STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366478	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Pointe Nursing & Rehabilitation	117 Bartlett Street Marietta, OH 45750

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 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** 34299 Based on observation, interview, record review, and facility policy review, the facility failed to evaluate and treat a resident's skin condition. This affected one of one resident (#31) reviewed for non pressure skin impairment. The facility census was 71. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including psoriasis. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #31 required partial to moderate assistance with showers and or bathing and supervision with personal hygiene. The assessment indicated Resident #31 had no skin impairments however received application of ointment/medication to site other than his feet. Review of the physician orders dated May 2024 revealed Resident #31 had an order for Ketoconazole external shampoo 2 percent to apply to scalp topically every day shift on Monday and Thursday for Seborrhea. Review of the Medication Administration Record for May 2024 revealed Resident #31 received the shampoo as ordered. There was not a physician's order to address Resident #31 psoriasis or redness noted to chin. Review of nursing progress notes revealed on 05/07/24 at 12:02 P.M. Registered Nurse (RN) #116 documented Resident #31 reported itching and dry areas of skin to his neck and face. Resident #31 stated he had put medicated cream on the areas before and had relief of symptoms. Physician Assistant (PA) was in the facility to see Resident #31 and wrote an order for hydrocortisone one percent, topically to rash on the right neck and face two times daily for 10 days. The nursing progress notes were silent on red, blotchy area to Resident #31 chin. Review of the plan of care dated 08/10/23 revealed Resident #31 had alteration in skin integrity as evidenced by a rash related to psoriasis present on bilateral buttocks. On 08/08/23 Resident #31 may keep medication at bedside for self administration. The goal was Resident #31 would be free from signs and symptoms of infection, and have no increased pain related to skin impairment by the target date (no date). The interventions included to assess area for size, color and drainage as needed, assess for pain and provide treatment per the physician orders, body check weekly and as needed, notify the physician and family of changes as needed and the staff to provide skin care as needed. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the last non pressure weekly skin assessment dated [DATE] revealed no areas of concern. The medical record did not include evidence Resident #31 was seen by dermatology. The medical record did not include a self medication assessment for Resident #31. Observations of Resident #31 on 05/20/24 at 10:20 A.M., 05/22/24 at 2:43 P.M. and on 05/23/24 at 12:30 P. M. revealed Resident #31 had a bright red, blotchy area to his chin. Interview on 05/23/24 at 12:30 P.M. with Resident #31 confirmed he had a bright red blotchy area to his chin. Resident #31 stated it was itchy and was not sure if the nurse had put anything on it or notified the physician. Interview on 05/22/24 at 9:40 A.M. with the Director of Nursing (DON) confirmed there were not any residents in the facility that self administered medications. An observation on 05/22/24 at 2:10 P.M. of Resident #31 room with RN #125 confirmed in the top drawer of Resident #31 bedside table was a tube of Desonide lotion 0.05%, apply topically two times daily to skin redness, itching or discomfort related to atopic dermatitis. The cream was filled by the pharmacy on 04/12/21 and stated to discard by 04/12/22. RN #125 stated it was unknown if Resident #31 used the medication. RN #125 confirmed there was not an order for Resident #31 to have the medication or an order to keep at bedside for self administration. An interview on 05/22/24 at 2:30 P.M. with the MDS nurse #187 confirmed the plan of care indicated Resident #31 may keep medicated cream at bedside for self administration. MDS nurse #187 also confirmed there was not a current treatment order for residents skin, and Resident #31 did not have a self medication assessment. An interview on 05/23/24 at 12:34 P.M. with RN #182 confirmed Resident #31 continued to have a bright red blotchy area to his chin. RN #182 stated she would notify the physician. RN #182 stated skin assessments were completed two times weekly and with care. The State tested Nursing Assistants (STNA) were good about reporting skin issues, however, no one had reported it to her. Review of the facility policy titled Medication Storage/Bedside Storage of Medications dated 06/21/17 revealed resident who were able to self administer medications may be allowed to store at bedside. The procedure included a written physician order, stored in a locked area, and periodically reassess the ability of the resident to continue self administering medications. The facility did not provide a policy for non pressure related skin impairment.

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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	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** 07316 Based on observations, staff interview, resident interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents. This affected one of one residents reviewed for falls (#12). The facility census was 71. Findings include: Review of the medical record for Resident #12 revealed an admitted [DATE] and diagnoses including morbid obesity, chronic obstructive pulmonary disease, and chronic respiratory failure. Review of a fall risk assessment 02/29/24 revealed the resident was at risk for falls and had a history of a fall in the last 30 days. It indicated the resident's balance was not steady moving from a seated to standing position or with walking. Review of an incident report revealed on 03/04/24 at 4:30 P.M. Resident #12 was noted on the floor in her bathroom. The resident was sitting on her buttocks facing the grab bar with her legs straight out in front of her. The resident stated that staff assisted her to the bathroom and gave her the call light. However, she stated she let go of the call light cord and thought she could transfer herself back to her recliner. She stated her pants leg got under her socks and her foot slipped. She then fell on to her buttocks. There was no injury noted. The resident's son was notified and was to bring in shorter pants. Physician's orders were obtained on 03/04/24 for a low bed and pants to be ankle length or shorter for fall prevention. A fall risk assessment 03/04/24 continued to indicate the resident was at risk for falls due to a history of falls and unsteady balance. It indicated the resident was only able to stabilize with staff assistance. Review of a Minimum Data Set assessment completed 03/07/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. It indicated the resident required substantial/maximal assistance from staff with sit to stand, chair/bed transfer, toilet transfer, and walking 10 feet. Review of an incident report dated 03/12/24 at 8:30 P.M. revealed Resident #12 had fallen in the bathroom. Nursing assistant stated she assisted resident to bathroom and placed call light cord in resident's hand before leaving. Nursing assistant came back to check on resident and observed resident on floor. The resident was sitting up on buttocks with legs straight out in front of resident. Resident leaning up on side of toilet. The resident stated she got off the toilet, became dizzy, fell , and hit her head off the rim of the toilet. The resident was noted to have a 1.2 by 1.2 by 0.1 centimeter open area to the back of her head which was actively bleeding. The resident was transferred to the emergency room for evaluation. Review of nurses notes revealed on 03/13/24 at 12:10 A.M. the hospital emergency room called and stated the resident received two staples to the open area on back of scalp. The resident returned to the facility on [DATE] at 3:26 A.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall risk assessment dated [DATE] stated the resident had a history of falls in the past 30 and 90 days. It stated the resident had unsteady balance and was only able to stabilize with staff assistance. Review of the plan of care revealed on 03/01/24 and revised 03/13/24 the resident was noted to be at risk for falls due to debilitation, weakness, impaired vision, history of falls, syncope, psychotropic medication use, and poor safety awareness. On 03/12/24 interventions were added for staff to offer to toilet every two hours and not leave resident unattended while toileting. Interview with Resident #12 on 05/20/24 at 2:43 P.M. revealed she had fallen twice at the facility. She stated she got hurt when she fell in the bathroom and hit her head and had to get stitches. Observations on 05/21/24 at 3:06 P.M. revealed Resident #12 to be in the bathroom of her room. Nursing assistant #137 was observed leaving the room. Resident #12 was alone in her bathroom in her room. Observations on 05/21/24 at 3:12 P.M. revealed the call light to be on in Resident #12's room. Nursing assistant #137 went to the room and assisted Resident #12 from the bathroom to her chair with the use of a walker. Interview with Licensed Practical Nurse #103 on 05/23/24 at 9:35 A.M. revealed staff are to stay with Resident #12 when she is in the bathroom. She stated staff are not to leave the room. She confirmed Resident #12 had experienced two falls in the bathroom. Interview with the Director of Nursing on 05/23/24 at 9:43 A.M. revealed staff are to stay close by, either in bathroom or in the resident's room, when she is in the bathroom.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on interviews and record review, the facility failed to monitor a dialysis site per the resident centered care plan. This affected one resident (#26) of one resident reviewed who was receiving dialysis. The facility census was 71. Findings include: Review of the medical record for Resident #26, revealed an admitted [DATE]. Diagnoses included: type 2 diabetes mellitus with diabetic neuropathy, heart failure, chronic kidney disease, stage 4 (severe) and dysphagia, oral phase. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15. The resident was assessed to require independent with bed mobility and transfers from bed and chairs, with supervision or touching assistance with tub/shower transfers and partial moderate assistance with shower/bathe self. Review of the progress note dated 04/10/24 for Resident #26 revealed the placement of a central venous line (CVL) for dialysis with no documentation on the location and the site had a dry bandage to it. Review of the active care plan for Resident #26 revealed to monitor permacath every shift for bleeding. Further record review for this resident revealed no monitoring of the permacath every shift and no documentation of the location of the site by the facility. Interview on 05/22/24 at 1:54 P.M. with Resident #26 revealed she lets the facility know if there is an issue with her permacath and stated They do not come in here at night to check my bandage, but I let them know if there is an issue. Observation on 05/22/24 at 1:59 P.M. of Resident #26 revealed a site to the left upper chest, dressing was clean and dry. Interview on 05/22/24 at 2:14 P.M. with the Director of Nursing (DON) verified Resident #26's active care plan stated to monitor permacath for bleeding every shift with no monitoring documentation and no site location ever being noted throughout the resident's record.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview and record review, the facility failed to ensure residents with Post Traumatic Stress Disorder (PTSD) were appropriately evaluated to identify the cause of the resident's PTSD and minimize triggers and/or re-traumatization. This affected two residents (#23 and #24) of two residents identified by the facility as having PTSD/trauma. The facility census was 71. Findings include: 1. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including major depressive disorder, anxiety disorder, bipolar disorder and dated 03/23/23 PTSD. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #24 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 with no behaviors however, did self isolate at times. Resident #24 required staff assistance to complete activities of daily living. The assessment identified Resident #24 had diagnoses of anxiety, depression, bipolar disorder, and PTSD. Review of the Brief Trauma Questionnaire dated 04/03/23 revealed Resident #24 had no traumatic events or triggers. Further record review for this resident revealed no assessment had been completed to identify the cause of PTSD for Resident #24 and to identify potential triggers which may cause re-traumatization. Review of the updated plan of care dated 03/24/24 for Resident #24 revealed no plan of care was in place addressing the cause of the PTSD, the triggers which may cause re-traumatization or interventions to reduce the risk of re-traumatization and provide care for PTSD. An observation and interview with Resident #24 on 05/20/24 at 1:45 P.M. revealed Resident #24 appeared sad, and withdrawn. Resident #24 stated she was depressed and sad but she had to work through it. An interview on 05/23/24 at 12:20 P.M. with State tested Nursing Assistant (STNA) #129 stated she was not sure which residents on her hall had PTSD. STNA #129 also stated she was not aware Resident #24 had PTSD, did not know what the triggers were or how to react to the triggers. STNA #129 stated she had not received education on PTSD or trauma informed care. An interview 05/23/24 at 12:24 P.M. with STNA #153 stated she was aware that Resident #24 had PTSD possibly related to a boating accident. However, STNA #153 did not know what Resident #24 triggers were or what to do if resident exhibited symptoms. STNA #153 stated she had not received education on PTSD or trauma informed care. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/23/24 at 1:29 P.M. with the Director of Nursing (DON) revealed the facility did not have a policy on PTSD or trauma informed care. The DON stated the facility completed a brief trauma informed care assessment on admission along with a plan of care. The DON verified the assessment did not identify the cause of the PTSD and possible triggers. Also verified the plan of care for Resident #24 did not include triggers or interventions to prevent or minimize the risk of re-traumatization. 47987 2. Review of the medical record for Resident #23, revealed an admitted [DATE]. Diagnoses included, but were not limited to: generalized anxiety disorder, polyneuropathy, and paraplegia. Post traumatic Stress Disorder (PTSD) and hallucinations were added to the list of diagnoses as of 03/08/24. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14. The resident was assessed to have an active diagnosis of PTSD. Review of the active care plans for Resident #23 revealed no plan of care was in place until 05/23/24 addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Further record review for this resident revealed no assessment had been completed to identify the cause of PTSD for Resident #23 and to identify potential triggers which may cause re-traumatization. Interview with the Regional Nurse on 05/28/24 at 2:22 P.M. verified an assessment of the cause of PTSD and possible triggers for Resident #23 had not been completed and additionally verified there had not been a plan of care implemented for Resident #23 to minimize the risk of re-traumatization until 05/23/24 with verbal confirmation of the triggers without an actual assessment.

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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** 47987 Based on interview and record review, the facility failed to administer medication as ordered for Resident #26 after dialysis treatments. This affected one resident (#26) of one resident reviewed for dialysis. The facility census was 71. Findings include: Review of the medical record for Resident #26, revealed an admitted [DATE]. Diagnoses included: type 2 diabetes mellitus with diabetic neuropathy, heart failure, chronic kidney disease, stage 4 (severe), anxiety, depression, parkinson's disease, and dysphasia, oral phase. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15. The resident was assessed to require independent with bed mobility and transfers from bed and chairs, with supervision or touching assistance with tub/shower transfers and partial moderate assistance with shower/bathe self. Review of active physician orders for Resident #26 revealed the following medications were to be given upon rise at 7:00 A.M.: 1. calcitrol oral capsule 0.25 micrograms (MCG) one capsule by mouth every Monday, Wednesday and Friday. 2. Duloxetine Hydrochloride (HCL) oral capsule delayed release particles give 90 milligrams (mg) by mouth one time a day for depression/anxiety. 3. Carbidopa-Levodopa oral tablet 25-100 MG give one tablet by mouth two times a day for parkinson's. 4. Ferrous Sulfate oral tablet 325 MG give one tablet by mouth one time a day for anemia. 5. Fexofenadine HCL oral tablet 180 MG give one tablet by mouth daily. 6. Flonase Allergy Relief Nasal Suspension 50 MCG/ACT two sprays alternating nostrils one time a day for allergies. 7. Gabapentin oral tablet 600 MG give one tablet by mouth two times a day for pain. 8. Lokelma (Sodium Zirconium Cyclosilicate) oral packet 10 grams (GM) give one packet by mouth one time a day for hyperkalemia. 9. Magnesium oral tablet 500 MG give one tablet by mouth two times a day for supplement. 10. Multivitamin oral tablet give one tablet one times a day for supplement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. Omeprazole oral capsule delayed release 40 MG give one capsule by mouth one time a day for Gastroesophageal Reflux Disease (GERD). 12. Saccharomyces boulardii capsule give one capsule by mouth two times a day for probiotic. 13. Sodium Bicarbonate oral tablet 650 MG give by mouth three times a day for GERD. 14. Tums (Calcium Carbonate) oral tablet chewable give one tablet by mouth four times a day for GERD. 15. Vitamin D 3 oral tablet 125 MCG (5000 units) give one capsule by mouth one times a day for supplemental health. Review of May 2024 Medication Administration Record (MAR) for Resident #26 revealed for the dates of 05/06/24, 05/08/24, 05/10/24, 05/13/24, 05/15/24, 05/17/24, 05/20/24 and 05/22/24 the 15 medications ordered for upon rise at 7:00 A.M. were not administered. Interview on 05/22/24 at 1:56 P.M. with Resident #26 revealed she has not been receiving her morning medications on the days she goes out for dialysis, even when she returns. Interview on 05/22/24 at 2:14 P.M. with the Director of Nursing (DON) verified Resident #26 did not receive her 15 morning medications as ordered on her dialysis days dated 05/06/24, 05/08/24, 05/10/24, 05/13/24, 05/15/24, 05/17/24, 05/20/24 and 05/22/24. She stated I will get this fixed right now with the House Doctor so she can get them after as it does her no good before and that is why the nurses are not giving them.