPN #21 entered the room. At 9:31 A.M., CNA #12 entered the resident's room. At 9:39 A.M., CNA#12 and CNA #11 entered the resident's room. At 9:41 A.M., multiple nurses entered the resident's room and at 9:41 A.M., EMS entered the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the electronic monitoring device video footage from Resident #60's room dated [DATE] revealed the following observations for Resident #60:</p> <p>a. At 7:40 A.M., CNA #13 entered Resident #60's room with a breakfast tray to feed him breakfast, which included fried eggs, sausage patties, toast, and diced pears. CNA #13 raised his bed and the head of the bed (HOB) minimally and prepared his tray.</p> <p>b. At 7:45 A.M., Resident #60 coughed, and CNA #13 immediately looked up from her phone in her lap at the resident. CNA #13 was able to give the resident one additional bite of pears, and then he refused to eat after multiple attempts by CNA #13.</p> <p>c. At 7:48 A.M., CNA #13 got up, moved the bedside table with his breakfast tray on it near the window, lowered his bed, and left Resident #60's room. The resident's call light was hanging over the headboard from the back, looped down between the headboard and mattress and out of the resident's reach.</p> <p>d. At 7:49 A.M., Resident #60 coughed up white phlegm and expelled a piece of food, which appeared to be a pear.</p> <p>e. From 7:50 A.M. through 7:53 A.M., Resident #60 continued to forcibly cough and expelled more white secretions from his mouth.</p> <p>f. From 7:55 A.M. through 8:16 A.M., Resident #60 continued to cough intermittently.</p> <p>g. At 8:17 A.M., LPN #22 entered Resident #60's room, poured a medicine cup of medications in the resident's mouth, and placed a cup of water with a straw in it in the resident's mouth. LPN #22 obtained a blood pressure of ,d+[DATE] millimeters of mercury (mm/Hg) in the resident's right wrist. LPN #22 noticed the resident was coughing and asked if he could cough it up and asked if his throat was hurting. LPN #22 stated to Resident #60 he sounded gurgly and stated, you feel cold. LPN #22 stated she would have NP #80 come see him later. LPN #22 raised the HOB and left the room. LPN #22 did not complete an oxygen saturation level or complete an assessment on Resident #60.</p> <p>h. At 8:25 A.M., Resident #60 had white phlegm-like secretions protruding from bilateral nostrils and increased mouth breathing.</p> <p>i. From 8:35 A.M. through 8:58 A.M., Resident #60 appeared to be working harder to breathe with an open mouth and using his accessory (chest) muscles.</p> <p>j. At 8:59 A.M., CNA #12 entered the room to pick up his breakfast tray. CNA #12 noticed the white phlegm-like secretions from his nose and stated, you're not feeling good huh. CNA #12 wiped his nose, picked up his breakfast tray, and left the room.</p> <p>k. From 9:04 A.M. through 9:13 A.M., Resident #60 had produced more white phlegm-like secretions from bilateral nostrils going over his mustache and near the opening to his mouth.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>l. At 9:14 A.M., UM/LPN #21 entered Resident #60's room, noticed the thick white secretions coming from Resident #60's bilateral nostrils and stated she was going to put on gloves. UM/LPN #21 wiped his nose and instructed Resident #60 to blow his nose into the tissue. UM/LPN #21 covered the resident with a blanket and exited the room at 9:17 A.M. No assessment was completed.</p> <p>m. From 9:20 A.M. through 9:26 A.M., Resident #60 had increased white phlegm-like secretions protruding from bilateral nostrils, was taking shallow, rapid breaths through his mouth using accessory muscles.</p> <p>n. From 9:27 A.M. to 9:30 A.M, Resident #60 had copious amounts of thick white secretions protruding from bilateral nostrils but significantly more on right side, which was now observed in Resident #60's beard. Resident #60 was observed with signs of respiratory distress.</p> <p>o. At 9:31 A.M., CNA #12 entered Resident #60's room with linens. CNA #12 wiped his nose and exited the room.</p> <p>p. At 9:33 A.M., Resident #60 was seen with copious amount of white frothy secretions protruding from his mouth and down into his beard with respiratory distress and respirations diminished.</p> <p>q. At 9:34 A.M., CNA #11 and CNA #12 entered Resident #60's room and observed the white frothy secretions coming from his mouth. CNA #12 wiped his mouth.</p> <p>r. At 9:37 A.M., Resident #60 stopped breathing. CNA #11 checked for breathing and CNA #12 left the room.</p> <p>s. At 9:38 A.M., LPN #22 entered Resident #60's room and started sternal rubs and attempted to get a blood pressure.</p> <p>t. At 9:40 A.M., CPR was initiated on Resident #60. A backboard was placed underneath the resident along with an AED (automated external defibrillator - a medical device that can help people experiencing sudden cardiac arrest).</p> <p>u. At 9:48 A.M., EMS arrived in Resident #60's room and took over resuscitation measures for approximately 25 minutes when the resident expired.</p> <p>Review of the nurse's progress note for Resident #60 dated [DATE] at 9:25 A.M. authored by LPN #22, revealed an order by NP #80 for a stat chest x-ray related to congestion.</p> <p>Review of the EMS report dated [DATE], revealed EMS was dispatched to the facility at 9:40 A.M. for cardiac arrest. EMS arrived at the resident's bed at 9:50 A.M. and assumed CPR and life saving measures. The resident was found to be in asystole (a lethal heart rhythm), no vital signs and CPR was continued. EMS had to suction the resident's airway prior to inserting an endotracheal (ET) tube (a tube inserted into an airway to provide manual respirations). EMS administered advanced cardiac life support (ACLS) for approximately 25 minutes when the resident's power-of-attorney (POA) arrived and requested EMS to cease the life saving measures. EMS contacted medical control for a field termination and the resident was pronounced dead at 10:16 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the witness statement dated [DATE] at 12:59 P.M. revealed CNA #12 reported seeing Resident #60 only when she was getting ready to provide a bed bath. CNA #12 stated he was spitting up, and she assisted with blowing his nose and looked in the back of his throat. CNA #12 saw nothing in his throat, and he kept spitting up.</p> <p>Review of a witness statement dated [DATE] at 1:11 P.M., revealed CNA #11 went into Resident #60's room at roughly 9:30 A.M. with CNA #12 to perform a bed bath. CNA #11 reported it appeared Resident #60 had vomited. CNA #12 was cleaning him up while CNA #11 got the bath basin ready. When CNA #12 returned with the basin, CNA #11 came out of the bathroom after washing her hands and asked if Resident #60 was breathing. CNA #11 told CNA #12 Resident #60 was not breathing. CNA #12 ran to find a nurse, while CNA #11 stayed with Resident #60. Once a nurse entered the room, CNA #11 went to get the crash cart.</p> <p>Review of the witness statement dated [DATE] at 1:45 P.M., revealed CNA #13 entered Resident #60's room with a breakfast tray. CNA #13 repositioned Resident #60 to eat. CNA #13 fed him three bites of food. Resident #60 started calling her names and sounded congested. CNA #13 notified LPN #22.</p> <p>Review of the nurse's progress note for Resident #60 dated [DATE] at 2:03 P.M. authored by UM/LPN #21, revealed at approximately 9:21 A.M. the nurse was in the room to check on the resident and nasal drainage was noted. The nurse assisted the resident with blowing his nose. No other complaints were voiced, or signs/symptoms of distress noted at this time. At approximately 9:30 A.M., two aides were in with the resident preparing for a bed bath when the resident became unresponsive. The nurses were immediately notified and responded to the room. The nurse observed the resident not breathing, verified the code status, and initiated CPR. EMS and the family were notified. An AED was applied to the resident with no shock advised. At 9:49 A.M., EMS arrived and took over the life saving measures. Resident #60 remained asystole, and the time of death was 10:14 A.M. NP #80 was notified and gave orders to release the body to the funeral home. The DON called the coroner to release the body to the funeral home. Post-mortem care was provided. The family entered the room and asked the funeral home to be notified. At approximately 12:00 P.M., the funeral home arrived to retrieve the body.</p> <p>Review of the witness statement dated [DATE] at 3:44 P.M., revealed LPN #22 administered Resident #60's morning medications and noted congestion. LPN #22 obtained his blood pressure and received an order for a stat chest x-ray from NP #80. LPN #22 notified Resident #60's sister of the new orders. CNA #12 notified LPN #22 that Resident #60 didn't look right. Upon entering Resident #60's room, LPN #22 noticed he was not breathing. LPN #22 verified code status and instructed CNA #12 to get another nurse and call a code blue. LPN #22 lowered the head of the bed and began chest compression and suctioned his mouth. EMS arrived on site and took over care.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with CNA #12 on [DATE] at 4:04 P.M., revealed CNA #13 fed Resident #60 breakfast on [DATE] and she reported Resident #60 barely ate. CNA #12 reported she went into the resident's room to pick up his breakfast tray when she noticed a white substance coming out of his nose. CNA #12 wiped his nose, left the room and notified LPN #22 the resident looked like he needed to be suctioned. CNA #12 stated at approximately 9:31 A.M. her and CNA #11 went into Resident #60's room to give him a bed bath and upon entering the room, CNA #12 noted the resident had thick white secretions similar to foam coming out of his nose and mouth. CNA #12 wiped the resident's mouth and nose, but he kept spitting up the foamy substance. CNA #12 reported she looked at the resident, and he was not breathing. CNA #12 stated she asked CNA #11 if he was breathing, and she said no. CNA #12 went to get the nurse (LPN #22) while CNA #11 stayed with the resident. LPN #22 came in and assessed him, and then initiated a code. CNA #12 went to get other nurses and notified them of the incident.</p> <p>Interview with CNA #13 on [DATE] at 11:36 A.M., revealed she fed Resident #60 breakfast on [DATE]. The resident had sausage patties, fried eggs, toast, and diced pears. CNA #13 reported the resident started coughing, stopped eating, and wouldn't allow her to give him a drink or complete eating, which was unlike him because the resident normally ate 75 to 100 % of his food. She was the primary staff member that fed him lunch and breakfast and he was not congested or coughing prior to feeding him. CNA #13 reported she told LPN #22 the resident sounded like he was congested. CNA #13 spoke to LPN #22, who stated she would notify the provider.</p> <p>Interview with UM/LPN #21 via phone on [DATE] at 7:20 P.M., revealed she was completing her morning rounds on [DATE] at approximately 9:15 A.M. when she went into Resident #60's room and noticed a whiteish secretion pouring from his nose. UM/LPN #21 stated she grabbed tissues and had the resident blow his nose. UM/LPN #21 reported he was mouth breathing at that time but had no other signs of respiratory distress. UM/LPN #21 reported she was notified a code was initiated on Resident #60 a little after 9:30 A.M., and she went to assist.</p> <p>Interview with LPN #22 via phone on [DATE] at 7:39 P.M., revealed CNA #13 came to her on the morning of [DATE] and reported Resident #60 appeared congested and could possibly vomit. LPN #22 reported she went into his room, administered his routine morning medications, checked his blood pressure and pulse and noticed the resident had congestion. LPN #22 stated she did not complete an assessment on Resident #60. LPN #22 stated she obtained an order for a stat chest x-ray. LPN #22 stated she saw her supervisor (UM/LPN #21) go in to assess him and have him blow his nose. LPN #22 revealed she was notified by CNA #12 that the resident didn't look right so she responded to the resident's room and noticed Resident #60 was not breathing and appeared gray. LPN #22 checked his code status, began CPR, had staff notify the other nurses and called 911.</p> <p>A follow-up interview with UM/LPN #21 via phone on [DATE] at 10:05 A.M., verified she did not complete an assessment on Resident #60 when she was in the resident's room on [DATE] and noticed the white secretions coming from the resident's nose. UM/LPN #21 stated she had the resident blow his nose and reported these findings to LPN #22 and instructed her to check on the resident frequently.</p> <p>A follow-up interview with CNA #13 on [DATE] at 11:29 A.M., while reviewing the videos, stated Resident #60 sounded congested after she started feeding him breakfast. CNA #13 reported Resident #60 started coughing, became more agitated than usual, and then refused to eat. CNA #13 stated he was not coughing or congested prior to breakfast. CNA #13 verified she reported to LPN #22, Resident #60 sounded very congested, didn't eat very much, and appeared as if he could vomit.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A follow-up interview with LPN #22 on [DATE] at 12:19 P.M., while reviewing the videos, revealed she went into Resident #60's room at 8:17 A.M. to give him his routine morning medications and to get a routine blood pressure. LPN #22 stated CNA #13 reported to her Resident #60 sounded congested, didn't eat well, and looked like he could vomit. LPN #22 stated when she administered his morning medications, he sounded gurgly, which was not normal for him, and she reached out to the on-call provider to get an order for a STAT chest x-ray. LPN #22 verified she did not complete any kind of assessment on Resident #60. LPN #22 verified CNA #12 and UM/LPN #21 informed her of Resident #60's congestion before he coded. LPN #22 verified she did not go back into his room between when she administered his medications and before the resident coded.</p> <p>A follow up interview with UM/LPN #21 on [DATE] at 12:58 P.M., while reviewing the videos, verified Resident #60 had a change in condition on [DATE] when the resident was observed with mucous pouring out of his nose. UM/LPN #21 verified the mucous was not a normal finding for Resident #60. UM/LPN #21 verified she did not complete any kind of assessment or obtain vital signs on Resident #60. UM/LPN #21 verified she told LPN #22 about his condition and instructed her to check on the resident frequently.</p> <p>Interview with the DON on [DATE] at 1:54 P.M., while reviewing the videos, verified Resident #60 had a change in condition on [DATE] and stated the expectations were for nursing staff to complete an assessment on a resident when a change in condition was identified. The DON verified Resident #60 was not accurately assessed by nursing staff after Resident #60 had a change in condition.</p> <p>Interview with NP #80 on [DATE] at 2:14 P.M., revealed LPN #22 sent her a text message on [DATE] at 9:10 A.M. noting Resident #60 sounded severely congested and had crackles in his lungs. NP #80 stated she ordered a STAT chest x-ray and duo neb (combination of ipratropium and albuterol medications via hand-held nebulizer to treat respiratory conditions) every eight hours. NP #80 reported her expectations would be for the nurses to complete a thorough assessment of the residents prior to reaching out to her, so she could understand what was going on with the residents. NP #80 revealed severe congestion was not Resident #60's baseline.</p> <p>Interview on [DATE] at 4:37 P.M. with Medical Director (MD) #90, while reviewing the videos, verified the resident was having a change in condition due to the congestion and unknown white frothy secretions was not a baseline for Resident #60. MD #90 stated he did not know what the white frothy secretions were coming from the resident's nostrils and mouth but stated it could have been a sign/symptom of aspiration. MD #90 stated if a resident was having an acute change in condition, his expectations would be for the nursing staff to complete a timely and thorough assessment.</p> <p>Review of the facility document titled LPN Job Description revealed LPN duties included evaluating the resident's care needs, conditions, develop and or add to existing plan of care for the individual resident, instruction and observation of adherence to treatment or care protocols prescribed per the physician, and completing rounds and providing supervision of nursing staff care being provided.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Change of Condition, dated [DATE], revealed the facility staff would report identified significant changes in a resident's status. Skilled resident or residents with an active illness will be assessed every day based on the resident's specific needs and issues. Documentation of the condition would be noted in the nurse's charting or interdisciplinary charting as indicated. A significant change in a resident's condition included a resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158336.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on review of the medical record, staff interviews, and job description, the facility failed to ensure interventions were implemented timely in order to appropriately treat a urinary tract infection (UTI). This affected one (#112) of four residents reviewed for infections. The facility census was 111.</p> <p>Findings include:</p> <p>Review of the closed medical record of the Resident #112 revealed an admitted [DATE] with a discharge date of [DATE]. Diagnoses included osteomyelitis of vertebra, mood disorder, generalized anxiety disorder (GAD), and atrial fibrillation.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #112 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11. This resident was dependent on staff for all activities of daily living (ADLs).</p> <p>Review of the care plan dated 08/07/24 revealed Resident #112 had a UTI. Interventions included to give antibiotic therapy as ordered, obtain and monitor vital signs, monitor intake and output, obtain and monitor laboratory (lab)/diagnostic work as ordered and report results to the provider, follow up as indicated, and encourage adequate fluid intake as diet allowed.</p> <p>Review of the nurse's progress note dated 08/07/24 at 12:00 A.M., revealed Resident #112 complained of suprapubic tenderness on exam. Resident #112 was noted to have cloudy urine in the Foley catheter bag with a moderate amount of sediment present. The resident was afebrile with stable vital signs. The plan was to collect a urinalysis (UA) with culture and sensitivity (UA C&S) and continue monitoring vitals signs and change in condition, mood, or behavior.</p> <p>Review of a physician order dated 08/07/24 revealed Resident #112 was ordered to have an UA C&S every shift for urinary discomfort.</p> <p>Review of a physician order dated 08/13/24 revealed Resident #112 was ordered an UA C&S every shift for urinary discomfort.</p> <p>Review of the UA C&S results for Resident #112 dated 08/19/24 at 7:29 A.M. revealed the resident's urine was collected on 08/16/24. The results determined the resident had an abnormal UA and the C&S determined the resident was positive Klebsiella Pneumoniae.</p> <p>Review of the nurse's progress note for Resident #112 dated 08/19/24 at 3:42 P.M. revealed the resident's UA C&S was final and new orders were received to start Macrobid (antibiotic) 100 milligrams (mg) twice a day for seven days.</p> <p>Review of the physician order for Resident #112 dated 08/19/24 revealed the resident was ordered Macrobid 100 mg two times a day for UTI.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Nurse Practitioner (NP) #80 on 11/14/24 at 2:35 P.M. revealed if dayshift nurses had difficulties getting a UA completed, it would be passed on to the next shift. NP #80 reported it can be difficult for staff to get a resident's urine if residents are continent, but with an indwelling catheter, there should be no delay in getting a urine sample. NP #80 verified Resident #112 had a urinary catheter at that time. NP #80 also verified Resident #112 was seen on 08/07/24 and complained of suprapubic pain, which was why she ordered a UA C&S. NP #80 verified Resident #112 did not start on antibiotics until 08/19/24.</p> <p>Interview with the Director of Nursing (DON) on 11/14/24 at 3:00 P.M., verified Resident #112 had an original order for a UA C&S dated 08/07/24 and the resident did not have a UA C&S collected until 08/16/24, which caused a delay in the administration of an antibiotic to the resident.</p> <p>Review of the Licensed Practical Nurse (LPN) Job Description revealed duties included to evaluate resident care needs, condition, developed and or added to existing plan of care for the individual resident, instruction and observation of adherence to treatment or care protocols prescribed per the physician, and completing rounds and providing supervision of nursing staff care being provided.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159762 and OH00159005.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on medical record review and staff interview, the facility failed to ensure the physician and nurse practitioner (NP)'s progress notes were timely written and signed at each visit. This affected three (#30, #32, and #75) of the three residents reviewed for physician progress notes. The facility census was 111.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of upper lobe of right bronchus, anxiety disorder, chronic kidney disease , and depression.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine.</p> <p>Review of the progress note for Resident #30 dated 11/12/24 at 12:00 A.M. authored by NP #80, revealed the NP's note was signed on 11/13/24 at 10:17 P.M.</p> <p>2) Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, diabetes mellitus, convulsions, and atrial fibrillation.</p> <p>Review of the Quarterly MDS assessment dated [DATE] revealed Resident #32 had severe cognitive impairment as evidenced by a BIMS score of seven.</p> <p>Review of progress note for Resident #32 dated 10/15/24 at 11:00 P.M. with a date of service on 10/16/24 and authored by NP #80, revealed the NP's note was signed on 10/18/24 at 12:50 P.M.</p> <p>Review of the progress note for Resident #32 dated 10/28/24 at 11:00 P.M. authored by NP #80, revealed the NP's note was signed on 10/29/24 at 12:48 P.M.</p> <p>Review of the progress note for Resident #32 dated 11/04/24 at 12:00 A.M. authored by NP #80, revealed the NP's note was signed on 11/05/24 at 9:13 P.M.</p> <p>Review of the progress note for Resident #32 dated 11/05/24 at 12:00 A.M. authored by NP #80, revealed the NP's was signed on 11/07/24 at 9:45 A.M.</p> <p>Review of the progress note for Resident #32 dated 11/11/24 at 12:00 A.M. authored by NP #80, revealed the NP's note was signed on 11/13/24 at 9:20 A.M.</p> <p>Review of the progress note for Resident #32 dated 11/13/24 at 12:00 A.M. authored by NP #80 revealed the NP's note was signed on 11/15/24 at 12:33 A.M.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Heritagespring Healthcare Center of West Chester		STREET ADDRESS, CITY, STATE, ZIP CODE 7235 Heritagespring Drive West Chester, OH 45069	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note for Resident #32 dated 11/14/24 at 12:00 A.M. authored by NP #80 revealed the NP's note was signed on 11/15/24 at 10:09 P.M.</p> <p>3) Review of the medical record for Resident #75 revealed an admitted [DATE] with a discharge date of [DATE]. Diagnoses included fracture of right femur, diabetes mellitus, anxiety disorder, and Alzheimer's disease.</p> <p>Review of the Significant Change MDS assessment dated [DATE] revealed Resident #75 was unable to complete a BIMS because she was rarely/never understood.</p> <p>Review of the progress note for Resident #75 dated 09/09/24 at 12:00 A.M. authored by NP #80 revealed the NP's note was signed on 09/11/24 at 9:31 P.M.</p> <p>Review of the progress note for Resident #75 dated 09/20/24 at 12:00 A.M. authored by NP #80 revealed the NP's note was signed on 09/22/24 at 10:53 P.M.</p> <p>Review of the progress note for Resident #75 dated 09/25/24 at 12:00 A.M. authored by NP #80 revealed the NP's note was signed on 09/27/24 at 7:59 P.M.</p> <p>Review of the progress note for Resident #75 dated 10/06/24 at 11:00 P.M. with a date of service of 10/07/24 authored by NP #80, revealed the NP's note was signed on 10/08/24 at 11:01 P.M.</p> <p>Review of the progress note for Resident #75 dated 10/15/24 at 11:00 P.M. with a date of service of 10/16/24 authored by NP #80 revealed the NP's note was signed on 10/18/24 at 12:59 P.M.</p> <p>Interview on 11/14/24 at 2:35 P.M. with NP #80 revealed she did not chart her visits while she saw the residents. NP #80 reported when she was hired, she was instructed by her manager she had up to 48 hours to complete and sign her progress notes after seeing the residents. NP #80 verified her progress notes were not signed and completed at the time of the visit for residents.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on medical record review, staff interviews, and review of a job description of the Medical Director (MD), the facility failed to ensure residents were seen at least every 60 days after the initial assessment by the physician. This affected two (#30 and #75) of three residents reviewed for physician visits. The facility census was 111.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, DM II, convulsions, and atrial fibrillation.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of seven.</p> <p>Review of the physician progress notes dated July through November 2024 revealed Resident #32 had not been seen by MD #90, who was the resident's physician, since 07/19/24.</p> <p>2) Review of the medical record for Resident #75 revealed an admitted [DATE] with a discharge date of [DATE]. Diagnoses included fracture of right femur, type two diabetes mellitus (DM II), anxiety disorder, and Alzheimer's disease.</p> <p>Review of the Significant Change MDS assessment dated [DATE] revealed Resident #75 was unable to complete a BIMS because she was rarely/never understood.</p> <p>Review of the physician progress notes dated February through October 2024 revealed Resident #75 had not been seen by MD #90, who was her physician, since 02/27/24.</p> <p>Interview on 11/14/24 at 4:37 P.M. with the Administrator verified Resident #32 and Resident #75 had not been evaluated by their physician every 60 days.</p> <p>Review of the job description for the medical director, revealed the medical provider must acquire, maintain, and apply knowledge of social, regulatory, political, and economic factors that relate to resident care services in the long-term setting. The medical director would coordinate and oversee medical care and treatment including physician services and services of other professionals as they relate to resident care. The medical director would oversee that all necessary medical services provided to residents were adequate and appropriate.</p>		

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<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** 44412</p> <p>Based on review of the medical record, review of video footage from the electronic monitoring device, staff interviews, and job description of a licensed practical nurse (LPN), the facility failed to ensure accurate documentation in a resident's medical record. This affected one (#60) of three residents reviewed for documentation. The facility census was 111.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #60 revealed an admitted [DATE]. Diagnoses included major depressive disorder, emphysema, peripheral vascular disease (PVD), and hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was dependent on staff for all activities of daily living (ADLs).</p> <p>Review of the vital signs record for Resident #60 dated 10/24/24 revealed the following: blood pressure was 114/72 millimeters of mercury (mmHg), heart rate was 69 beats per minute (bpm), and oxygen saturation of 94 percent (%) on room air.</p> <p>Review of the electronic monitoring device video footage in Resident 60's room dated 10/24/24 at 8:17 A.M., LPN #22 entered Resident #60's room, poured a medicine cup of medications in the resident's mouth, and placed a cup of water with a straw in it in the resident's mouth. LPN #22 obtained a blood pressure of 114/72 millimeters of mercury (mm/Hg) in the resident's right wrist. LPN #22 noticed the resident was coughing and asked if he could cough it up and asked if his throat was hurting. LPN #22 stated to Resident #60 he sounded gurgly and stated, you feel cold. LPN #22 stated she would have NP #80 come see him later. The resident's left arm stayed tucked under the sheets and under his leg hanging over the right side of the bed. LPN #22 raised the HOB and left the room. LPN #22 did not complete an oxygen saturation level or complete an assessment on Resident #60.</p> <p>Interview with LPN #22 on 11/12/24 at 12:29 P.M. with Director of Nursing (DON) in the room and while reviewing the video footage of Resident #60's care, verified she did not complete an oxygen saturation on Resident #60. LPN #22 verified she documented a pulse oximetry of 94 %.</p> <p>Review of the LPN Job Description revealed duties included to evaluate resident care needs, maintain appropriate documentation per the resident chart and the facility policies, instruction and observation of adherence to treatment or care protocols prescribed per the physician, and completing rounds and providing supervision of nursing staff care being provided.</p>		

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<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** 44412</p> <p>Based on review of the video footage from the electronic monitoring device, staff interviews, observations, and policy review, the facility failed to ensure appropriate hand hygiene was maintained during resident care. This affected two (#60 and #114) of three residents reviewed for infection control. The facility census was 111.</p> <p>Findings include:</p> <p>1) Review of the medical record for Resident #60 revealed an admitted [DATE]. Diagnoses included major depressive disorder, emphysema, peripheral vascular disease (PVD), and hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was dependent on staff for all activities of daily living (ADLs).</p> <p>Review of the electronic monitoring device video footage dated 10/24/24 at approximately 7:39 A.M. revealed Certified Nurse's Aide (CNA) #13 entered Resident #60's room with his breakfast tray. CNA #13 put the breakfast tray down on the bedside table. CNA #13 picked up the bed controller from the floor and raised the resident's bed. CNA #13 repositioned Resident #60 in bed. CNA #13 walked over to the bedside table after touching her face with her hand and moved the table over to the bed to prepare for feeding Resident #60. No hand hygiene was completed during the above observations and CNA #13 was not wearing any gloves. CNA #13 uncovered Resident #60's breakfast tray. During observation, CNA #13 removed the utensils from the napkin by grabbing the ends that would touch the resident's food. CNA #13 used the butter knife to cut up the resident's sausage then fed it to the resident. CNA #13 picked up the toast with her bare hands, buttered the toast and applied jelly. Throughout the video footage, CNA #13 was touching her personal phone sitting on her lap and rubbing her hands on her pants as she continued feeding Resident #60 without performing any kind of hand hygiene.</p> <p>Interview on 11/12/24 at 11:29 A.M. with CNA #13 while watching the electronic monitoring video footage, verified there were several infection control concerns including no hand hygiene or use of gloves while feeding Resident #60 his breakfast.</p> <p>2) Review of the medical record for Resident #114 revealed an admitted [DATE]. Diagnoses included atrial fibrillation, retention of urine, dementia, and chronic kidney disease (CKD) stage three.</p> <p>Review of the care plan dated 10/30/24 revealed Resident #114 had an indwelling Foley catheter related to urinary retention. Interventions included catheter care and empty bag every shift and as needed, change catheter, tubing, and/or bag per order and as needed for obstruction, non-functioning, or accidental removal, check catheter tubing for kinks, enhanced barrier precautions (EBP) due to indwelling catheter, and monitor and report signs and symptoms of infection including pain, burning, blood-tinged urine, cloudiness, no output, increase temperature, altered mental status, and foul-smelling urine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS assessment dated [DATE] revealed Resident #114 had severe cognitive impairment as evidenced by a BIMS score of seven and dependent on staff for being incontinent. Review of section H for bowel and bladder, revealed Resident #114 had an indwelling catheter and was frequently incontinent of bowel.</p> <p>Observation of catheter care and peri-care for Resident #114 on 11/14/24 at 1:57 P.M. performed by Certified Nurse's Aide (CNA) #17 and assistance from Unit Manager /Licensed Practical Nurse (LPN) #21, revealed CNA #17 had to be coached and instructed by LPN #21 during catheter care. Unit Manager/LPN #21 instructed CNA #17 to change her gloves and wash hands after providing care from a dirty to clean area. CNA #17 also touched Resident #114's sheets and comforter without changing her gloves and performing hand hygiene before she started cleaning the catheter tubing. CNA #17 was instructed again by Unit Manager/LPN #21 to change her gloves and wash her hands after cleaning the catheter tubing but had picked up a clean washcloth before doing so. CNA #17 used the same washcloth she contaminated to rinse the catheter tube of Resident #114.</p> <p>Interview on 11/14/24 at 2:10 P.M. with Unit Manager/LPN #21 verified she had to coach and instruct CNA #17 on multiple occasions to change her gloves and wash her hands during Resident #114's catheter and peri-care.</p> <p>Interview on 11/14/24 at 2:12 P.M. with CNA #17 verified she handled Resident #114's sheets prior to cleaning catheter tubing and did not change her gloves or complete any hand hygiene. CNA #17 also verified she used the contaminated washcloth to rinse the catheter tubing.</p> <p>Review of the facility policy titled, Hand Hygiene, dated August 2024 revealed all team members of the facility would follow hand hygiene guidelines to reduce the incidence of health care associated infections. Indications for handwashing included when hands were visibly soiled or dirty. Staff are to change gloves during patient care if moving from a contaminated body site to a clean body site. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient. Decontaminate hands after removing gloves.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00159762 and OH00159005.</p>		