STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366367	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Canal Winchester Post-Acute Rc	6725 Thrush Drive Canal Winchester, OH 43110

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure Resident #30's needs were addressed in a timely manner when she waited for 29 minutes for her call light to be answered. This affected one resident (#30) of one resident reviewed for call lights. The facility census was 61. Findings include: Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses including acute embolism and thrombosis of unspecified deep veins of right lower extremity, adult failure to thrive, type two diabetes mellitus, hypertension, chronic pain syndrome, and muscle weakness. Review of Resident #30's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed intact cognition. She required substantial or maximal assistance to roll left and right in bed. Interview on 09/25/24 at 10:43 A.M. Resident #30 revealed she was uncomfortable in her current position and wanted someone to pull her up. The call light was triggered at that time. Observation on 09/25/24 at 11:12 A.M. revealed Resident #30's call light was still on. At that time State tested Nursing Assistant (STNA) #277 entered Resident #30's room and asked her what she wanted. Resident #30 repeated she was uncomfortable and wanted assistance adjusting in the bed. Interview on 09/25/24 at 11:12 A.M. with STNA #277 verified she answered the call light. She reported all the other aides were busy assisting other residents. Review of facility policy titled 'Call light- Answering' undated, revealed call lights were to be answered within three to five minutes.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observation, interview, and record review, the facility failed to ensure the security and confidentiality of medical records during routine medication administration, leaving information visible to the public. This affected two (Resident #104 and #105) out of three residents observed during medication administration. The facility census was 61. Findings include: 1. Review of the medical record for Resident #105 revealed an admitted [DATE] with diagnoses not limited to metabolic encephalopathy, vascular dementia, hypertension, pneumonia and gastro-esophageal disease. Review of Minimum Data Set (MDS) 3.0 assessment completed 09/21/24 revealed Resident #105 was moderately cognitively impaired. Observation of medication administration on 09/24/24 at 7:37 A.M. with Registered Nurse (RN) Supervisor #207 began by reviewing the medication administration record (MAR) for medications to be administered to Resident #105. Resident # 105 required a blood pressure reading prior to administration of her medications which required RN supervisor #207 to obtain a blood pressure measurement before preparing the medications. RN supervisor #207 was observed to grabbed the blood pressure cuff off the medication cart and walked away, leaving Resident's #105 MAR open. Information available to any passerby included medication details, scheduled timing, resident date of birth, and room number. Upon return the MAR was active on the computer screen and two housekeepers were found in the hallway cleaning nearby. The director of nursing was walking the halls, and an aide was providing care to various residents throughout the hall. The RN needed to return to the resident at a later time to obtain a retake of the blood pressure before administering the morning medications. 2. Review of the medical record for Resident #104 revealed an admitted [DATE] with diagnoses not limited to osteoarthritis, cognitive communication deficit, need for assistance with personal care, bradycardia and acute kidney failure. Review of Minimum Data Set (MDS) 3.0 assessment completed 09/17/24 revealed the resident was moderately cognitively impaired. Observation of medication administration on 09/24/24 at 7:37 A.M. with Registered Nurse (RN) Supervisor #207 began by reviewing the medication administration record (MAR) for medications to be given to Resident #104. Resident # 104 required a blood pressure reading prior to administration of her medications which required RN supervisor #207 to obtain a blood pressure measurement before preparing the medications. RN supervisor #207 was observed to grab the blood pressure cuff off the med cart and walked away, leaving resident #104 MAR open. Information available to any passerby included medication details, timings, date of birth, and room number. Upon return, it was found the MAR application had since been closed by another staff member during blood pressure monitoring. RN supervisor #207 began preparing medication; once completed, the cart was locked and left it without closing the MAR. Upon return, the MAR was still opened on the computer screen. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/24/24 at 8:32 A.M. with RN supervisor #207 confirmed both (resident #104 and #105) medical records were visible to the public while away from the laptop. This surveyor informed the RN that the medical record was closed by another staff member while we were in another resident's room. Interview on 09/24/24 at 10:22 A.M. with Assistant Director of Nursing #200 confirmed that leaving the medication cart, residents' medical records should not be visible or accessible to the public. Review of the confidentiality of information policy, undated, revealed that it is the facility's policy to treat all resident information confidentially and that access to resident medical records will be limited to the staff and consultants providing services to the residents. Review of confidentiality and trade secrets dated 01/2018 revealed that employees must at all times protect the confidentiality and privacy of the residents. Employees should not discuss or disclose to individuals outside of the company personal information regarding residents, their names, conditions, or medical care.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observation, interview and record review the facility failed to provide set up meal assistance to a resident with limited range of motion. This affected one (Resident #213) of three residents who require set up assistance with meals. The facility census was 61. Findings include: Review of the medical record for Resident #213 revealed an admitted [DATE] with diagnoses not limited to osteoporosis, left femur nailing, muscle weakness, need for assistance with personal care, fracture of upper end of left humerus and history of falls. Review of admission Minimum Data Set (MDS) 3.0 assessment completed 09/16/24 revealed Resident #213 had a severe cognitive impairment, required set up assistance with eating and oral hygiene. Review of admission assessment completed 09/09/24 revealed upon admission, Resident #213 presented with left upper extremity edema and expressed a daily pain level of 3 due to fractures in the left femur and humerus. Nutritional assessment indicated Resident #213's nutritional status was probably inadequate, as she rarely consumed a complete meal and generally only ate about half of meals. Mobility assessment showed the resident was very limited; she could make occasional slight adjustments in body or extremity position but was unable to make frequent or significant changes independently. Review of the care plan dated 09/25/24 revealed Resident #213 was at risk for altered nutrition related to an unspecified fracture in the neck of the left femur. The goal was for the resident to receive adequate nutrition to meet her estimated dietary needs. Review of physician order dated 09/19/24 revealed Resident #213 required assistance with meal setup and cleanup. Review of occupational therapy (OT) progress report dated 09/10/24 revealed Resident #213 requires a referral due to identified decreased strength in both upper extremities, limited functional mobility, and a need for minimal to moderate assistance with tasks. The initial OT assessment indicated the resident required help with personal care and either supervision or hands-on assistance while eating. Justification for continued skilled services included limitations in range of motion. Review of range of motion assessment completed 09/09/24 revealed Resident #213 had identified limitations that interfered with her activities of daily living (ADLs), necessitating assistance with these tasks. Review of physician notes dated 09/14/24 revealed Resident #213 had a closed fracture of the left humerus and was receiving nonoperative management, including a sling, pain control, and physical therapy. Review of progress note dated 09/09/24 revealed Resident #213 was non-weight bearing on her left upper extremity. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/25/24 at 8:46 A.M. with Resident #213 revealed she received pancakes, a sausage patty, and Cheerios for breakfast. The resident was seen eating the sausage patty with her bare hands because her meal was not set up properly, and the food had not been cut. She noted difficulty removing the lid from the Cheerios container due to limited movement in her arms and requested staff assistance with cutting food and removing lids. Interview on 09/25/24 at 8:43 A.M. with State tested Nursing Assistant #305 revealed she denied any residents in her assignment, including Resident #213 requiring assistance with meals. Interview on 09/25/24 at 8:46 A.M. with Regional Nurse Consultant #300 confirmed if the resident has orders for setup or cleanup assist with eating, staff should provide assistance at every meal.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observation, record review, staff interview and review of the facility policy, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevent program to ensure residents were thoroughly assessed, interventions were initiated timely and in place as planned and/or staff timely identified the development new pressure ulcers. This affected two residents (#216 and #213) of six residents reviewed for pressure ulcers. The facility census was 61. Actual Harm occurred on 08/04/24 when Resident #216, who was at risk for pressure ulcer development and dependent on staff for activities of daily living, was assessed to develop 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 sacrum. On 08/13/24 the wound physician assessed the pressure ulcer to be a Stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). The resident was admitted to the facility on [DATE] with intact skin. The facility failed to ensure adequate interventions were in place to prevent the develop of this unstageable pressure ulcer and to timely identify the ulcer before it was found unstageable. Findings include: 1. Review of the medical record for Resident #216 revealed an admitted [DATE] with diagnoses including arthritis, urinary tract infection, acute kidney failure, muscle weakness, spinal stenosis, and body mass index (BMI) of 42. Review of local hospital documentation from the resident's hospitalization from [DATE] to 07/31/24 revealed no documentation supporting Resident #216 had any type of skin impairment/sacral pressure ulcer prior to discharge from the hospital/prior to admission to the facility. Review of an admitting nurse progress note dated 07/31/24 revealed a skin assessment was completed with no noted concerns for skin impairments. Review of nursing admission assessment completed 07/31/24 revealed the assessment contained a Braden skin assessment that indicated the resident scored a 16 placing her at mild risk for skin breakdown based on the following scoring criteria: the resident was slightly limited in mobility, skin was occasionally moist, the resident was chair fast, the resident had adequate nutrition, and the resident was at mid friction/shear risk. These factors left the resident at mild risk for skin impairment and injuries. Additionally, the resident was receiving steroid medication therapy, which recognized the resident as a high risk for skin breakdown. The admission assessment documented the resident had no skin alterations. Review of a baseline care plan revealed a wound goal was not applicable with no wound prevention and/or treatment approaches added for the resident at the time of admission or based on her assessed risk for skin breakdown. Review of a skilled nursing note dated 08/02/24 revealed Resident #216's skin was intact, warm, and dry. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of wound grid documentation dated 08/04/24 revealed Resident #216 had an in-house acquired 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 injury (to the sacrum) measuring 24 centimeters (cm) in length by 15 cm in width by an undetermined depth. The wound description indicated a wound bed with 70% slough present, moderate serous exudate present, with deep tissue injury noted to the surrounding sacrum wound bed. Review of the physician's orders revealed a new order dated 08/04/24 to cleanse sacrum with normal saline, pat dry, apply calcium alginate, and then place dry dressing. Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. The assessment revealed the resident was dependent (on staff) for toileting, hygiene and bed mobility. The assessment also revealed the resident was at risk for developing pressure ulcers/injuries and exhibited no behaviors or rejection of care. Review of the wound physician notes dated 08/13/24 revealed Resident #216 developed a Stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure ulcer, first found by facility staff on 08/04/24. Resident #216 was evaluated by the wound physician on 08/13/24. During the assessment, the wound was classified as a Stage IV pressure ulcer located on the sacrum, measuring eight cm in length by eight cm width with five cm depth, resulting in a total surface area of 64 cm. A procedure was completed where the doctor surgically excised 12. 8 cm of devitalized tissue, and necrotic periosteum and bone were removed at a depth of five cm. The nonviable tissue in the wound bed decreased from 30 percent to 10 percent. There was a treatment ordered to apply calcium alginate and Santyl, and apply a gauze island with a border once daily for 30 days. Review of a physician's progress note dated 08/16/24 revealed new diagnosis of pressure injury of sacral region of back: noted on 08/06/24. During an interview on 09/25/24 at 8:01 A.M. with Resident #216, the resident verified staff identified she had a wound to her sacrum after she admitted to the facility. Interview on 09/25/24 at 11:24 A.M. with Registered Nurse (RN) #304 revealed she completed the admitting skin assessment on Resident #216 on 07/31/24, however she stated she did not thoroughly assess the resident's buttocks area due to a concern for an invasion of privacy. RN #304 revealed the facility policy required a second nurse from management to complete a second skin assessment 24 hours after admission. Interview on 09/25/24 at 11:26 A.M. with the Director of Nursing (DON) verified the facility assessed Resident #216's sacral wound as being in-house acquired because it was identified five days after admission. During the interview, the DON confirmed the lack of interventions to prevent pressure ulcer development at the time of admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/26/24 at 11:36 A.M. with the DON, Regional Nurse Consultant #300, and Assistant Director of Nursing #238 confirmed if a resident was identified at risk when completing a Braden assessment, interventions should be implemented, such as an air mattress, offloading supports, and frequent turns to prevent acquiring a wound. They confirmed Resident #216 was admitted to the facility on [DATE] with a nursing assessment documenting the absence of pressure areas. Staff confirmed Resident #216 was assessed to have an unstageable pressure ulcer on 08/04/24. During the interview, the DON confirmed facility staff also failed to complete a second skin check per skin policy and implement dressings and interventions timely. Interview on 09/26/24 at 11:39 A.M. with Wound Physician (WP) #307 confirmed facility staff first identified a pressure ulcer on Resident #216's sacrum approximately five days after admission. Attempts to observe the resident's skin/wound care were made during the onsite survey; however, staff, who were aware of the surveyor's request to observe the area/wound care completed wound care without allowing the surveyor to observe. Review of the facility undated policy titled Pressure Injuries: Assessment, Prevention and Treatment revealed it was the facility policy to identify residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries and provide care for existing pressure injuries. Review of the facility undated policy titled Admission Skin Assessment Protocol revealed the Assistant Director of Nursing would complete a second skin assessment the following business day (after admission) and document any new findings in the clinical record. 2. Review of the medical record for Resident #213 revealed an admitted [DATE] with diagnoses including osteoporosis, left femur nailing, muscle weakness, need for assistance with personal care, fracture of upper end of left humerus and history of falls. Review of the Braden skin assessment dated [DATE] revealed Resident #213 was at moderate risk for skin breakdown, necessitating close monitoring and intervention. Review of a functional limitation of the range of motion assessment completed on 09/09/24 revealed Resident #213 had limitation on one leg, with partial loss of voluntary movement. The summary identified significant challenges in ability to complete activities of daily living. Review of admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #213 had severe cognitive impairment, required substantial (staff) assist with bed mobility and was at risk for pressure ulcer development. Review of the care plan dated 09/25/24 revealed Resident #213 was at risk of skin breakdown related to impaired mobility, cognitive challenges, and poor nutritional intake. Care approaches included applying skin prep to bilateral heels as ordered to prevent skin injury and encouraging/assisting the resident to float her heels as tolerated, alongside implementing bilateral offloading boots. Review of physician's orders dated 09/18/24 revealed an order for off-loading boots to both heels while in bed to promote healthy skin integrity due to the resident's limited mobility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/23/24 at 10:31 A.M. with Resident #213 and the resident's family concerns were voiced related to facility staff not placing support boots under the resident's feet while she was in bed. Observation at the time of the interview revealed the resident was in bed without any type of off-loading boots in place. Observations on 09/24/24 at 3:15 P.M., 4:26 P.M., and 5:20 P.M. revealed the resident was in bed and did not have off-loading boots in place at the time of these observations. Interview on 09/24/24 at 5:22 P.M. with Licensed Practical Nurse (LPN) #306 confirmed Resident #213 required off-loading pressure boots while in bed and acknowledged they were not being utilized at that moment. LPN #306 emphasized the need for the boots due to the resident's high risk of skin issues and impaired mobility. Review of the facility undated policy titled Pressure Injuries: Assessment, Prevention and Treatment revealed it was the facility policy to implement interventions to prevent the development of pressure injures which included floating heels or keeping heels off the bed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, medical record review, and facility policy review, the facility failed to ensure fall interventions were in place for Resident #2 and #19 and failed to ensure complete and timely investigations were completed for Resident #2 and #205. This affected three residents (#2, #19, and #205) of five residents reviewed for falls. The facility census was 61. Findings include: 1. Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses including senile degeneration of brain, unspecified fracture of left talus, dislocation of internal left hip prosthesis, unspecified dementia, depression, anxiety disorder, chronic kidney disease, and overactive bladder. Review of Resident #2's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed intact cognition. She had one fall with no injury since admission and one fall with a non-major injury. Review of Resident #2's fall investigation (event) dated 08/23/24 revealed at 7:13 P.M. she had a fall in her room that was unwitnessed. The immediate intervention was to put the bed in the lowest position and check on her every two hours. The interdisciplinary team (IDT) agreed a low bed was an appropriate safety intervention. Review of Resident #2's neurological assessments dated 08/23/24 revealed her vital signs were not assessed on six occasions, and respiratory status was not assessed on one additional occasion. Review of Resident #2's progress note dated 08/24/24 revealed on 08/23/24 at 7:00 P.M. the resident was found on the floor in her room. She was assessed with no concerns and notifications were completed. Neurological checks were initiated. Review of Resident #2's progress note dated 08/24/24 revealed she was observed lying on the floor under the bed. The resident stated she was reaching to grab something and slid off the bed. She complained of left side pain but had no additional injuries. Hospice was notified and ordered a floor mat for the resident. Review of Resident #2's fall investigation dated 08/24/24 revealed at 5:15 P.M. the resident had a fall in her room while reaching. The provider was notified and gave an order for a fall mat. Review of Resident #2's neurological assessments dated 08/24/24 revealed vital signs were not assessed for the first eight checks. No assessment was completed at 8:45 P.M. and 9:45 P.M. as scheduled. Additionally, the last five scheduled assessments were not completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's plan of care dated 08/25/24 revealed the resident was at risk for falls and injury related to confusion or altered mental status, poor vision, history of falls, incontinence, and medication use. Interventions included evaluating safety devices, observing residents in room for safety needs, encouraging them to wear glasses, educating about limitations and safety concerns, and encouraging them to use call light, and added 09/23/24 a mat to the right side of the bed and low bed due to poor safety awareness. Review of Resident #2's progress note dated 09/05/24 revealed the resident was heard yelling and was found sitting on the floor beside the bed with her back against the bed and holding onto the side rail. She appeared to have pulled herself to the side of the bed and slipped off of the air mattress. Hospice was notified and ordered an air mattress with bolsters. Review of Resident #2's fall investigation dated 09/05/24 revealed it was not completed or closed until 09/23/24. The resident was found on the floor in her room with previous interventions in place. The new intervention was an air mattress with bolsters. Review of Resident #2's physician order dated 09/23/24 revealed an order for low bed due to poor safety awareness. Review of Resident #2's physician order dated 09/23/24 revealed an order for mat to right side of bed. Observation on 09/23/24 at 10:00 A.M., 11:39 A.M. and 1:40 P.M., revealed Resident #2 in bed, her bed was high and no floor mat was in place. Observation on 09/24/24 at 8:37 A.M., 10:03 A.M., 10:41 A.M., 11:12 A.M., and 1:30 P.M. revealed Resident #2 in bed, no fall mat was in place. Interview on 09/24/24 at 1:33 P.M. with Assistant Director of Nursing (ADON) #236 verified a fall mat was not in place, despite one being present in her room. She additionally verified the order had been put in place the previous day so the staff may not have been aware they needed to use it. Interview on 09/25/24 at 2:27 P.M. with the Director of Nursing (DON) verified neurological assessments were not completed for Resident #2. She additionally verified the 09/05/24 fall investigation had not been completed timely. The DON additionally verified she had added the orders and care plan for fall interventions on 09/23/24. Review of the policy 'Fall Investigation' dated 06/03/19, revealed it was the facility's policy to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. After a fall an assessment was to be completed for the medical record and a fall event would be completed for the fall. 2. Review of Resident #38's medical record revealed an admitted [DATE] with diagnoses including hypertension, muscle weakness, vascular dementia, chronic diastolic heart failure, dysphagia, bipolar disorder, and cognitive communication deficit. Review of Resident #38's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had a severe cognitive impairment. He had no falls since readmission or previous assessment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's physician order dated 01/10/22 revealed his bed was to be in the lowest position. Review of Resident #38's plan of care dated 09/10/24 revealed the resident was at risk for falls and injury related to confusion, poor vision, history of falls, incontinence, antihypertensive, and gait stability. Interventions included encouraging the resident to be in the dining room for all meals, encouraging to rest after meals, dycem to his wheelchair, bed in lowest position, nonskid footwear, and evaluating safety devices. Observation on 09/25/24 at 10:00 A.M., 10:40 A.M., 10:45 A.M., 11:11 A.M., and 11:16 A.M. revealed Resident #38 in bed, his bed was not in the lowest position. Interview on 09/25/24 at 11:16 A.M. with Agency State tested Nursing Assistant (STNA) #301 verified Resident #38's bed was not in the lowest position. Review of the policy 'Fall Investigation' dated 06/03/19, revealed it was the facility's policy to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. After a fall an assessment was to be completed for the medical record and a fall event would be completed for the fall. 49039 3. Review of the medical record for Resident #205 revealed an admitted [DATE] with diagnoses not limited to dementia, abnormalities of gait and mobility, difficulty in walking, need for assistance with personal care and repeated falls. Review of the incident report dated 09/25/24 revealed that Resident #205 had a fall with no injury on 09/21/24. After the fall, the physician and family were notified. Interventions implemented included non-skid strips in front of the bath. Review of progress notes dated 09/21/24 at 7:30 A.M. revealed the nurse was notified that the resident was on the floor by the bed. The nurse assessed Resident #205 and found no concerns of injury. Review of clinical admission documentation dated 09/19/24 revealed that Resident #205 was oriented to self, had three or more falls in the past three months, was regularly continent, had no visual impairment, and had balance problems with decreased muscular coordination. The baseline care plan indicated that the resident was at high risk of falls, with approaches to orient to the room and call light system and implement fall prevention measures as indicated. Review of the care plan dated 09/25/24 revealed that Resident #205 is at risk for falls/injury related to impulsive behavior, confusion, poor vision, a history of falls, and incontinence of bowel and urine. Approaches included therapy services to work with the resident, educating the resident about limitations and safety concerns, encouraging the use of the call light, wearing glasses, and implementing frequent checks. Review of physician orders dated 09/25/24 revealed non-skid strips were placed on the left side of the bed due to poor safety awareness. (continued on next page)

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	366367	A. Building B. Wing	09/26/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 10:21 A.M. with the Director of Nursing (DON) confirmed that the fall report was not completed timely for the incident on 09/21/24. The DON also confirmed that interventions implemented to prevent additional falls were not carried out in a timely manner.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure Resident #38 had reasonable access to fluids. They additionally failed to ensure Resident #19 was weighed monthly and failed to ensure Resident #2's significant weight change was addressed and that her nutrition status was accurately assessed. This affected three residents (#2, #19, and #38) of six residents reviewed for nutrition and hydration. The facility census was 61. Findings include: 1. Review of Resident #38's medical record revealed an admitted [DATE] with diagnoses including hypertension, muscle weakness, vascular dementia, chronic diastolic heart failure, dysphagia, bipolar disorder, and cognitive communication deficit. Review of Resident #38's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had a severe cognitive impairment. He required set up or clean up assistance with eating. Review of Resident #38's plan of care on 09/23/24 revealed it did not address hydration. Review of Resident #38's fluid intake from 08/26/24 to 09/24/24 revealed on 08/26/24 he received 500 milliliters (ml), on 08/27/24 he received 480 ml, on 08/28/24 he received 790 ml, on 08/29/24 he received 1200 ml, on 08/30/24 he received 620 ml, on 08/31/24 he received 240 ml, on 09/01/24 he received 790 ml, on 09/02/24 he received 980 ml, on 09/03/24 he received 850 ml, on 09/04/24 he received 480 ml, there was no fluid intake documented on 09/05/24, on 09/06/24 he received 1080 ml, on 09/07/24 he received 840 ml, on 09/08/24 he received 1190 ml, on 09/09/24 he received 950 ml, on 09/10/24 he received 850 ml, on 09/11/24 he received 550 ml, on 09/12/24 he received 480 ml, on 09/13/24 he received 1100 ml, there was no fluid intake documented on 09/14/24, on 09/15/24 he received 550 ml, on 09/16/24 he received 800 ml, on 09/17/24 he received 920 ml, on 09/18/24 he received 240 ml, on 09/19/24 he received 890 ml, on 09/20/24 he received 2,280 ml, on 09/21/24 he received 720 ml, on 09/22/24 he received 240 ml, on 09/23/24 he received 600 ml, and on 09/24/24 he received 890 ml. Observation of Resident #38 on 09/23/24 at 11:07 A.M. and 11:37 A.M. revealed him sitting in the activities room without fluids. At 1:42 P.M. and 4:03 P.M. Resident #38 was observed in the dining room without fluids. Observation of Resident #38 on 09/24/24 at 10:00 A.M., 10:31 A.M., 11:15 A.M., 1:25 P.M., and 1:57 P.M. revealed he was in the dining room without fluids. Observation of Resident #38 on 09/25/24 at 10:00 A.M., 10:40 A.M., 10:45 A.M., and 11:11 A.M., revealed Resident #38 in bed without fluids. Observation of Resident #38 at 11:40 A.M., 1:26 P.M., 2:03 P.M., 3:42 P. M., and 4:01 P.M. revealed he was in the dining room without fluids. Interview on 09/25/24 at 4:01 P.M. with Certified Medication Aide (CMA) #221 verified Resident #38 did not have fluids at the table. She reported fluids were passed a few times a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 4:30 P.M. with MDS Coordinator #247 verified there was no hydration care plan in place. She reported she would not put one in place unless the resident was on a diuretic or had problems with hydration. Interview on 09/26/24 at 10:19 A.M. with Director of Nursing (DON) revealed fluids were to be passed once a shift and as needed. 2. Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses including senile degeneration of brain, unspecified fracture of left talus, dislocation of internal left hip prosthesis, unspecified dementia, depression, anxiety disorder, chronic kidney disease, and overactive bladder. Review of Resident #2's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed intact cognition. She was 60 inches tall and weighed 115 pounds. She was on a mechanically altered diet and had problems with coughing or choking during meals or when swallowing medications and had complaints of difficulty or pain with swallowing. Review of Resident #2's progress note dated 08/20/24 revealed she admitted to the facility on hospice. Review of Resident #2's weights revealed on 08/20/24 she weighed 115.0 pounds. Review of Resident#2's wound grid dated 08/20/24 revealed she had a stage three pressure ulcer to the sacrum measuring 6.0 centimeters (cm) by 3.0 cm by 0.1 cm. Review of Resident #2's physician order dated 08/21/24 to 08/22/24 revealed a diet order for mechanical soft, no added salt, with a thin liquid consistency. Review of Resident #2's physician order dated 08/22/24 to 08/23/24 revealed a diet order for puree, no added salt, with a thin liquid consistency. Review of Resident #2's physician order dated 08/23/24 to 08/25/24 revealed a diet order for puree, no added salt, and thin liquid consistency, with two handled cup for drinks. Review of Resident #2's physician order dated 08/25/24 to 09/10/24 revealed a diet order for puree, no added salt, nectar thick liquid consistency and a two handled cup for drinks. Review of Resident #2's weights revealed on 08/26/24 she weighed 107.8 pounds. This was a severe 6.2% weight loss in six days. Review of Resident #2's progress notes from 08/26/24 to 09/25/24 revealed no evidence the physician or dietitian was notified of the residents severe weight loss. Review of Resident#2's wound grid dated 08/27/24 revealed she had a stage three pressure ulcer to the sacrum measuring 6.0 cm by 3.0 cm by 0.1 cm. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's meal intake records from 08/21/24 to 08/29/24 revealed on 08/21/24 she consumed 51 percent (%) to 75% of her breakfast and lunch and consumed none of her dinner. On 08/22/24 she ate 51% to 75% of her breakfast and dinner and 76% to 100% of her lunch. There was no meal intake documentation for 08/23/24 and 08/24/24. On 08/25/24 the only meal documented was 51% to 75% and on 08/26/24 she consumed 76% to 100% of breakfast, 51% to 75% of lunch, and 1% to 25% of dinner. On 08/27/24 she consumed 26% to 50% of breakfast, 1% to 25% of lunch, and there was no documentation for dinner. On 08/28/24 she consumed 1% to 25% of her breakfast and lunch and 51% to 75% of her dinner. On 08/29/24 she consumed none of her breakfast and 1% to 25% of her lunch and dinner. Review of Resident #2's nutrition assessment dated [DATE] revealed the resident was on a mechanically soft diet with nectar thick liquids. She had no chewing or swallowing problems. Her intake at meals was 76 % to 100%. It was noted that Resident #2 had a pressure ulcer and she was 60 inches tall and weighed 115 pounds. Her estimated needs were 1306 to 1560 calories a day, 0.8 grams per kilogram (kg) of protein per day, and 25 milliliters per kilogram of fluid per day. Review of Resident #2's physician order dated 09/05/24 revealed an order for no weights for comfort. Review of Resident #2's physician order dated 09/10/24 revealed an order for mechanical soft, no added salt, thin liquids, and a two handled cup for all liquids. Review of Resident #2's physician's orders from 08/23/24 to 09/25/24 revealed no order for a supplement. Review of Resident #2's plan of care revised 09/23/24 revealed the resident was at risk for altered nutrition related to puree diet, dementia, impaired cognition, hospice care, and poor appetite with noted weight loss. Interventions included offering menu alternatives and providing diet as ordered. Review of Resident #2's wound grid revised 09/24/24 revealed she had a stage three pressure ulcer to the sacrum measuring 0.3 cm by 0.5 cm by 0.1 cm. Interview on 09/26/24 at 11:55 A.M. and 2:14 P.M. with Registered Dietitian (RD) #302 revealed she was newer to long term care and up until the middle of August 2024 someone else had been taking care of significant weight changes. She used the electronic medical record to print a weight variance report to find weight changes. She reported she had printed this report last on 08/26/24 and had missed Resident #2's significant weight change. She reported it was facility policy to address weight loss within a week. RD #302 verified that she could address weight changes with hospice residents. She reported she usually implemented four ounces of the house supplement a couple times a day for weight loss. RD #302 additionally verified Resident #2's diet order was incorrectly documented, and her meal intakes were not accurately reflected in the 08/29/24 assessment. RD #302 verified Resident #2 had a pressure ulcer that increased her protein needs, which was noted at the time of the 08/29/24 assessment. She reported that 0.8 g/kg was the estimated protein needs for all residents because they were not likely to meet their protein needs anyway. However, she verified this was insufficient for pressure ulcers. RD #302 verified she had not made any recommendations for Resident #2 despite her increased needs due to her pressure ulcer. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 1:12 P.M. with the DON reported the nurse who obtained Resident #2's 09/26/24 weight was not aware it had been a significant weight change. She reported the admission weight had not been in the vitals at that time, so it had not triggered for a significant weight loss. The DON verified the physician and dietitian were not notified of her weight loss. Review of the policy 'Weight/Reweigh policy' undated, revealed the monthly weight was to be obtained by the nursing staff for all residents by the seventh day of the month. Reweighing of a resident was to be completed when there was a five pound weight change for a resident who weighed under 100 pounds. The family, resident, and physician were to be notified of any significant weight variance by the nursing staff and the notification was to be documented in the medical record. 3. Review of Resident #19's medical record revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, cognitive communication deficit, aphasia, schizoaffective disorder, unspecified dementia, major depression, hypertension, and obsessive compulsive behavior (psychotic disorder with obsessive). Review of Resident #19's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had severely impaired cognition. He'd had no falls since previous assessment. He weighed 157 pounds and had no significant weight changes. Review of Resident #19's plan of care dated 07/22/24 revealed he was at risk for altered nutrition related to his diagnoses and diuretic use that may lead to a weight fluctuation. On 06/13/24 he triggered for significant weight loss; however, this was determined to be inaccurate based on his usual weights, he had a history of refusing weights. Interventions included maximizing self-feeding using adaptive as ordered, meal alternatives as needed, supplements as ordered, and diet as ordered. Review of Resident #19's weights revealed 03/05/24 he weighed 176 pounds, on 04/01/24 he weighed 157.2 pounds, and on 06/05/24 he weighed 157.2 pounds. There were no further weights listed from 03/01/24 to 09/25/24. Review of the progress notes for May 2024, July 2024, August 2024, and from 09/01/24 to 09/25/24 revealed no documentation that Resident #19 had refused to have his weight obtained. Additionally, there was no evidence the physician was notified that Resident #19 refused a weight. Interview on 09/26/24 at 1:12 P.M. with the Director of Nursing (DON) revealed she had spoken to a nurse that usually worked with Resident #19 and they reported he sometimes refused all kinds of care including weights. The nurse had told the DON she had not documented these instances. The DON verified there was no evidence Resident #19 was refusing the weights or that the physician was notified. Review of the policy 'Weight/Reweigh policy' undated, revealed the monthly weight was to be obtained by the nursing staff for all residents by the seventh day of the month.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and medical record review the facility failed to ensure nonpharmacological interventions were attempted and documented prior to administering 'as needed' anxiety medication. This affected one resident (#2) of five residents reviewed for unnecessary medications. The facility census was 61. Findings include: Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses including senile degeneration of brain, unspecified fracture of left talus (08/23/24), dislocation of internal left hip prosthesis, unspecified dementia, hypertension, depression, anxiety disorder, chronic kidney disease. chronic pain, and overactive bladder. Review of Resident #2's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed intact cognition. Review of Resident #2's plan of care dated 09/06/24 revealed the resident received psychotropic medications including an antidepressant and antianxiety medication. Interventions included physician and pharmacist to review medication and dosage, work with the physician if any possibility of reduction exists according to their assessment, and observing for side effects. Review of Resident #2's physician order dated 08/22/24 revealed an order for Lorazepam (antianxiety) 0.5 milligrams (mg) four times a day as needed. Review of Resident #2's Medication Administration Record (MAR) from 08/25/24 to 09/24/24 revealed Lorazepam 0.5 milligrams (mg) 'as needed' was administered once on 08/25/24 and 08/26/24, twice on 08/27/24, once on 08/28/24, 08/29/24, 08/31/24, 09/01/24, and 09/02/24, twice on 09/03/24 and 09/04/24, once on 09/07/24, 09/12/24, 09/15/24, 09/16/24, and 09/17/24, twice on 09/18/24, once on 09/21/24, and twice on 09/22/24. Review of the administration documentation revealed nonpharmacological interventions were only documented on 08/25/24. Interview on 09/25/24 at 2:27 P.M. with the Director of Nursing (DON) verified nonpharmacological interventions were not documented and should have been.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on record review, facility staff interview and policy review the facility failed to ensure one (Resident #42) timely received speech therapy services regarding a change in nutritional condition/status. This affected one of five residents reviewed for nutrition. The facility census was 61. Findings Include: Review of Resident # 42's medical record revealed an admitted [DATE]. Further review revealed diagnoses of chronic obstructive pulmonary disease, unspecified, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Dysphagia, oropharyngeal phase, diabetes and encounter for attention to gastrostomy tube. Review of the Minimum Data Set, dated dated dated [DATE] revealed Resident #42 had a feeding tube and was receiving a mechanically altered diet. Review of Resident #42's physician's orders revealed an order dated 06/07/24 that read moist mechanical soft (no breads) with nectar thick liquids. Review of Resident #42's nursing progress notes dated 07/23/24 revealed the resident was noted to have difficulty swallowing the mechanical soft diet and was downgraded to a pureed diet until a recommendation was provided by the speech language pathologist (SLP). Review of Resident #42's physician's orders revealed an order dated 07/23/24 read regular pureed with nectar thick liquids. Review of Resident #42's medical records from 07/23/24 to 09/26/24 revealed evidence that SLP #303 was notified of Resident #42's swallowing issue. Further review of Resident #42's medical record revealed no evaluation, or treatment was completed by SLP #303 from 07/23/24 to 09/26/24. Interview with SLP #303 on 09/26/24 at 11:00 A.M. revealed she was not aware Resident #42 had experienced swallowing issues and had a change made in the consistency of his diet on 07/23/24 until the week of 09/23/24. SLP #303 stated that she would have seen the resident at the time of the swallowing issue and diet change if she had been aware. Interview with the Director of Nursing (DON) on 09/26/24 at 12:14 P.M. revealed the process for diet changes related to swallowing issues, was for the nurse to put in the order for the diet change and then the DON would print the order and give it to therapy in the next facility morning meeting. She further stated she did not know how the order from 07/23/24 was missed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observation, record review, facility staff interview and policy review the facility failed to ensure appropriate hand hygiene was conducted during medication administration for Resident #105 of three reviewed (#28 and #104), and the facility failed to ensure enhanced barrier precautions were in placed and followed for three (Resident #2, #19 and #104) of three reviewed for EBP. The facility census was 61. Findings include: 1. Review of the medical record for Resident #105 revealed an admitted [DATE] with diagnoses not limited to metabolic encephalopathy, vascular dementia, hypertension, pneumonia and gastro-esophageal disease. Review of Minimum Data Set (MDS) 3.0 assessment completed 09/21/24 revealed Resident #105 was moderately cognitively impaired. Observation of medication administration on 09/24/24 at 7:37 A.M. with Registered Nurse (RN) Supervisor #207 revealed after administering Resident #105's medication, hand hygiene was not performed. RN Supervisor #207 arrived at the nurse's cart, unlocked it, and began reviewing the Medication Administration Record (MAR) for Resident #105. Once completed, this RN removed the prepackaged medication pouch, along with medication cards and a shared facility bottle of vitamins from the cart. The medications prepared were Amlodipine (used to treat high blood pressure), Calcium Citrate (supplement), Cholecalciferol (vitamin), Clopidogrel (prevents blood clots), Docusate Sodium (stool softener), Ezetimibe (lowers cholesterol), Magnesium Oxide (supplement), Memantine (used to treat dementia), Pantoprazole (used to treat acid reflux), and Metoprolol (used to treat high blood pressure). When all medications were gathered into the cup, the nurse poured the resident a glass of water and locked the cart. The nurse entered the room without performing hand hygiene and assisted Resident #104 with taking the medications. Once they were taken, RN Supervisor #207 exited the room without performing hand hygiene. Interview on 09/24/24 at 8:32 A.M. with RN Supervisor #207 confirmed hand hygiene was not conducted upon entry to Resident #105's room or upon exit. Interview on 09/24/24 at 10:22 A.M. with the Assistant Director of Nursing #200 confirmed hand hygiene should be conducted before preparing residents' medications and after exiting residents' rooms. Review of Resident #105's service plan dated 09/14/24 revealed staff should encourage/assist resident with proper hand hygiene and staff to maintain infection precautions per order. Review of hand washing/hand hygiene policy undated revealed hand hygiene should be conducted before direct contact with residents, before preparing or handling medications, after contact with residents intact skin and after contact win inanimate objects. 2. Review of the medical record for Resident #104 revealed an admitted [DATE] with diagnoses not limited to osteoarthritis, cognitive communication deficit, need for assistance with personal care, bradycardia and acute kidney failure. Review of Minimum Data Set (MDS) 3.0 assessment completed 09/17/24 revealed he was moderately cognitively impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of medication administration on 09/24/24 at 7:47 A.M. with Registered Nurse (RN) Supervisor #207 revealed a large bottle of hand sanitizer was present on the nurse's cart. The nurse reviewed the medication administration records for medications to be given to Resident #104. Informed a blood pressure measurement would need to be obtained prior to preparing the medication, RN Supervisor #207 grabbed the blood pressure cuff off the med cart and entered Resident #104's room. Posted on the room door was an enhanced barrier precautions sign, indicating staff are required to perform hand hygiene before entering and upon exiting the room. RN Supervisor #207 introduced herself and informed the resident a blood pressure measurement would need to be obtained. The nurse placed the blood pressure cuff with contaminated hands and without gloves. Upon exiting the room, hand hygiene was not conducted, and the nurse began preparing medications. When the medication preparation was completed, RN Supervisor #207 locked the cart and entered the room without performing hand hygiene. Upon entry, a family member was asking about the precautions listed on the door. RN Supervisor #207 informed the family there was no awareness of any restrictions and would speak with the Director of Nursing about the isolation. Upon exit, hand hygiene was not conducted. Interview on 09/24/24 at 8:28 A.M. with RN Supervisor #207 and the Director of Nursing (DON) revealed for residents on enhanced barrier precautions, staff are required to perform hand hygiene prior to entrance and after exiting the room. The DON informed the RN the precautions are implemented for residents with wounds or drains. Interview on 09/24/24 at 8:32 A.M. with RN Supervisor #207 confirmed hand hygiene was not conducted upon entry to Resident #104's room or upon exit. Review of Resident #104 physician orders dated 09/24/24 revealed the resident was on enhanced barrier precautions. Review of Resident #104 care plan dated 09/24/24 revealed the resident requires enhanced barrier precautions related to chronic wound. Approaches of post signage to alert caregivers of the need for enhanced barrier precautions, staff to perform frequent hand hygiene before and after patient contact/care, utilize the use of gowns and gloves during high contact resident care activities when in room. Review of enhanced barrier precautions policy dated 04/01/24 revealed hand hygiene is to be preformed frequently and prior to exiting the room. 43064 3. Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses including senile degeneration of brain, unspecified fracture of left talus, dislocation of internal left hip prosthesis, unspecified dementia, depression, anxiety disorder, chronic kidney disease, and overactive bladder. Review of Resident #2's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. She was 60 inches tall and weighed 115 pounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366367	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Canal Winchester Post-Acute Rc	6725 Thrush Drive Canal Winchester, OH 43110

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's wound grid dated 08/20/24 revealed she had a stage three pressure ulcer to the sacrum measuring 6.0 centimeters (cm) by 3.0 cm by 0.1 cm. Review of Resident #2's wound grid revised 09/24/24 revealed she had a stage three pressure ulcer to the sacrum measuring 0.3 cm by 0.5 cm by 0.1 cm. Review of Resident #2's medical record on 09/25/24 revealed there were no orders or plan of care for enhanced barrier precautions (EBP). Observation of Resident #2 on 09/23/24 at 10:00 A.M., 11:39 A.M., and 1:40 P.M. revealed EBP were not in place. There was no sign or personal protective equipment in or around Resident #2's room. Observation of Resident #2 on 09/24/24 at 8:37 A.M., 10:03 A.M., 11:12 A.M. and 1:30 P.M. revealed EBP were not in place. There was no sign or personal protective equipment in or around Resident #2's room. Observation of Resident #2 on 09/26/24 at 8:59 A.M. and 10:19 A.M. revealed EBP were not in place. There was no sign or personal protective equipment in or around Resident #2's room. Interview on 09/26/24 at 10:19 A.M. with the Director of Nursing (DON) verified EBP were not in place and should be due to her pressure ulcer. 4. Review of Resident #19's medical record revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, cognitive communication deficit, aphasia, schizoaffective disorder, unspecified dementia, major depression, hypertension, and obsessive-compulsive behavior (psychotic disorder with obsessive). Review of Resident #19's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had severely impaired cognition. He was on an antipsychotic and antidepressant. He had no pressure ulcers. Review of Resident #19's wound note dated 09/17/24 revealed the resident had a stage three pressure ulcer to the sacrum that had been present for more than 10 days. It measured 0.6 centimeters (cm) by 0.8 cm by 0. 2 cm. Observation on 09/23/24 at 9:40 A.M. and on 09/24/24 at 8:43 A.M. revealed no EBP were in place. There was no sign or personal protective equipment in or around Resident #19's room. Review of #19's plan of care dated 09/24/24 revealed he required enhanced barrier precautions related to a chronic wound. Interventions included observing the resident for signs of infection, educating the resident on EBP precautions, EBP supplies to be placed in their room, posting signage to alert caregivers, and utilizing the use of PPE, gowns and gloves during high contact resident care activities when in room. Review of Resident #19's physician order dated 09/24/24 revealed an order for EBP. Observation on 09/25/24 at 10:00 A.M. revealed EBP sign was posted in Resident #19's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366367	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Canal Winchester Post-Acute Rc	6725 Thrush Drive Canal Winchester, OH 43110

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/26/24 at 10:19 A.M. with the Director of Nursing (DON) verified Resident #19 had not had EBP in place prior to 09/24/24. Review of the policy titled Enhanced Barrier Precautions Policy dated dated 04/01/24 revealed: The Facility will utilize Enhanced Barrier Precautions (EBP) as part of their infection prevention and control program to help prevent the development and transmission of communicable disease and infections. Enhanced Barrier Precautions (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in co junction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO) to staff hands and clothing. EBP are indicated for residents with any of the following: Infection or colonization when Contact Precautions do not otherwise apply; or Chronic Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized. For the purpose of this policy, chronic wounds do not include shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. Examples of chronic wounds include pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers