

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/02/2025
NAME OF PROVIDER OR SUPPLIER  Landings of Westerville Health and Rehab The		STREET ADDRESS, CITY, STATE, ZIP CODE  350 County Line Road West Westerville, OH 43082	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on medical record review, staff interviews, and facility policy review, the facility failed to honor Resident #15 's right to have a camera surveillance in her room when her camera was unplugged and not reconnected to power. This affected one resident (Resident #15) out of 15 residents identified by the facility as having surveillance cameras in their rooms. Facility census was 109. Findings include: Review of Resident #15's medical record revealed an admission date of 11/27/2023 with diagnoses that included but were not limited to cerebral infarction, emphysema, acute chronic respiratory failure with hypoxia, diabetes mellitus, atrial fibrillation and depression. Review of Resident # 15's most recent Minimum Data Set (MDS) 3.0 assessment dated , 07/25/25 revealed a Brief Interview for Mental Status (BIMS) score of six indicating the resident was cognitively impaired. The resident was assessed to require total assistance from staff with activities of daily living. Review of Resident # 15's progress notes dated 08/05/25 revealed that Unit Manager (UM) # 379 removed a power strip from the resident's room. Interview on 09/02/25 at 1:35 P.M. with UM # 379 revealed on 08/05/25 he removed a power strip from Resident #15's room that was attached to her surveillance camera. UM # 379 confirmed he did not plug the camera to a power source after he removed the power strip. UM #379 stated the camera was not plugged in by any staff member, and family was notified and he was unsure when family came to the facility to reconnect the camera. Interview on 09/02/25 at 4:05 P. M. with the Administrator revealed she was unaware the surveillance camera in Resident #15's room was not reconnected to power after the power strip was removed by the facility staff. Review of facility policy titled Electronic Monitoring in Resident Rooms dated March 23, 2022 revealed: The Facility will permit residents and legally authorized people to install and use electronic monitoring devices in accordance wit applicable laws. Only authorized facility personnel are permitted to install electronic monitoring devices in resident rooms.</p>

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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on medical record review, review of facility training, and staff interviews, the facility failed to ensure that residents with Nothing by Mouth (NPO) orders did not receive any liquids by mouth during oral care. This affected one (Resident #15) out of 17 residents the facility identified as NPO. The facility census was 109. Findings include: Review of Resident #15's medical record revealed an admission date of 11/27/2023 with diagnoses that included but were not limited to cerebral infarction, emphysema, acute chronic respiratory failure with hypoxia, diabetes mellitus, atrial fibrillation, tracheostomy dependent and depression. Review of Resident # 15's most recent Minimum Data Set (MDS) 3.0 assessment dated , 07/25/25 revealed a Brief Interview for Mental Status (BIMS) score of six indicating the resident was cognitively impaired. The resident was assessed to require total assistance from staff with activities of daily living and oral hygiene care. Review of Resident #15's progress notes dated 08/14/25 by Unit Manager (UM) # 379 revealed family was contacted regarding the scant amount of liquid Resident #15 received from her Chlorhexidine (antimicrobial) administration on 8/12/25. Review of Resident # 15's current monthly physicians orders dated 08/25/25, revealed an NPO diet order and an order for Chlorhexidine Gluconate Solution (medication used for oral care with NPO residents) 0.12%; give 15 milliliters (ml) orally four times a day. Review of Resident #15's August 2025 Medication Administration Record (MAR) revealed Licensed Practical Nurse (LPN) # 200 signed as administering Chlorhexidine Gluconate Solution on 08/12/25 at 9:00 P.M. Interview on 09/02/25 at 1:35 P.M. with UM # 379 revealed that Nurse #200 poured a small amount of chlorhexidine medication in the front of Resident #15's mouth to thoroughly clean her bottom teeth. He also stated that Director of Nursing (DON) #393 was aware and had educated the staff on oral care for NPO residents. Interview on 09/02/25 at 2:25 P.M. with DON #393 revealed he was aware of the incident and had educated nursing and respiratory therapy staff on oral care with chlorhexidine for NPO patients on 08/13/25. Review of facility training titled Oral Care with Chlorhexidine -NPO patients undated revealed the following step by step instructions: 1. Verify &amp; prepare: Confirm order, allergies, NPO status, aspiration risk. Wash hands and apply gloves. 2. Position: head of bed (HOB) 30-45 upright OR side-lying if unable. 3. Application: Pour 10-15 ml into a cup, soak foam swab (no double dipping). 4. Cleaning: Swab inner cheeks, gums, tongue, teeth - replace swab if soiled. 5. Suction: Yankauer/inline suction during care. If alert, spit into basin (no rinsing with water). 6. Completion: Dispose of supplies, remove personal protective equipment (PPE), document care and findings.</p>		