STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366400	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beavercreek Health and Rehab	3854 Park Overlooke Drive Beavercreek, OH 45431

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 0686 Level of Harm - Minimal harm or potential for 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** 46613 Based on medical record review, staff interviews and policy review, the facility failed to ensure a newly identified skin issue was assessed timely and treatments were initiated. The facility also failed to ensure treatments to a pressure ulcer were completed as ordered. This affected one (#30) out of the three residents reviewed for pressure ulcers. The facility census was 70. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE] with medical diagnoses of nontraumatic intracerebral hemorrhage, chronic respiratory failure, left hemiplegia, vascular dementia, anxiety, and depression. Review of the medical record for Resident #30 revealed a Minimum Data Set (MDS) assessment, dated 10/01/24, which indicated Resident #30 had severe cognitive impairment and was dependent for all activities of daily living (ADL's). The MDS indicated Resident #30 did not have a pressure ulcer. Review of medical record for Resident #30 revealed physician orders dated 10/10/24 for left knee brace, staff to apply during day shift as tolerated for up to eight hours which was discontinued on 10/30/24 and an order to monitor skin on left knee for any redness due to knee brace every shift. Further review of the physician orders revealed an order dated 11/01/24 to cleanse left knee with normal saline or wound cleanser and apply betadine daily. Review of the medical record for Resident #30 revealed a Braden assessment which indicated Resident #30 was at high risk for skin breakdown. Review of the medical record for Resident #30 revealed Treatment Administration Record (TAR) for October 2024 which revealed no documentation to support the facility completed left knee skin checks as ordered on 10/24/24, 10/26/24, 10/28/24, or 10/29/24. Further review of the October 2024 TAR revealed documentation to support the facility applied Resident #30's left leg brace from 10/10/24 until discontinued on 10/30/24. Review of the November 2024 TAR revealed no documentation to support the facility completed wound care to Resident #30's left knee on 11/02/24, 11/03/24, 11/04/24, 11/05/24, 11/08/24, 11/09/24, 11/15/24, and 11/17/24. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Beavercreek Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3854 Park Overlooke Drive Beavercreek, OH 45431	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #30 revealed a Physical Therapy note dated 10/16/24 which stated passive range of motion (PROM) to left knee and left hip were completed. The note stated left orthotic donned with new scab to left knee. The note continued to state left orthotic doffed, and plan was to continue with PROM until left knee healed. The note stated the nurse was notified of the new scab with redness to Resident #30's left knee. Review of the medical record for Resident #30 revealed Physical Therapy notes dated 10/23/24 which stated red scab to left knee, a note dated 10/24/24 which stated checked skin integrity before donning orthotic to left lower extremity, a note dated 10/25/24 which stated Resident #30 tolerated orthotic being donned yesterday for five hours and scab intact to left knee, and lastly a note dated 10/30/24 which stated during PROM Resident #30's left knee appeared to be redder and more inflamed. The note continued to state noted necrotic scab intact but discoloration around area and new thinning of skin noted. The note stated Resident #30's nurse was notified and would not apply orthotic until area was healed. Review of the medical record for Resident #30 revealed a nurses' note dated 10/30/24 at 10:13 A.M. which stated Resident #30's left knee has red area, so therapy notified to discontinue brace. Review of the medical record for Resident #30 revealed weekly skin assessment dated [DATE], 10/22/24, and 10/29/24 all indicated Resident #30's skin was intact, and no skin issues were noted. Further review of the medical record for Resident #30 revealed a Weekly Pressure Ulcer documentation assessment, dated 11/01/24, which stated Resident #30 have an unstageable pressure ulcer to left knee (front) which measured 6 centimeters (cm) by 6 cm by less than 0.1 cm, necrotic. Review of the Weekly Pressure Ulcer documentation assessment dated [DATE] stated Resident #30's left knee unstageable pressure ulcer was healing and measured 3.5 cm by 3.0 cm with necrotic tissue. Review of the medical record for Resident #30 revealed a Wound Physician progress note, dated 10/30/24, which stated Resident #30 had an unstageable pressure ulcer to left knee (necrotic) which measured 6 cm by 6 cm. The note stated Resident #30 was wearing a brace to left leg to straighten her knee and was noted to have a pressure wound to anterior knee where brace was placed. The wound was described as central area of black dry eschar with surrounding deep tissue injury changes. Review of the Wound Physician note dated 11/13/24 stated Resident #30 continued with unstageable pressure ulcer to left knee which measured 3.5 cm by 3 cm and the wound was healing. Interview on 11/19/24 at 8:15 A.M. with Physical Therapy Manager (PTM) #182 confirmed Resident #30's physical therapy note dated 10/16/24 was written by Physical Therapist (PT) #180 and the note indicated Resident #30 had a scab to her left knee, the orthotic was doffed, and the nurse was notified. Interview on 11/19/24 at 8:45 A.M. with Assistant Director of Nursing (DON) #143 confirmed the medical record for Resident #30 did not contain documentation to the facility completed left knee skin checks as ordered on 10/24/24, 10/26/24, 10/28/24, or 10/29/24. ADON #143 also confirmed the medical record for Resident #30 did not contain documentation to support wound care to the left knee unstageable pressure ulcer was completed as ordered on 11/02/24, 11/03/24, 11/04/24, 11/05/24, 11/08/24, 11/09/24, 11/15/24, and 11/17/24. ADON #143 stated he was not aware Resident #30 had any skin breakdown to left knee until after 10/30/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/19/24 at 10:10 A.M. with [NAME] President of Clinical (VPC) #108 confirmed the physical therapy note, dated 10/16/24, indicated Resident #30 was noted to have a skin issue to left knee and that the nurse was notified. VPC #108 confirmed Resident #30's medical record contained documentation to support the facility continued to place brace to left leg until the order was discontinued on 10/30/24. Interview on 11/19/24 at 10:21 A.M. with PT #180 via phone confirmed she provided treatment for Resident #30 on 10/16/24 when she observed a scab to Resident #30's left knee. PT #180 stated the scab was about the size of a dime and stated she notified the nurse on the hall that day but could not remember the name of the nurse. PT #180 stated the ADON #143 was also present when the nurse was notified of the scab to Resident #30's knee. PT #180 stated the nursing staff were informed to no longer place the brace to Resident #30's left leg until the wound healed. Review of the facility policy titled, Prevention of Pressure Injuries, revised April 2020, stated to inspect resident's skin on a daily basis when performing or assisting with personal cares or ADL's and identify any signs of developing pressure injuries. The policy stated review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device and to monitor regularly for comfort and signs of pressure-related injury. This deficiency represents non-compliance investigated under Complaint Number OH00159378 and Complaint Number OH00158451.

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NAME OF PROVIDER OR SUPPLIER: Beavercreek Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 3854 Park Overlooke Drive Beavercreek, OH 45431	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and policy review, the facility failed to ensure medications were administered as ordered. This affected one (#75) out of five residents reviewed for medication administration. The facility census was 70. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] with medical diagnoses of chronic obstructive pulmonary disease, heart failure, atrial fibrillation, dementia with psychosis, paranoid schizophrenia, and diabetes mellitus. Review of the medical record revealed Resident #75 enrolled onto Hospice services [DATE] and expired on [DATE]. Review of the medical record for Resident #75 revealed a significant change Minimum Data Set (MDS) assessment, dated [DATE], which indicated Resident #75 had severe cognitive impairment and required substantial/maximum assistance for eating and bed mobility and was dependent upon staff for toilet hygiene and bathing. The MDS indicated Resident #75 did not transfer during the review window. Review of the medical record for Resident #75 revealed a physician order dated [DATE] for Morphine Sulfate (MSO4) 10 milligram (mg) per milliliter (ml) to give 0.25 ml by mouth three times per day for pain or shortness of breath. Review of the medical record for Resident #75 revealed the Medical Administration Record (MAR) for [DATE] which indicated Resident #75 received the MSO4 three times a day as ordered daily from [DATE] to [DATE]. Further review of Resident #75's Controlled Drug Record revealed no documentation to support the facility administered the MSO4 for the 2:00 P.M. on [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of the Controlled Drug Record for Resident #75's MSO4 revealed no concerns related to the amount of MSO4 signed out daily and the amount remaining in the medication bottle daily. Interview on [DATE] at 3:07 P.M. with Licensed Practical Nurse (LPN) #155 confirmed she documented on Resident #75's MAR that he received the 2:00 P.M. doses of MSO4 on [DATE], [DATE], [DATE], [DATE], and [DATE]. LPN #155 confirmed Resident #75's Controlled Drug Record did not contain documentation to support the MSO4 was administered at 2:00 P.M. on [DATE] through [DATE]. LPN #155 stated she did not administer Resident #75's 2:00 P.M. doses of MSO4 on [DATE] through [DATE] because Resident #75 was usually sleeping or resting comfortably at the time of the administration. LPN #155 stated she was not sure why she documented on the MAR that the MSO4 was administered instead of writing a progress note as to why the medication was not administered. Review of the facility policy titled, Medication Administration, revised [DATE], stated medications are administered in a safe and timely manner and as prescribed. The policy stated medications are to be administered in accordance with prescriber's orders, including any required time frame. The policy stated if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document appropriately on the resident Medication Administration Record (MAR). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00158451.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observations, staff interviews, and policy review, the facility failed to follow infection control procedures for a resident in Contact Precautions. This affected one (#13) out of three residents reviewed for wound care. The facility census was 70. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE] with medical diagnoses of alcoholic cirrhosis of liver, chronic obstructive pulmonary disease, chronic Hepatitis C, resistant to multiple antibiotics, and carrier or suspected carrier of Methicillin-resistant staphylococcus aureus (MRSA). Review of the medical record for Resident #13 revealed an admission Minimum Data Set (MDS) assessment, dated 09/16/24, which indicated Resident #13 was cognitively intact and required set-up assistance for all activities of daily living. Review of the medical record for Resident #13 revealed a physician order dated 09/10/24 for Contact Precautions. Review of the medical record for Resident #13 revealed physician orders dated 09/12/24 to cleanse right lateral calf, right medial shin, left medial calf, left anterior shin with normal saline, apply xerofoam, cover with abdominal pad, and wrap with kerlix daily. Further review, revealed a physician order dated 10/16/24 to right abdominal Pleurex drainage catheter dressing change when drained and to cleanse with normal saline, apply gauze and cover with Tegaderm and an order dated 11/16/24 to cleanse right dorsal second toe with normal saline and apply skin prep daily. Review of the medical record for Resident #13 revealed weekly non-pressure documentation dated 11/13/24 which stated Resident #13 had vascular ulcers to right dorsal second toe, left anterior shin, left medial calf, right lateral calf, and right medial shin with drainage noted. Review of the medical record for Resident #13 revealed a comprehensive care plan dated 09/24/24 which stated Infection actual or at risk related to pneumonia. Carrier or suspected carrier of MRSA. Interventions included isolation cart and signage on the resident's door and to follow standard precautions. Further review revealed a care plan dated 09/12/24 which stated Resident #13 had wounds to left anterior shin, left medial calf, right lateral calf, right lateral ankle, left upper shin and right medial shin. The care plan stated Resident #13 chooses not to allow staff to complete dressing changes at times. Interventions included treatments as ordered. Review of the medical record for Resident #13 revealed no lab results to confirm the MRSA to her wounds was colonized. Review of the medical record for Resident #13 revealed hospital documentation dated 09/10/24 which stated Resident #13 was under Contact Precautions related to MRSA to left and right leg wounds and extended-spectrum beta-lactamase (ESBL) to left and right leg wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/18/24 at 8:39 A.M. revealed a Contact Precaution sign posted on Resident #13's door and an isolation cart located outside of Resident #13's room with personal protective equipment (PPE). The observation revealed State tested Nursing Assistant (STNA) #102 enter Resident #13's room without donning any PPE. STNA #102 was observed speaking with Resident #13 and taking Resident #13's breakfast tray out of her room. STNA #102 was not observed performing hand hygiene prior to exiting Resident #13's room or after placing breakfast tray in cart in the hallway. Interview on 11/18/24 at 8:42 A.M. with STNA #102 confirmed Resident #13 had a Contact Precaution sign posted on her door and an isolation cart located outside of the room. STNA #102 confirmed she did not donn PPE prior to entering Resident #13's room nor did she perform hand hygiene after leaving Resident #13's room. STNA #102 stated she thought Resident #13 was only on Enhanced Barrier Precautions not Contact Precautions. Interview on 11/18/24 at 3:18 P.M. with [NAME] President of Clinical (VPC) #108 confirmed the medical record for Resident #13 did not contain documentation to support MRSA was colonized. VPC #108 confirmed Resident #13 continued with vascular wounds to bilateral lower extremities and Resident #13 refused treatments at times and preferred to complete the treatments herself. VPC #108 stated Resident #13 was educated on proper wound care but probably should remain in Contact Precautions due to risk for infection control concerns when Resident #13 completed her own wound care. Review of the facility policy titled, Isolation- Categories of Transmission Based Precautions (TBP), stated TBP are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. The policy stated Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The policy stated staff and visitors wear gloves (clean, non-sterile) when entering the room and gloves are to be removed and hand hygiene performed before leaving the room. The policy also stated staff and visitors would wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. This deficiency is based on incidental findings discovered during the course of this complaint investigation.