STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366470	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Woods at New Albany	4588 Wesley Woods Blvd New Albany, OH 43054

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and policy review, this facility failed to provide proper percutaneous endoscopic gastrostomy (PEG) tube care including checking placement of the PEG tubing prior to administering medication as well as flushing the tubing with water prior to the administration of medication. This affected one (Resident #2) of the one resident reviewed for PEG tube care. The facility identified Resident #2 was the only resident with a PEG tube. The facility census was 15. Findings include: Review of the medical record revealed an admission date of 10/31/23. Diagnosis included protein-calorie malnutrition, gastrostomy status, and cognitive communication deficit. Review of Resident #2's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #2 was noted to require a PEG feeding tube for nutritional support. Review of the physician order dated 11/20/23 revealed an order to check placement of the PEG tube and residual, document residual and notify the medical director if residual was greater than 500 milliliters (ml). Also noted was an order dated 01/17/24 to flush the PEG tube with 60 ml's of free water before and after administering medication. Observation on 06/11/25 at 9:54 A.M. of Registered Nurse (RN) #155 administering medication for Resident #2 revealed PEG tube placement and residual was not checked prior to administration of medication nor was the PEG tube flushed with 60 ml's of water. Interview on 06/11/25 at 10:30 A.M. with RN #155 confirmed the placement and residual checks for Resident #2's PEG tube were not completed nor was the PEG tube flushed with 60 ml's per physician orders. Review of the facility policy titled Enteral Tube Medication Administration, dated January 2019 revealed, with gloves on, check for proper tube placement using air and auscultation only, never check placement with water. It also stated to check gastric content for residual feeding, return residual volume to the stomach and report any residual above 100 ml.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on medical record review, observation, staff interview and facility policy review, the facility failed to ensure oxygen tubing was dated to reflect the date the tubing was last changed and failed to ensure oxygen tubing was changed per facility policy. This affected four residents (#3, #7, #115, and #116) of four residents reviewed for oxygen care. The facility census was 15. Findings include: 1. Review of the medical record for Resident #115 revealed an admission date of 05/27/25. Diagnoses included pneumonia, chronic obstructive pulmonary disease (COPD), and need for assistance with personal care. Review of Resident #115's physician orders for June 2025 revealed an order for Resident #115 to wear supplemental oxygen at 2 liters (L) per minute via nasal cannula for oxygen saturations less than 90 percent (%) as needed for hypoxia. Observation on 06/09/25 at 10:13 A.M. and again on 06/10/25 at 10:23 A.M. revealed the oxygen tubing connected to the oxygen concentrator located in Resident #115's room did not have a date indicating the last time the tubing had been changed. Interview on 06/10/25 at 10:23 A.M. with Registered Nurse (RN) #155 confirmed Resident #115 had an order for supplemental oxygen as needed and currently had oxygen supplies, including tubing, without a date on it. RN #155 claimed the oxygen tubing was supposed to be changed weekly and whoever changed the tubing was to use a piece of tape to wrap around the tubing with the date it was changed on it. Review of the undated facility policy titled Oxygen Storage, revealed for oxygen in residents rooms, the oxygen tubing should be changed every other week and dated when changed. 2. Review of the medical record for Resident #116 revealed an admission date of 05/12/25. Diagnoses included dementia, asthma, pneumonia, and acute and chronic respiratory failure. Review of Resident #116's physician orders for June 2025 revealed an order for supplemental oxygen at 2 to 4 liters (L) per minute via nasal cannula for oxygen saturations less than 90 percent (%) as needed for hypoxia. Observation on 06/09/25 at 10:13 A.M. and again on 06/10/25 at 10:23 A.M. revealed the oxygen tubing connected to the oxygen concentrator located in Resident #116's room did not have a date indicating the last time the tubing had been changed. Resident #116 was noted to be wearing the oxygen connected to the concentrator. Interview on 06/10/25 at 10:23 A.M. with Registered Nurse (RN) #155 confirmed Resident #116 had an order for supplemental oxygen as needed and currently had oxygen supplies, including tubing, without a date on it. RN #155 claimed the oxygen tubing was supposed to be changed weekly and whoever changed the tubing was to use a piece of tape to wrap around the tubing with the date it was changed on it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy titled Oxygen Storage, revealed for oxygen in residents rooms, the oxygen tubing should be changed every other week and dated when changed. 3. Review of the medical record for Resident #7 revealed an admission date of 04/10/23 with diagnoses including traumatic brain injury, chronic kidney disease, obstructive sleep apnea, and atelectasis (collapsed lung). Review of Resident #7's physician order dated 06/08/25 revealed an order to wear oxygen as needed (PRN). Observation on 06/10/25 at 10:20 A.M. with Registered Nurse (RN) #155 revealed Resident #7's oxygen tubing was not dated. Interview on 06/10/25 at 10:20 A.M. with Registered Nurse (RN) #155 confirmed the oxygen tubing for Resident #7 was not dated. Review of the undated facility policy titled Oxygen Storage, revealed for oxygen in residents rooms, the oxygen tubing should be changed every other week and dated when changed. 4. Review of the medical record for Resident #3 revealed an admission date of 12/13/24 with diagnoses including systolic (congestive) heart failure, aneurysm of other specified arteries, and hypertension. Review of Resident #3's physician order dated 04/01/25 revealed and order for an as needed (PRN) oxygen 2 to 5 liters (L) per minute for shortness of breath. Observation on 06/09/25 at 10:11 A.M. revealed Resident #3 sitting up in her bed receiving oxygen via nasal cannula through a concentrator set at 3 L per minute. The oxygen tubing for Resident #3 was labeled 05/21/25, indicating the tubing was changed 19 days prior. Interview on 06/10/25 at 10:18 A.M. with Registered Nurse (RN) #155 confirmed that oxygen tubing should be changed weekly. Observation and interview on 6/10/25 at 10:22 A.M. with RN #155 confirmed the oxygen tubing for Resident #3 was labeled 05/21/25 and should have already been changed. Review of the undated facility policy titled Oxygen Storage, revealed for oxygen in residents rooms, the oxygen tubing should be changed every other week and dated when changed.

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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	Ensure medication error rates are not 5 percent or greater. Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure less than 5 percent (%) medication error rate was maintained when three errors were noted out of 32 opportunities for error, resulting in an error rate of 9.38%. This affected one (Resident #2) of the three residents observed for medication administration. The facility census was 15. Findings include: Review of the medical record for Resident #2 revealed an admission date of 10/31/23. Diagnoses included gastrostomy status, hypertension, and peripheral vascular disease. Review of Resident #2's physician orders for June 2025 revealed medications including Losartan Potassium oral tablet with instructions to give 50 milligrams (mg) in the morning via PEG tube for hypertension and it also stated to hold the medication if the residents systolic blood pressure was less than 105, Calcium Carbonate oral tablet 600 mg with instructions to give one tablet via PEG tube two times a day for supplement, Tramadol Hydrochloride oral tablet 50 mg with instructions to give one tablet via PEG tube two times a day for pain, and an order to flush the residents PEG tube with 60 milliliters (ml) of free water before and after administering medication with 5 ml's between each medication. Observation on 06/11/25 at 9:54 A.M. revealed Registered Nurse (RN) #155 gathered all scheduled medications for Resident #2, then she crushed all of the medication together and placed them into the same medication cup. RN #155 was then observed adding a small amount of water to the cup. All medications were noted to be administered at the same time and not separated with the 5 ml's of water flushed between each medication. Additionally, at no point did RN #155 check Residents #2's blood pressure prior to the administration of the Losartan Potassium medication. Interview on 06/11/25 at 10:30 A.M. with RN #155 confirmed Resident #2's medication was administered all at once and a water flush was not completed between each medication. RN #155 also confirmed that she had not taken the vital signs for Resident #2 yet that day. Review of the undated facility policy titled Enteral Tube Medication Administration, revealed staff were to administer each medication separately and flush the tubing between each medication.

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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** Based on medical record review, observations, staff interview, and facility policy review, this facility failed to ensure Enhanced Barrier Precautions (EBP) were in place and/or implemented timely for Resident #2, #7, and #114 who required EBP. Additionally, the facility failed to ensure proper infection control was maintained with the administration of Resident #2's eye drops. This affected three residents (#2, #7, and #114) of the six residents reviewed for infection control. The facility census was 15. Findings include: 1. Review of the medical record for Resident #114 revealed an admission date of 05/26/25. Diagnoses included hemiplegia and hemiparesis following an cerebral infarction affecting the right dominant side, type two diabetes, and retention of urine. Review of Resident #114's physician orders revealed orders dated 05/27/25 for Foley catheter care every shift and to change the Foley bag every two weeks and as needed, on 05/29/25 the resident was ordered a treatment to the right and left forearm with instructions to gently cleanse the wound and wound bed, pat dry, apply calcium alginate with silver, and cover with a dry clean dressing every day shift for skin tears, and on 06/09/25 the resident was ordered EBP every day and night shift. Interview on 06/11/25 at 2:30 P.M. with the Director of Nursing (DON) confirmed Resident #114 was admitted to the facility with a Foley catheter in place as well as treatments in place for wound care which would indicate the need for Enhanced Barrier Precautions (EBP) to have been implemented. The DON confirmed Resident #114 was admitted on [DATE] and the EBP was not initiated until 06/09/25. Review of undated facility policy titled, Enhanced Barrier Precautions revealed EBP were to be implemented for residents with open wounds requiring dressings as well as for residents with indwelling medical devices (e.g. urinary catheter, feeding tube). EBP expanded the use of personal protective equipment (PPE) and referred to the use of gown and gloves during high contact resident care activities. The policy stated EBP should be used during high-contact resident care activities including dressing, bathing/showering, providing hygiene, changing linens, changing briefs or assisting with toileting and providing wound care. 2. Review of the medical record for Resident #2 revealed an admission date of 10/31/23. Diagnoses included protein-calorie malnutrition, gastrostomy status, and cognitive communication deficit. Review of Resident #2's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision making abilities. Resident was noted to require a feeding tube for nutritional support. Review of Resident #2's physician orders revealed that all ordered medications were to be administered through a percutaneous endoscopic gastrostomy (PEG) tube. Also noted was an order dated 02/11/24 for PEG tube care including cleaning around the PEG insertion site with saline wound cleanser, pat dry, then apply a split four by four drain sponge daily, an order dated 06/12/24 for EBP every day and night shift, and an order dated 03/12/25 for Propylene Glycol-Glycerin Ophthalmic solution 1-0.3 percent (%) with instructions to instill one drop in both eyes every 24 hours as needed for dry eyes. (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 06/11/25 at 9:54 A.M. of medication administration via PEG tube for Resident #2 revealed Registered Nurse (RN) #155 was wearing only gloves and failed to don the appropriate personal protective equipment (PPE), including a gown, which was required for a resident who would be under EBP, due to having an indwelling medical device such as a PEG tube. After the medication administration observation, RN #155 was observed completing the residents PEG tube insertion site dressing change. After completing the dressing change, RN #155 proceeded to place eye drops in Resident #2's eyes. At no time during the observations of medication administration, PEG dressing change, or eye drop administration, did RN #155 change gloves or complete hand hygiene. Interview on 06/11/25 at 10:00 A.M. with RN #155 revealed Resident #2 required EBP due to her PEG tube, but since she did not have an infection, gloves were the only thing required to provide care including medication administration and the PEG tube dressing change. RN #155 confirmed she did not change her gloves in between care tasks nor did she complete hand hygiene between care tasks. Interview on 06/11/25 at 3:00 P.M. with the Director of Nursing (DON) confirmed Resident #2 had an order for EBP. The DON confirmed RN #155 should have used gloves and a gown when administering medications via PEG tube and when completing PEG tube dressing care. Review of undated facility policy titled, Enhanced Barrier Precautions revealed EBP were to be implemented for residents with open wounds requiring dressings as well as for residents with indwelling medical devices (e.g. urinary catheter, feeding tube). EBP expanded the use of personal protective equipment (PPE) and referred to the use of gown and gloves during high contact resident care activities. The policy stated EBP should be used during high-contact resident care activities including dressing, bathing/showering, providing hygiene, changing linens, changing briefs or assisting with toileting and providing wound care. 3. Review of the medical record for Resident #7 revealed an admission date of 04/10/23. Diagnoses included, but were not limited to, traumatic brain injury, chronic kidney disease, chronic venous insufficiency, sarcopenia, non-pressure chronic ulcer of other part of left lower leg limited to breakdown of skin, non-pressure chronic ulcer of other part of left lower leg with fat layer exposed, and chronic venous hypertension (idiopathic) with ulcer of left lower extremity. Review of the physician order dated 06/12/24 for Resident #7 revealed an order for Enhanced Barrier Precautions (EBP) every day and night shift. Review of the Braden Scale for Predicting Pressure Sore Risk dated 04/06/25 for Resident #7 revealed the resident was determined to be at high risk for skin breakdown. The report also revealed Resident #7 was bedfast and immobile. Review of the Wound Evaluation and Management Summary report dated 06/11/25 for Resident #7 revealed the autoimmune disease-induced wound of the left, inferior calf that was 2.4 centimeters (cm) by 1.2 cm by 0. 1 cm in size, there was 100 percent (%) granulation tissue and exudate that was moderate serous (thin watery fluid). Observation on 06/10/25 at 9:29 A.M. revealed the door to Resident #7's room had a blue sign on the door that stated, Stop. See nurse before entering. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/10/25 at 10:21 A.M. with Registered Nurse (RN) #155 revealed that the Enhanced Barrier Precautions for Resident #7 were only for when she was completing wound care and that the aides didn't have to wear gowns as he didn't have an infection. Interview on 06/10/25 at 11:57 A.M. with Certified Nursing Assistant #113 revealed she didn't know why Resident #7 had the stop sign on the door and that the aides didn't have to wear any additional personal protective equipment (PPE) as he didn't have a wound. Observation on 06/11/25 at 8:26 A.M. revealed Resident #7's room door had a standard EBP sign which described the situations where EBP (gown and gloves) were required including: dressing, bathing/showering, transferring, changing linens, providing hygiene, device care or use (central line, catheter, feeding tube, tracheostomy) and wound care. Interview on 06/11/25 at 2:45 P.M. with the Director of Nursing (DON) confirmed Resident #7 was on EBP and that both, nurses and aides, needed to be wearing a gown and gloves when they provided high contact clinical care. Review of undated facility policy titled, Enhanced Barrier Precautions revealed EBP were to be implemented for residents with open wounds requiring dressings as well as for residents with indwelling medical devices (e.g. urinary catheter, feeding tube). EBP expanded the use of personal protective equipment (PPE) and referred to the use of gown and gloves during high contact resident care activities. The policy stated EBP should be used during high-contact resident care activities including dressing, bathing/showering, providing hygiene, changing linens, changing briefs or assisting with toileting and providing wound care.