STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366494	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landings of Westerville Health and Rehab The	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on interview, observation, record review, and facility policy review, the facility failed to ensure residents had updated accurate care plans for two Residents (#30 and #65) out of six Residents reviewed for care plans. The facility census was 113. Findings Include: Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses of encephalopathy, asthma with acute exacerbation, morbid obesity, chronic kidney disease, anxiety and depression. Resident was documented to be alert and oriented to person, place and time with no cognitive deficits. On 04/06/23 Resident #65 saw the facility contracted eye doctor and was diagnosed with cataracts in both eyes. Optometrist recommended removal of the cataracts and Resident #65 declined. Review of Resident #65 care plan last dated 01/13/25 did not include identification of resident having cataracts, referral for cataract surgery and use of ophthalmic medication. Interview on 03/05/25 at 2:00 P.M. with Regional Registered Nurse #164 confirmed Resident #65's care plan did not include identification and care for cataracts. 34291 2. Medical record review for Resident #30 revealed an admitted [DATE]. Medical diagnoses included spinal cord compression, diabetes, malnutrition, and spinal stenosis. Review of the care plan for Resident #30 dated 09/26/24 revealed she was at risk for falls related to debilitation, weakness, pain, personal history of falls, and use of the psychotic medications. Interventions were to encourage and remind to ask for assistance, have commonly used articles within reach, and maintain a clear pathway. Further review of the care plan revealed Resident #30 may require assistance with Activities of Daily Living (ADL's) and may be at risk of developing complications associated with decreased ADL self-performance. Interventions included re-position/perform mobility with two-person assistance, toilet with two-person assistance, and assist bars to the bed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact. Her functional status was dependent for eating, toileting, bed mobility, and transfers were not applicable. She was always incontinent for bowel and bladder. Interview with the Director of Nursing (DON) on 03/05/25 at 11:04 A.M. revealed the care plan for Resident #30 was not accurate as it documented Resident #30 to require two person assistance with ADL care and did not reflect Resident #30 being dependent on staff for her ADL care. The DON confirmed the care plan had not been revised to reflect Resident 30's actual care needs. Review of the facilities Care Plan Policy, dated 01/01/2015 revealed the facility will have updated versions of Resident Assessment Instrument (RAI) manual in hard copy from format accessible to members of the team responsible for completion of these areas.

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on observations, resident interview, and medical record review, the facility failed to implement physician orders causing a delay in treatment for one resident (#65) . The census was 113. Findings Include: Review of the medical record for Resident #65 revealed an admitted [DATE] with medical diagnoses of encephalopathy, asthma with acute exacerbation, morbid obesity, chronic kidney disease, anxiety and depression. Resident #65 was documented to be alert and oriented to a person, place and time with no cognitive deficits. Review of Resident #65's annual eye examination dated 04/06/23 the Resident #65 revealed the resident was seen by the facility eye doctor and was diagnosed with cataracts in both eyes. Optometrist recommended removal of the cataracts and Resident #65 declined. Review of Resident #65's annual eye examination dated 05/03/24 revealed Resident #65 agreed to have cataract surgery due to a decrease in vision. The optometrist instructed the facility to set up consultation at a specialist office for cataract surgery. Review of the Resident record revealed on 10/14/24 at 9:30 A.M. Resident #65 had a follow up appointment with the Optometrist who confirmed a consultation visit was not scheduled for the removal of Resident #65 cataracts. Review of the nurse's progress notes from 05/03/24 to 03/03/25 revealed no indication of the referral being made to the eye specialist. Interview on 03/03/25 at 4:25 P.M. with Resident #65 who appeared to be upset revealed no one in the facility listened to her when she was to see a specialist for cataract removal in both eyes. She said the eye doctor instructed the staff to set up an appointment for a specialist to remove the cataracts in May of 2024, but they never did. When the eye doctor came back to the facility on [DATE] he was furious and asked her why she did not see a specialist. She explained, multiple times she spoke to the nurses and the unit manager about making the appointment, but no one ever did. On 01/03/25 she finally saw the specialist and was told she had too much pressure behind her eyes and could not have her cataract surgery until the pressure was treated. Since 01/03/25 she saw the specialist one more time and surgery has not been recommended due to the pressure in her eyes. Interview on 03/05/25 at 1:00 P.M. with the Director of Nursing verified a consult with an eye specialist was not made until after Resident #65 seen the optometrist on 10/14/25. The first available appointment for Resident #65 was scheduled for 02/21/25.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 34291 Based on medical record review, staff and resident interviews, and policy review, the facility failed to ensure proper positioning technique was implemented during incontinence care which resulted in a fall out of bed with a major injury. Actual Harm occurred on 10/16/24 when Resident #30, who was cognitively intact, at risk for falls and dependent on staff for turning, repositioning, and toileting sustained a fall out of bed when one staff member was providing incontinent care, and the resident fell to the floor fracturing her left femur due to improper positioning technique. This affected one (Resident #30) of three residents reviewed for falls. The census was 113. Findings included: Medical record review for Resident #30 revealed an admitted [DATE]. Medical diagnoses included spinal cord compression, diabetes, malnutrition, and spinal stenosis. Review of the care plan for Resident #30 dated 09/26/24 revealed she was at risk for falls related to debilitation, weakness, pain, personal history of falls, and use of the psychotic medications. Interventions were to encourage and remind to ask for assistance, have commonly used articles within reach, and maintain a clear pathway. Further review of the care plan revealed Resident #30 may require assistance with Activities of Daily Living (ADL's) and may be at risk of developing complications associated with decreased ADL self-performance. Interventions included re-position/perform mobility with two-person assistance, toilet with two-person assistance, and assist bars to the bed. Review of the fall assessment dated [DATE] revealed Resident #30 had a five as a score indicating the resident was at moderate risk for falls. The resident had not had previous falls and wasn't easily distracted. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact. Her functional status was dependent for eating, toileting, bed mobility, and transfers were not applicable. She was always incontinent of bowel and bladder. Review of the progress notes dated 10/16/24 at 10:00 A.M. revealed a Certified Nursing Aide (CNA) reported to the nurse Resident #30 had fallen. The nurse entered the room and the resident was observed (on the floor) on the right side of the bed with head towards the bathroom, lying on her left side. Her feet were extended towards the foot of the bed. She was assessed head to toe, vital signs were taken, and the left leg was shorter than the right leg. There were multiple skin tears. Her leg was immobilized utilizing a pillow and a blanket. She was assisted back into the bed with three person assistance. Resident #30 complained of pain to her left hip and she was medicated for pain. The physician was called and an order was obtained for a STAT X-ray of the left hip. Wounds were cleansed and treatment was implemented. Review of the X-ray for Resident #30 dated 10/16/24 revealed there was a left femoral neck fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the statement by CNA #89 dated 10/16/24 revealed she was providing incontinence care for Resident #30 and after she finished changing the brief she realized the bed pad was wet, so she reached out with one hand to get an incontinence pad off a night stand, and with the other hand she was holding onto the pad the resident was lying on and the resident fell out of bed onto the floor. Review of Interdisciplinary Team (IDT) progress note dated 10/16/24 revealed CNA #89 was responsible for the resident's care at the time of the incident reported the following details surrounding the resident's fall: CNA #89 came and got the nurse and the manager and stated Resident #30 fell out of bed when she was changing her. CNA #89 stated that she had her rolled over facing left and went to reach for a pad, the resident was reaching for the left assist bar and rolled out of the bed to the floor, small laceration to back of left scalp, several skin tears to left arm, hematoma and skin tear to left leg, wounds cleaned and dressed, resident complained of left hip pain, and she was given pain medications and neurological checks were started. The resident stated I don't know what happened. The Power of Attorney (POA) was called related to the resident's fall, and does not want resident sent to the hospital at this time. Interview with Resident #30 on 03/03/25 at 12:12 P.M. revealed she had fallen out of the bed about six to seven months ago. She stated one aide was changing her brief and wasn't watching her and she rolled out of the bed onto the floor and hit the cabinet behind the bed and broke her leg and her hip. She stated it took four to five staff members to get her back into the bed. She said she was under hospice care and didn't want to go out to the hospital for care, she and her power of attorney wanted to be comfort measures. Interview with CNA #89 on 03/04/25 at 2:13 P.M. revealed she went into the room to provide incontinence care for Resident #30 and got her brief on her and rolled her away from her and denied the resident was rolled too far to the edge of the bed and said she noticed the pad under the resident had feces on it. The aide stated she reached around to grab a new pad with her right hand while her left hand was holding onto the rolled-up pad near the resident. CNA#89 admitted she was holding the pad and not the resident. She said the resident rolled out of the bed. She stated the resident may have tried to grab the side rail or her remote, but she wasn't sure because she could not see what the resident was doing while she reached around for the pad. She said she was alone in the room, so she left the resident on the ground and went to the hall and got a coworker to stay with the resident and went and got the nurse. She said the resident wasn't a two-person assistance until she had this fall and now this was the new intervention. Interview with Registered Nurse (RN) #92 on 03/04/25 at 2:49 P.M. revealed she was the nurse who was taking care of Resident #30 on the day of 10/16/24. She stated CNA #89 stepped out into the hallway and yelled for her to come to Resident #30's room because the resident had fallen out of bed. She stated when she got to the room the resident was on her left side on the floor. She was assessed and her leg was immobilized and she was put back to bed. She notified the physician and she came in to see the resident. She said the CNA either left the room to get the linens or left the resident in the bed to get the linens in the room. Either way the CNA left the resident in bed and she fell . Review of the procedures policy entitled CNA Mock Skills not dated revealed: (1) Adjust the bed to a comfortable height and the lower the head completely. (2) Place the patient on the side of the bed facing away from the intended direction of turning. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(3) Transfer the upper trunk first, supporting the shoulders, then the lower trunk, supporting the hips. (4) Raise the side rail and move to the opposite side of the bed. (5) Flex the knee not near the mattress and place a hand on the patient's hip and shoulder. (6) Roll the patient toward you onto their side.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, staff and resident interviews, and policy review, the facility failed to ensure proper positioning technique was implemented during incontinence care which resulted in a fall out of bed with a major injury. Actual Harm occurred on 10/16/24 when Resident #30, who was cognitively intact, at risk for falls and dependent on staff for turning, repositioning, and toileting sustained a fall out of bed when one staff member was providing incontinent care, and the resident fell to the floor fracturing her left femur due to improper positioning technique. This affected one (Resident #30) of three residents reviewed for falls. The census was 113. Findings included: Medical record review for Resident #30 revealed an admitted [DATE]. Medical diagnoses included spinal cord compression, diabetes, malnutrition, and spinal stenosis. Review of the care plan for Resident #30 dated 09/26/24 revealed she was at risk for falls related to debilitation, weakness, pain, personal history of falls, and use of the psychotic medications. Interventions were to encourage and remind to ask for assistance, have commonly used articles within reach, and maintain a clear pathway. Further review of the care plan revealed Resident #30 may require assistance with Activities of Daily Living (ADL's) and may be at risk of developing complications associated with decreased ADL self-performance. Interventions included re-position/perform mobility with two-person assistance, toilet with two-person assistance, and assist bars to the bed. Review of the fall assessment dated [DATE] revealed Resident #30 had a five as a score indicating the resident was at moderate risk for falls. The resident had not had previous falls and wasn't easily distracted. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact. Her functional status was dependent for eating, toileting, bed mobility, and transfers were not applicable. She was always incontinent of bowel and bladder. Review of the progress notes dated 10/16/24 at 10:00 A.M. revealed a Certified Nursing Aide (CNA) reported to the nurse Resident #30 had fallen. The nurse entered the room and the resident was observed (on the floor) on the right side of the bed with head towards the bathroom, lying on her left side. Her feet were extended towards the foot of the bed. She was assessed head to toe, vital signs were taken, and the left leg was shorter than the right leg. There were multiple skin tears. Her leg was immobilized utilizing a pillow and a blanket. She was assisted back into the bed with three person assistance. Resident #30 complained of pain to her left hip and she was medicated for pain. The physician was called and an order was obtained for a STAT X-ray of the left hip. Wounds were cleansed and treatment was implemented. Review of the X-ray for Resident #30 dated 10/16/24 revealed there was a left femoral neck fracture. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the statement by CNA #89 dated 10/16/24 revealed she was providing incontinence care for Resident #30 and after she finished changing the brief she realized the bed pad was wet, so she reached out with one hand to get an incontinence pad off a night stand, and with the other hand she was holding onto the pad the resident was lying on and the resident fell out of bed onto the floor. Review of Interdisciplinary Team (IDT) progress note dated 10/16/24 revealed CNA #89 was responsible for the resident's care at the time of the incident reported the following details surrounding the resident's fall: CNA #89 came and got the nurse and the manager and stated Resident #30 fell out of bed when she was changing her. CNA #89 stated that she had her rolled over facing left and went to reach for a pad, the resident was reaching for the left assist bar and rolled out of the bed to the floor, small laceration to back of left scalp, several skin tears to left arm, hematoma and skin tear to left leg, wounds cleaned and dressed, resident complained of left hip pain, and she was given pain medications and neurological checks were started. The resident stated I don't know what happened. The Power of Attorney (POA) was called related to the resident's fall, and does not want resident sent to the hospital at this time. Interview with Resident #30 on 03/03/25 at 12:12 P.M. revealed she had fallen out of the bed about six to seven months ago. She stated one aide was changing her brief and wasn't watching her and she rolled out of the bed onto the floor and hit the cabinet behind the bed and broke her leg and her hip. She stated it took four to five staff members to get her back into the bed. She said she was under hospice care and didn't want to go out to the hospital for care, she and her power of attorney wanted to be comfort measures. Interview with CNA #89 on 03/04/25 at 2:13 P.M. revealed she went into the room to provide incontinence care for Resident #30 and got her brief on her and rolled her away from her and denied the resident was rolled too far to the edge of the bed and said she noticed the pad under the resident had feces on it. The aide stated she reached around to grab a new pad with her right hand while her left hand was holding onto the rolled-up pad near the resident. CNA#89 admitted she was holding the pad and not the resident. She said the resident rolled out of the bed. She stated the resident may have tried to grab the side rail or her remote, but she wasn't sure because she could not see what the resident was doing while she reached around for the pad. She said she was alone in the room, so she left the resident on the ground and went to the hall and got a coworker to stay with the resident and went and got the nurse. She said the resident wasn't a two-person assistance until she had this fall and now this was the new intervention. Interview with Registered Nurse (RN) #92 on 03/04/25 at 2:49 P.M. revealed she was the nurse who was taking care of Resident #30 on the day of 10/16/24. She stated CNA #89 stepped out into the hallway and yelled for her to come to Resident #30's room because the resident had fallen out of bed. She stated when she got to the room the resident was on her left side on the floor. She was assessed and her leg was immobilized and she was put back to bed. She notified the physician and she came in to see the resident. She said the CNA either left the room to get the linens or left the resident in the bed to get the linens in the room. Either way the CNA left the resident in bed and she fell . Review of the procedures policy entitled CNA Mock Skills not dated revealed: (1) Adjust the bed to a comfortable height and the lower the head completely. (2) Place the patient on the side of the bed facing away from the intended direction of turning. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(3) Transfer the upper trunk first, supporting the shoulders, then the lower trunk, supporting the hips. (4) Raise the side rail and move to the opposite side of the bed. (5) Flex the knee not near the mattress and place a hand on the patient's hip and shoulder. (6) Roll the patient toward you onto their side.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record review, interview, and facility policy review, the facility failed to administer antibiotic medication to one, Resident #100, of three reviewed for antibiotic use. The facility census was 113. Findings Included: Review of the record for Resident #100 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, chronic respiratory failure with hypoxia, osteomyelitis of vertebra sacral and sacrococcygeal, type two diabetes, and dependence of respiratory ventilator and oxygen. Review of quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #100 had was unable to complete a brief interview of mental status (BIMS) indicating the he was severely cognitively impaired. Resident #100 dependent on staff for oral care, toileting, personal hygiene, bathing, dressing upper and lower body, and placing shoes on and off feet. Review of the plan of care dated 05/15/24 revealed Resident #100 had altered health maintenance related to progressive physical and mental status, related to anemia, contractures, history of ileus, diffuse anoxic brain damage, osteomyelitis, seizures, and sepsis. Administer medication as ordered, administer oxygen per physician order, monitor effectiveness of pain medications or side effects and report to medical director, monitor for signs and symptoms of cardiac distress, and monitor for symptoms of distress, infection, increased temperature, redness, warmth of swelling, and elevated white blood count, and decreased urine output. Review of hospital document dated 10/16/24 for Resident #100 revealed the Resident admitted to the hospital on 10/08/24 with severe sepsis, was noted to have cardiac arrest in the Emergency Department, and be admitted to the Intensive Care Unit (ICU) on 10/08/24. Septic shock resolved on 10/13/24 when the resident was transferred out of ICU. Resident remained in the hospital and was discharged back to the facility on [DATE]. The document revealed the resident was to have the following medication changes; start taking these medications Cefpodoxime (antibiotic) 200 mg take one tablet two times a day for 14 days, Ciprofloxacin (antibiotic) 750 mg take one tablet two times a day for 14 days, Linezolid (antibiotic) 600 mg take one tablet two times a day, and stop taking Acetaminophen 160 mg/5 ml elixir. Review of progress note dated 10/17/24 at 12:10 A.M. by Licensed Practical Nurse (LPN) #73 revealed Resident #100 arrived via stretcher at 11:33 P.M. from the hospital. All orders have been verified. Review of physician order dated 10/17/24 revealed that Resident #100 had an order for Cefpodoxime Proventil Oral Suspension Reconstituted 100 MG/5 ML give gastric tube to give 10 ml enterally two times a day for sepsis for 14 days. To start on 10/17/24 at 6:00 A.M. Review of progress note dated 10/17/24 at 6:16 A.M. LPN #73 documented Cefpodoxime Proventil Oral Suspension Reconstituted 100 MG/5 ML. Medication was not available, awaiting arrival from pharmacy. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of progress note dated 10/18/24 at 11:56 P.M. LPN #19 documented Cefpodoxime Proventil Oral Suspension Reconstituted 100 MG per 5 ML. Pharmacy accidentally sent in tablet instead of reconstituted formula, per pharmacist the medication will be dropped shipped this morning. Review of progress note dated 10/19/24 at 5:40 A.M. LPN #19 documented Cefpodoxime Proxetil Oral Suspension Reconstituted 100 MG/5 ML. Awaiting delivery from the pharmacy for medication. Review of progress note dated 10/25/24 at 9:28 A.M. LPN #108 documented Cefpodoxime Proventil Oral Suspension Reconstituted 100 milligram (mg) per 5 milliliters (ml). Give 10 ml enterally two times a day for sepsis for 14 Days. Medication was unavailable, and pharmacy contacted. The pharmacist stated that medication is on back order. Review of the medication administration record from 10/01/24 through 10/31/24 revealed Resident #100 did not receive the following antibiotics: Cefpodoxime Proventil Oral Suspension Reconstituted 100 milligram per 5 milliliters for dates 10/17/24, 10/18/24, 10/19/24, and 10/25/24. Interview on 03/06/25 at 5:23 P.M. with Director of Nursing (DON) revealed the nurses did not chart in records they had notified the physician timely for all antibiotics that Resident #100 had missed on dates 10/17/24, 10/18/24, 10/19/24, and 10/25/24. Review of facility policy titled Change in Condition dated 10/18/2001 change of condition was defined as deterioration in health, mental, or psychological status of a resident related to a life-threatening condition, a significant alteration in treatment, or significant change in the resident's clinical conditions or status. One life threatening condition, depending on severity included infections. The unit supervisor or charge nurse will notify the resident, physician, and guardian of all changes as stated above, and any other situations requiring notification.