STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366462	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal Winchester Care Center	6800 Gender Road 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, interview, and facility policy review, the facility failed to ensure the primary care physician (PCP) was notified of elevated blood glucose levels outside of the physician ordered parameters. This affected one resident (#16) of five residents reviewed for unnecessary medications. The facility census was 80. Findings include: Review of the medical record for Resident #16 revealed an initial admitted [DATE] with the latest readmission of 04/05/24 with diagnoses including osteomyelitis, dysphagia, chronic obstructive pulmonary disease, diabetes mellitus, asthma, maple syrup urine disease, dissociative identity disorder, chronic kidney disease, hyperlipidemia, and hypertension. Review of the plan of care dated 08/23/22 revealed Resident #16 was at risk for hypo/hyperglycemia episodes. Interventions included accu-checks as ordered, administer medications as ordered, lab results as ordered with reported to PCP, monitor for signs/symptoms of hyperglycemia and hypoglycemia, monitor for signs/symptoms of infection, and notify physician of abnormal blood glucose monitoring results per order. Review of Resident #16's monthly physician orders for April 2024 identified an order dated 04/05/24 to obtain blood glucose before meals and at bedtime for blood glucose monitoring and blood glucose levels less than 60 or greater than 200, notify the resident's physician. Review of the resident's April 2024 MAR revealed on 04/05/24 at 9:00 P.M., the resident's blood glucose level was 218, on 04/07/24 at 9:00 P.M., the resident's blood glucose level was 225, on 04/10/24 at 9:00 P.M. , the resident's blood glucose level was 237, on 04/11/24 at 9:00 P.M., the resident blood glucose level was 248, on 04/12/24 at 7:00 A.M., the resident's blood glucose level was 208 and on 04/13/24 at 9:00 P.M., the resident's blood glucose level was 215. Review of the resident's medical record revealed no documented evidence that the resident's physician was notified of blood glucose levels above 200 in the month of April 2024. On 04/17/24 at 2:33 P.M., interview with Licensed Practical Nurse (LPN) #297 verified the resident's physician was not notified of the blood glucose levels above the physician ordered parameter of 200. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Change in Condition Notification, dated 08/09/23, revealed it was the policy of the facility to notify the resident, his or her attending physician/practitioner and the resident's designated representative of changes in the resident's medical/mental condition and/or status. This deficiency represents non-compliance investigated under Complaint Number OH00152459.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, observation, interviews and facility policy review, the facility failed to ensure nail care was provided for Resident #22 who was dependent on staff. This affected one resident (#22) of three residents reviewed for activities of daily living (ADL). The facility census was 80. Findings include: Review of the medical record for Resident #22 revealed an initial admitted [DATE] with diagnoses including cerebral infarction, chronic kidney disease, chronic obstructive pulmonary failure, anemia, diabetes mellitus, hyperlipidemia, hypertension, depression, insomnia, allergic rhinitis, constipation, pain, and dysphagia. Review of the plan of care dated 01/26/24 revealed Resident #22 had a self-care performance deficit related to ADL, abilities will fluctuate between therapy staff and nursing staff, confusion, fatigue, impaired balance, limited mobility, limited range of motion, and stroke. Interventions included ADL level varies with task and time of day, may provide more assistance at times to maintain safety as needed, bilateral floor mats while resident is in bed, discuss with resident/family/power of attorney (POA) any care concerns related to loss of independence, decline in function, assist with eating, toileting, personal hygiene, bathing, bed mobility, and wheelchair mobility every shift and as needed, one person assist with bathing, avoid scrubbing and pat dry sensitive skin, check nail length and trim and clean on bath day and as necessary, provide sponge bath when a full bath or shower cannot be tolerated, one person assist with personal hygiene, bed mobility, dressing, toileting, encourage the resident to participate to the fullest extent possible with each interaction, and transfer with mechanical lift and two assists. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had a moderate cognitive deficit. On 04/15/24 at 10:33 A.M., observation of Resident #22 revealed her fingernails were long, jagged, and dirty with a brown substance under the nails. On 04/17/24 at 9:18 A.M., observation of Resident #22 revealed her fingernails remained long, jagged, and dirty with a brown substance under the nails. On 04/17/24 at 9:23 A.M. interview with Registered Nurse (RN) #269 verified Resident #22's fingernails were long, jagged, and dirty with a brown substance under the nails. Resident #22 revealed she would like to have her nails cleaned as she was not able to get the brown substance from under her fingernails. Review of the facility policy titled, Nail Care, dated 04/16/13, revealed it was the facility's policy to clean the nail bed, to keep nails trimmed and to prevent infections. It was the responsibility of the RN, Licensed Practical Nurse (LPN) and/or State tested Nursing Assistant (STNA)to provide appropriate nail care as needed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, interview, record review, and facility policy review, the facility failed to identify an injury to Resident #35's left great toe and toenail. This deficient practice affected one resident (#35) out of two residents reviewed for general skin conditions. The facility census was 80. Findings include: An observation on 04/15/24 at 12:38 P.M. revealed Resident #35's left great left toe covered with a gauze bandage and secured with a piece of tape. There were no initials, date, or time written on the bandage. An observation on 04/16/24 at 2:26 P.M. revealed Licensed Practical Nurse Unit Manager (LPN UM) #205 removing the gauze bandage from Resident #35's left great toe. There was dark red drainage noted to the gauze bandage. Resident #35's left great toenail was observed to be thick and long curving towards the inside of the foot. There was dried dark red drainage observed on the outside edges of the toenail. The toenail was intact with no evidence of being trimmed or filed recently. Review of Resident #35's medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Lewy Bodies disorder, Alzheimer's disease, high blood pressure, and chronic obstructive pulmonary disease (COPD). Resident #35 had impaired cognition and was dependent on staff for care. Review of Resident #35's signed physician orders for the month of April 2024 revealed Resident #35 was admitted to hospice services for neurocognitive disorder with Lewy Bodies disease on 08/31/23. There were no orders for a treatment to Resident #35's left great toenail. Review of Resident #35's weekly skin assessment dated [DATE] at 5:00 P.M. revealed no new skin areas were observed. Review of Resident #35's progress notes dated 04/01/24 to 04/15/24 revealed there were no entries or documentation of Resident #35's left great toe skin injury requiring treatment of a bandage. Review of a podiatry visit progress note dated 04/04/24 revealed Resident #35 refused podiatry services on 04/04/24. Interview on 04/15/24 at 12:35 P.M. with Resident #35's spouse revealed there was a bandage on Resident #35's left great toe, and there had been no explanation from the facility staff as to why the bandage was in place on Resident #35's left great toe. Interview on 04/16/24 at 2:26 P.M. with LPN UM #205 revealed Resident #35 had refused podiatry services on 04/04/24. LPN UM #205 confirmed Resident #35's bandaged left great toe and the lack of treatment orders and progress notes related to bandaged left great toe. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/24 at 9:04 A.M. with the Director of Nursing (DON) revealed the investigation into Resident #35's bandaged left great toe results were at sometime within the last several days Resident #35 had gotten the toe caught in the bed covers causing the toenail to bleed. As of 04/16/24 the was a treatment order for Resident #35's left great toe to be cleansed with normal saline, swab with betadine, and leave open to the air until resolved. Review of the facility's policy titled Skin and Wound Guidelines, revised 03/20/24, revealed skin alterations and pressure injuries are evaluated and documented by the licensed nurse.

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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** 32654 Based on medical record review, observation, interview and facility policy review, the facility failed to ensure pressure reducing devices were in place for Resident #17. This affected one resident (#17) of three residents reviewed for pressure ulcers. The facility census was 80. Findings include: Review of the medical record for Resident #17 revealed an initial admitted [DATE] with the latest readmission of 01/28/24 with diagnoses including but not limited to osteomyelitis left ankle and foot, asthma, dementia, diabetes mellitus, chronic kidney disease, atrial flutter, anxiety disorder, spinal stenosis, convulsions, hypertension, dry eye syndrome, and gout. Review of the plan of care dated 11/24/23 revealed Resident #17 had actual impairment to skin related to fragile skin, incontinence, dementia, diabetes mellitus, chronic kidney disease, weakness, aging process, decreased mobility, decreased safety awareness, need for assistance, and right lateral malleolus was surgical, but documentation previously put as a pressure ulcer. X-ray was done and verified osteomyelitis, surgery completed to treat osteomyelitis and was previously on intravenous (IV) antibiotics. Interventions included treatment as ordered, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, complete Braden scale for predicting pressure ulcer per facility policy, educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage good nutrition and hydration in order to promote healthier skin, float heels from bed to reduce pressure , follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry, use lotion on dry skin, turn/reposition regularly to relieve pressure points and use caution during transfer and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of Resident #17's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was at risk for skin breakdown and had an unhealed pressure ulcer present on admission. The resident also had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) present on admission. The assessment indicated the resident had an infection to his foot. The facility implemented the interventions pressure reducing device to bed, application of nonsurgical dressings, applications of ointments/medications other than to feet, and application of dressings to feet. Review of the weekly skin and wound evaluation dated 03/20/24 revealed Resident #17 had a surgical wound to the left achilles that was present on admission. The wound measured 1.9 centimeters (cm) by 0.9 cm and described as being 50% granulation tissue and 50% slough. The wound was noted to have a moderate amount of serous draining. The facility documented the surgical incision had no depth but did have a cliff appearance to the wound edges. The resident was unable to follow-up with the podiatrist due to having clostridium difficile (c-diff), a bacterium that causes diarrhea and inflammation of the colon. The resident's appointment was rescheduled. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weekly skin and wound evaluation dated 03/27/24 revealed Resident #17 had a surgical wound to the left achilles that was present on admission. The wound measured 3.5 cm by 1.0 cm and described as being 50% granulation tissue and 50% slough. The wound was noted to have a moderate amount of serosanguinous drainage. The facility determined the wound was stable and had no change in plan of treatment. Review of the weekly skin and wound evaluation dated 04/03/24 revealed Resident #17 had a surgical wound to the left achilles that was present on admission. The wound measured 3.0 cm by 0.7 cm and described as being 50% granulation tissue and 50% slough. The wound was noted to have a moderate amount of serosanguinous drainage. The facility determined the wound had improved and had no change in plan of treatment. Review of the weekly skin and wound evaluation dated 04/10/24 revealed Resident #17 had a surgical wound to the left achilles that was present on admission. The wound measured 2.8 cm by 0.8 cm and described as being 50% granulation tissue and 50% slough. The wound was noted to have a moderate amount of serosanguinous drainage. The facility determined the wound had improved and had no change in plan of treatment. Review of Resident #17's monthly physician orders for April 2024 identified orders dated 01/31/24 house liquid protein 30 milliliters (ml) by mouth twice daily for wound healing, 03/06/24 cleanse the wound to the left achilles with normal saline (NS), pat dry, apply Medihoney, cover with calcium alginate, cover with abdominal (ABD) pad and wrap with Kerlix gauze. Wrap foot with ace wrap from toes to ankle until resolved. On 04/16/24 at 8:22 A.M., observation of Resident #17 revealed the heel protector care planned to be in place at all times was laying in the resident's wheelchair. Further observation revealed Resident #17 had no pressure reducing device to his left heel. On 04/16/24 at 12:46 P.M., observation of Resident #17 revealed the heel protector care planned to be in place at all times was still laying in the resident's wheelchair. Further observation revealed Resident #17 had no pressure reducing device to his left heel. On 04/16/24 at 1:00 P.M., interview with State tested Nursing Assistant (STNA) #323 verified Resident #17 had not had the care planned heel protector in place, and the resident's left achilles was laying directly on the bed. On 04/17/24 at 12:00 P.M., observation of Licensed Practical Nurse (LPN) #297 and LPN #239 provide the physician ordered treatment to the surgical incision to the left achilles revealed the bedside table was cleansed, a barrier was placed on the table and the required supplies were set-up. The staff washed their hands and donned disposable gloves. LPN #297 removed the ace wrap and the soiled dressing while LPN #239 supported the resident's left leg/heel off the bed. LPN #297 washed her hands and donned a pair of gloves. She then measured the wound at 1.4 centimeter (cm) by 0.3 cm. The depth of the wound was undetermined due to slough being present in the wound. LPN #297 washed her hands and donned a pair of gloves. She then cleansed the wound using normal saline and four by four gauze cleansing the wound in a circular motion. LPN #297 then washed her hands and donned a pair of gloves. The LPN then applied Medihoney to the wound using a sterile Q-tip. She then placed a piece of calcium alginate on the wound bed and covered the wound with an ABD pad. The LPN then wrapped the wound with Kerlix gauze and secured it with tape. She then applied the ace wrap from the toes to the ankle. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Skin and Wound Guidelines, dated last revised 03/20/24, revealed the individualized comprehensive care plan addresses the resident's problem, the goal for prevention and/or treatment and individualized interventions to address the resident's specific risk factors and the plan for reduction of risk.

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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** 32654 Based on medical record review, observation, interviews and facility policy review, the facility failed to ensure Residents #16 and #68 individualized fall preventative interventions were in place. This affected two residents (#16 and #68) of five residents reviewed for accidents. The facility census was 80. Findings include: 1. Review of the medical record for Resident #16 revealed an initial admitted [DATE] with the latest readmission of 04/05/24 with diagnoses including osteomyelitis, dysphagia, chronic obstructive pulmonary disease, diabetes mellitus, asthma, maple syrup urine disease, dissociative identity disorder, chronic kidney disease, hyperlipidemia, and hypertension. Review of the plan of care dated 08/23/22 revealed Resident #16 was at risk for falls and potential for injury related to confusion, conditioning, incontinence, poor communication/comprehension, cognitive impairment, diabetes mellitus, asthma, maple syrup urine disease, weakness, aging process, assistance devices and effects of medication per order. Interventions included anticipate needs every shift, bed against wall, bed to be in low position when in bed, Dycem (non-slip material) in Broda chair for safety, educate resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage resident to participate in activities that will promote exercise, physical activity for strengthening and improved mobility. evaluate, fall mat to floor, labs as ordered, and non-skid footwear to be worn when out of bed. Review of Resident #16's fall risk and injury prevention dated 01/10/24 revealed the resident was at risk for falls. Review of the plan of care dated 04/16/24 revealed Resident #16 was at risk for falls. Interventions included bed in low position when resident is in bed, call light within reach, and low bed. Review of Resident #16's monthly physician orders identified no orders related to fall interventions. On 04/15/24 at 10:50 A.M., observation of Resident #16 revealed the care planned individualized fall intervention of fall mat to floor was folded up and leaning against dresser across the room. State tested Nursing Assistant (STNA) #323 verified the care planned individualized fall intervention of fall mat to floor was not in place. Review of the facility policy titled, Fall Management Guidelines, dated 12/13/23, revealed a resident centered comprehensive care plan that addresses the fall management program, the goal for fall management, individualized interventions to address the resident's modifiable fall risk factors, interventions to try to minimize the consequences of risk factors that are not modifiable and the plan for reduction of risk and or risk for injury related to falls. 47569 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including history of breast cancer, dementia, chronic obstructive pulmonary disease (COPD), and history of falls. Resident #68 had moderately impaired cognition and was independent for most care and activities of daily living (ADL) tasks. Review of Resident #68's fall care plan initiated 05/24/23 revealed fall interventions implemented including Dycem to the wheelchair seat for safety dated 03/11/24, non-skid footwear to be worn when out of bed dated 05/24/23, non-skid strips placed at the side of the bed on the floor to help prevent feet from slipping when trying to stand dated 01/15/24, and the resident was non-compliant with asking for assistance for transfers dated 01/30/24. Review of Resident #68's Fall Risk and Injury Prevention assessment dated [DATE] revealed Resident #68 scored at 9 reflecting a moderate risk for falls. Review of Resident #68's medical record care profile revealed fall interventions list including Dycem to wheelchair seat for safety dated 03/11/24. An observation on 04/17/24 at 11:55 A.M. revealed Resident #68's wheelchair seat had a waffle air cushion lying on top of the foam pressure reducing cushion. Underneath the foam pressure reducing cushion were two packs of playing cards, several pieces of paper, and a magazine lying on the wheelchair vinyl seat. There were no pieces of Dycem on the vinyl seat or on the two cushions located on top of the vinyl seat. Interview on 04/17/24 at 1:28 P.M. with the Director of Nursing (DON) confirmed the absence of Dycem in the seat of Resident #68's wheelchair. The DON stated, The Dycem should be on top of the foam pressure reducing cushion instead of the air-filled waffle cushion. Review of the facility's policy titled, Fall Management Guidelines, dated 12/13/23, revealed the purpose of this policy is to provide guidelines to assist with fall risk identification and fall management of residents in the facility. This deficiency represents non-compliance investigated under Complaint Number OH00152459.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, interview, record review and facility policy review, the facility failed to have a physician's order for the use of oxygen for Resident #35. This deficient practice affected one resident (#35) out of two residents reviewed for respiratory care. The facility census was 80. Findings include: An observation on 04/16/24 at 12:43 P.M. revealed Resident #35 receiving oxygen via nasal cannula with tubing attached to an oxygen concentrator located at the bedside. The oxygen concentrator was set at four liters, and the oxygen tubing leading to Resident #35 was dated 04/14/24. Review of Resident #35's medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Lewy Bodies disorder, Alzheimer's disease, high blood pressure, and chronic obstructive pulmonary disease (COPD). Resident #35 had impaired cognition and was dependent on staff for care. Review of Resident #35's signed physician orders for the month of April 2024 revealed Resident #35 was admitted to hospice services for neurocognitive disorder with Lewy Bodies disease on 08/31/23. There were no orders for the use of oxygen for Resident #35. Review of Resident #35's Quarterly [NAME] Data Set (MDS) assessment dated [DATE] revealed in Section O Special Treatments and Procedures revealed oxygen use was not marked for Resident #35. Review of Resident #35's progress notes dated 04/01/24 to 04/16/24 revealed no documentation of Resident #35's use of oxygen. Review of Resident #35's care plan for the diagnosis of COPD dated 07/19/23 revealed no interventions documented for the use of oxygen. Interview on 04/16/24 at 2:26 P.M. with Licensed Practical Nurse Unit Manager (LPN UM) #205 confirmed Resident #35 was receiving oxygen via nasal cannula with the oxygen concentrator setting at four liters, and there were no physician orders for the use of oxygen for Resident #35. Review of the facility's policy titled Administration of Oxygen Policy, dated 09/25/13, revealed it is the center's policy to manage patient/residents utilizing oxygen per physician orders and clinical best practices.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, observation, interview and facility policy review, the facility failed to ensure a medication error rate of less than five percent. Twenty-nine opportunities for error were observed with three medication errors made resulting in a 10.34 percent error rate. This affected two residents (#17 and #19) of three residents observed during medication administration. The facility census was 80. Findings include: 1. Review of the medical record for Resident #19 revealed an initial admitted [DATE] with the latest readmission of 02/02/24 with diagnoses including but not limited to cerebrovascular accident with right sided hemiplegia, dysarthria and anarthria, dysphagia, atrial fibrillation, hypertension, chronic kidney disease, hyperlipidemia, anxiety disorder, major depressive disorder, dementia, hydrocephalus, gastro-esophageal reflux disease, epilepsy, congestive heart failure, and hypokalemia. Review of the plan of care dated 10/12/22 revealed Resident #19 had gastroesophageal reflux disease (GERD) related to hyperacidity. Interventions included give medications as ordered, monitor for side effects/effectiveness, monitor/document/report as needed signs/symptoms of GERD and obtain and monitor lab/diagnostic work as ordered, report results to physician and follow up as indicated. Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the monthly physician orders for April 2024 identified orders dated 02/02/24 Klor-Con M20 (potassium supplement) 20 milliequivalent's (mEq) by mouth twice daily and Famotidine (acid reducer) 20 milligrams (mg) by mouth daily. Observation on 04/16/24 at 8:27 A.M. of Licensed Practical Nurse (LPN) #281 prepare and administer Resident #19's morning medication revealed the LPN prepared and administered two Potassium Chloride 20 mEq totaling 40 mEq of Potassium Chloride by mouth. Further observation revealed the LPN prepared one Famotidine 10 mg and administered the medication when the physician orders read Famotidine 20 mg by mouth daily. Interview on 04/16/24 at 8:34 A.M. with LPN #291 verified she administered 10 mg of Famotidine instead of the physician ordered 20 mg of Famotidine. Interview on 04/16/24 at 9:33 A.M. with LPN #291 verified she administered 40 mEq of Potassium Chloride to Resident #19 instead of the physician ordered 20 mEq of Potassium Chloride. 2. Review of the medical record for Resident #17 revealed an initial admitted [DATE] with the latest readmission of 01/28/24 with the diagnoses including but not limited to osteomyelitis left ankle and foot, asthma, dementia, diabetes mellitus, chronic kidney disease, atrial flutter, anxiety disorder, spinal stenosis, convulsions, hypertension, dry eye syndrome, and gout. (continued on next page)

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	366462	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal Winchester Care Center	6800 Gender Road Canal Winchester, OH 43110

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #17's five-day MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of Resident #17's monthly physician orders for April 2024 identified orders dated 01/28/24 Cyclosporine Ophthalmic Emulsion 0.05 % with special instructions to instill one drop in right eye every 12 hours for eye dryness. Observation on 04/16/24 at 8:45 A.M. of LPN #291 administer Resident #17 his Cyclosporine Ophthalmic Emulsion 0.05 % revealed the LPN donned a pair of gloves when at the medication cart, picked up all medication entered the resident's room with a cup of medication, the individual use of eye drops and a cup of MIralax powder. The LPN placed the Miralax in a Styrofoam cup of ice water and administered the resident's medication all at once using the ice water with Miralax to swallow the medication. The LPN using the same gloves pulled the resident's left lower eye lid down and placed one drop into the eye. The LPN then moved to right eye and using the same gloves pulled the right lower eye lid down and placed one drop into the right eye. Interview on 04/16/24 at 8:46 A.M. with LPN #291 verified the Cyclosporine Ophthalamic Emulsion 0.05% eye drop was placed into the left eye with no physician's order. Review of the facility policy titled, Medication Administration, dated 08/07/23, revealed the purpose of the policy was to safely and accurately prepare and administer medication according to physician order, professional standards of practice and resident needs. Medications are administered in accordance with the following rights of medication administration, right resident, right medication, right dose, right route, right time and frequency, right documentation, right of the resident to refuse and right clinical indication. Review of the facility policy titled, Eye Drop or Ointment Administration, dated 09/14/23, revealed the licensed nurse should verify the physician order, gather and prepare necessary equipment, perform hand hygiene and don clean gloves, steady the hand by holding the medication as needed on the resident's forehead, with the other hand, pull down the lower eyelid to form a pouch of the conjunctiva sac instructing resident to look up, squeeze the prescribed number of drops into the conjunctiva sac avoiding the placement of the drop directly on the eyeball.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568 Based on record review, interview, observation and policy review, the facility failed to ensure food was served at a palatable and warm temperature. The deficient practice affected four residents (#9, #10, #29, and #49) and had the potential to affect all residents who received meals from the kitchen except two residents (#32 and #34) who were identified by the facility as receiving nothing by mouth (NPO). The facility census was 80. Findings include: 1. Review of medical record for Resident #9 revealed admitted [DATE] with diagnoses including diverticulosis of large intestine, dysphagia, and irritable bowel syndrome. Interview with Resident #9 on 04/15/24 at 3:13 P.M. revealed the food was served cold, and they have trouble with keeping temperature. 2. Review of medical record for Resident #10 revealed admitted [DATE] with diagnoses including congestive heart failure, type II diabetes, and morbid obesity. Interview with Resident #10 on 04/15/24 at 11:17 A.M. revealed the food was cold and lukewarm. 3. Review of medical record for Resident #29 revealed admitted [DATE] with diagnoses including type II diabetes, acute kidney failure, and morbid obesity. Interview with Resident #29 on 04/16/24 at 9:30 A.M. revealed the food was bad, sometimes undercooked, and sometimes overcooked. It was received cold. 4. Review of medical record for Resident #49 revealed an admitted [DATE] with diagnoses including legal blindness, cerebral infarction, and heart failure. Interview with Resident #49 on 04/15/24 at 4:32 P.M. revealed the food was terrible. It was too cold and too salty to eat. Observation of the tray line on 04/17/24 at 12:06 P.M. with Dietary Manager #299 revealed the lunch menu consisted of carrots, mashed potatoes, a fish sandwich, and French fries. A test tray was requested, and Dietary Manager #299 took starting temperatures of the food being placed on the test tray. Dietary Manager #299 confirmed the carrots were 124 degrees Fahrenheit (F), mashed potatoes were 121 degrees F, the fish sandwich was 124 degrees F, and the French fries were 172 degrees F on the test tray. The tray was then placed on the meal cart for the 200 Hall. The test tray left the kitchen on 04/17/24 at 12:11 P.M. Interview on 04/17/24 at 12:11 P.M. with Dietary Manager #299 revealed she wants food coming out of hot holding at 140 degrees F or above. Dietary Manager #299 also revealed they have not had issues with their food warmer, and she had not done test trays since she has been at the facility, but she planned on doing them. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/17/24 at 12:13 P.M. of the meal cart with the test tray arrived on the 200 Hall. The test tray was served on 04/17/24 at 12:29 P.M. after all other 200 Hall food trays were served. Observation of the test tray opened on 04/17/24 at 12:29 P.M. by Dietary Manager #299. Dietary Manager #299 checked the food on the tray and confirmed the food temperatures. The carrots were 113 degrees F, the mashed potatoes were 111 degrees F, and the French Fries were 118 degrees F. The food was tasted, and it was all lukewarm. Review of the Food Temperature Monitoring and Recording Policy, dated 01/01/12, stated time/temperature controlled for food safety (TCS food) shall be maintained at one hundred thirty-five degrees (135 F) or above OR at forty-one degrees (41 F) or less, except during preparation, cooking, or cooling. The policy also states All TCS hot food items must be served at a temperature of at least 135 F or above. This deficiency represents non-compliance investigated under Master Complaint Number OH00152577.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48568 Based on observation, interview, and record review the facility failed to ensure food was properly date labeled, clean dishware was clean, and food was held at proper hot holding temperatures. The deficient practice had the potential to affect all residents who received meals from the kitchen except two residents (#32 and #34) who were identified by the facility as receiving nothing by mouth (NPO). The facility census was 80. Findings include: 1. Observation on 04/15/24 at 11:28 A.M. with Dietary Manager #299 revealed three large plastic containers containing iced tea, lemonade, and punch were dated 04/15/24 to 04/25/24. A tub of chocolate pudding was also observed dated 4/13/24 to 5/13/24. Dietary Manager #299 changed the dates on the beverages to 4/15/24 to 4/20/24. Dietary Manager #299 was also observed changing the date on the pudding to an end date of 04/19/24. Interview on 04/15/24 at 11:28 A.M. with Dietary Manager #299 revealed time controlled for safety (TCS) foods are dated for five days at this facility. When questioned on what tells us about how long beverages should be dated for Dietary Manager #299 did not answer and changed dates on the containers. Observation on 04/15/24 at 11:55 A.M. with Corporate Nutrition Services Coordinator #356 of a container of hard-boiled eggs dated 4/8/24 to 4/14/24 in the make table. A container of wedge tomatoes dated 4/8/24-4/9/24 were observed in the make table as well. Interview on 04/15/24 at 11:57 A.M. with Corporate Nutrition Services Coordinator #356 confirmed the dates on both containers and threw the food items in the trash can. Interview on 04/15/24 12:08 PM with Corporate Nutrition Services Coordinator #356 and Dietary Manager #299 revealed they make iced tea with three bags of brew tea. Corporate Nutrition Services Coordinator #356 revealed they store made beverages no more than three days. Review of the Labeling and Dating Food Policy, dated 01/01/12, stated the following items must be dated with a seven-day use by date when stored in a refrigerated unit below 41 degrees Fahrenheit (F) unless otherwise specified by the manufacturer. The day the original container is opened or the day the food is properly cooked or cooled is counted as day one, plus six days. The food item will be discarded on or before the last date or day by which the food must be consumed. 2. Observation on 04/15/24 at 11:45 A.M. with Dietary Manager #299 revealed clear plastic food storage containers air drying on the air-dry rack were soiled with sticky residue and food debris still on the containers. Interview on 04/15/24 at 11:47 A.M. with Dietary Manager #299 confirmed the food particles and the residue came from their date label stickers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/15/24 at 11:47 A.M. of Dietary Manager #299 removing 14 clear plastic food storage containers off the clean air-drying rack and placing them back in the dishwasher station. Review of the General Cleaning and Sanitation of the Kitchen Policy, dated 11/17/22, stated it is the center's policy that the food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. The policy also stated employees will be trained on how to perform cleaning and sanitation tasks. 3. Observation of the tray line was made on 04/17/24 at 12:06 P.M. with Dietary Manager #299. The lunch menu consisted of carrots, mashed potatoes, a fish sandwich, and French fries. A test tray was requested, and Dietary Manager #299 took starting temperatures of the food being placed on the test tray. Dietary Manager #299 confirmed the carrots were 124 degrees F, mashed potatoes were 121 degrees F, the fish sandwich was 124 degrees F, and the French fries were 172 degrees F coming out of hot holding. Interview on 04/17/24 at 12:11 P.M. with Dietary Manager #299 revealed she wants food coming out of hot holding at 140 degrees F or above. Dietary Manager #299 also revealed they have not had issues with their food warmer. Interview on 04/17/24 at 1:16 P.M. with Corporate Nutrition Services Coordinator #356 revealed they want to hold hot foods at 140 degrees F or above. Review of the Food Temperature Monitoring and Recording Policy, dated 01/01/12, stated time/temperature controlled for food safety (TCS food) shall be maintained at one hundred thirty-five degrees (135 F) or above OR at forty-one degrees (41 F) or less, except during preparation, cooking, or cooling. The policy also states all TCS hot food items must be served at a temperature of at least 135 F or above.