STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365504	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Glen Health Services Corp	5155 North High Street Columbus, OH 43214

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on staff interview, review of the facility's Self-Reported Incidents (SRI), review of the facility's policy, and medical record review, the facility failed to timely report an allegation of sexual abuse to the State Survey Agency, the Ohio Department of Health. This affected one (Resident #162) of three residents reviewed for abuse. The facility census was 45. Findings include: Review of the Resident #162's medical record revealed an admitted [DATE]. Resident #162 was admitted with diagnoses of Parkinson's disease, dementia, and encephalopathy. Review of facility's SRI Control Number 218191 revealed the was submitted on 02/22/22 at 10:52 A.M. The SRI was related Resident #162 reporting an allegation of sexual abuse against STNA #66. Review of the facility's investigation related to SRI control number 218191, revealed at the end of day shift, Resident #162 was crying and reported to an state tested nursing aide (STNA) that a man had been trying to rape her in her room. She identified the man as STNA #66 . STNA #66 was sent home immediately. Interview on 09/08/22 at 3:35 P.M. with the Administrator and the Director of Nursing (DON) confirmed they did not notify the Ohio Department of Health of the abuse when the allegation was reported on 02/21/22. Review of the facility's undated policy titled Abuse, Neglect, Exploitation, and Mistreatment of Residents and Misappropriation of Resident Property revealed the Administrator or designee will report to the Ohio Department of Health (ODH) immediately (no later than two hours after allegation is made.)

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on medical record review, review of the facility's Self-Reported Incidents (SRI), staff interview and review of the facility's policy, the facility failed to complete a thorough investigation regarding a resident's allegation of sexual abuse. This affected one (Resident #162) of three residents reviewed for abuse. The facility census was 45. Findings include: Review of the Resident #162's medical record revealed an admitted [DATE]. Resident #162 was admitted with diagnoses of Parkinson's disease, dementia, and encephalopathy. Review of facility's SRI Control Number 218191 revealed the was submitted on 02/22/22 at 10:52 A.M. The SRI involved Resident #162 reporting an allegation of sexual abuse against State tested Nursing Aide (STNA) #66. On 02/21/22 at the end of day shift, Resident #162 was crying and reported to an STNA a man had been trying to rape her in her room. Review of facility's investigation of SRI Control Number 218191 revealed the facility interviewed four alert and oriented residents who resided on Resident #165's unit. The facility did not assess additional residents who were unable to answer questions about being abused. There was no evidence that Resident #162 was physically assessed for any injuries related to abuse on 02/21/22. Resident #162's medical record did not have documentation regarding Resident #162 alleging she was was crying and alleged a man had been trying to rape her. There was no documentation Resident #162's representative, or her physician were notified of the sexual abuse allegation. There was no evidence Resident #162 was physically assessed for any injuries related to abuse on 02/21/22. Interview on 09/08/22 at 3:35 P.M. with the Administrator and the Director of Nursing (DON) confirmed the facility did not complete any physical assessments for signs of abuse on Resident #162 and confused residents involving the SRI control number 218191. The Administrator and DON confirmed the allegation of abuse or the investigation was not documented in Resident #162's medical record. Review of the facility's undated policy titled Abuse, Neglect, Exploitation, and Mistreatment of Residents and Misappropriation of Resident Property revealed all alleged violations involving abuse will be investigated. The investigation includes physical examination of the alleged victim for signs and injury, or a psychological assessment if needed. A resident's nurses' notes will include the results of the resident's assessment, notification of the physician and the resident's representative, and any treatment provided involving the allegation.

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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** 44070 Based on resident, family, and staff interviews, review of the facility's policy, and record review, the facility failed to ensure medications were administered as physician ordered. This affected two (Residents #149 and #159) of five residents reviewed for medication. The facility census was 45. Findings include 1. Review of the medical record for Resident #159 revealed an admitted [DATE] at 5:54 P.M. Diagnoses included back pain, anxiety, and surgical stabilization of rib fractures for ribs five, six, seven, eight, and nine. Review of the hospital discharge referral documents dated 08/28/22 revealed Resident #159 had a historical diagnosis of back pain with multiple acute rib fractures requiring surgical revision and a diagnosis of anxiety. Resident was on several pain medications during her hospitalization and was weaning off intravenous (IV) Dilaudid (treats moderate to severe pain) and transitioning to oral Oxycodone (treats moderate to severe pain). Review of the hospital discharge summary dated 09/04/22 revealed the discharge medications included Oxycodone five milligram (mg) tablet immediate release with instructions to provide every six hours as needed (PRN) for pain and Alprazolam one mg tablet with instruction to provide every six hours as needed (PRN) for anxiety. The discharge summary revealed Resident #159 last received pain medications at 2:15 P. M. at the hospital. Review of the facility's physician order dated 09/04/22 revealed Resident #159 was ordered Oxycodone five mg tablet with instructions for oral tablet every six hours PRN and alprazolam tablet one tablet PRN every six hours for anxiety. Review of the plan of care dated 09/04/22 revealed Resident #159 was at risk for discomfort with interventions to administer medication as ordered, complete a pain assessment, offer non-pharmacological interventions and notify the physician of changes in pain. Review of the admission assessment dated [DATE] revealed Resident #159 had verbal indicators of pain. Resident #159 described the pain of ribs aching from her fractures. Review of the progress notes dated 09/05/22 at 2:27 A.M. revealed Resident #159 had verbal indicators of pain. The progress note dated 09/05/22 at 11:54 A.M. revealed Resident #159 had verbal indicators of pain. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #159 was cognitively intact. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) dated 09/04/22 to 09/07/22 revealed Resident #159 was not given any pain medication (Oxycodone) on 09/04/22 and the first time this medication was given since admission was 09/05/22 at 11:00 A.M. when Resident #159's pain was rated an eight, from a scale of zero (no pain) to a ten (most severe pain). Additionally, Resident #159 was not given any anxiety medication (Alprazolam) on 09/04/22 and the first time this medication was given since admission was 09/05/22 at 11:00 A.M. Interview on 09/06/22 at 1:45 P.M. with Resident #159 revealed she admitted on [DATE] around dinner time and was requesting anxiety and pain medication. Resident #159 reported she was informed by nursing staff she would have to wait until the pharmacy could process the scripts and deliver to the facility. Resident #159 reported she was crying and yelling out in pain and it made her anxious. Resident #159 stated she went almost 24 hours without pain or anxiety medications. Interview on 09/12/22 at 10:00 A.M. with Nurse Practitioner (NP) #200 revealed she had no knowledge of a delay in medication for Resident #159. NP #200 stated waiting 18 to 24 hours for pain and anxiety medications seemed like a long time. Interview on 09/12/22 at 10:28 A.M. with Registered Nurse (RN) #20 revealed she was assisting the other nurse but denied any involvement in the admission assessment, verifying medications, or calling the medical team. Interview on 09/12/22 at 10:37 A.M. with RN #21 revealed she completed the intake assessment while the other nurse reviewed the medications and hospital paperwork. RN #21 denied contacting the physician regarding her medications during the remainder of her shift and revealed no knowledge of issues with Resident #159's medications. RN #21 stated Resident #159 verbalized pain and anxiety during her intake and RN #21 reported she informed Resident #159 the facility was waiting on medication from the pharmacy. RN #21 stated the facility had a process to obtain single dose medications in case of emergencies and revealed knowledge of this process but denied putting in a request for Resident #159 to get her pain and anxiety medications timely. RN #21 verified Resident #159 did not receive any pain or anxiety medications during her shift. Interview on 09/12/22 at 11:06 A.M. with the Director of Nursing (DON) stated he was unaware of the delay in Resident #159 receiving her medications. The DON stated he would expect staff to assess the resident and if pain or anxiety medication was needed, the staff should follow the process to contact the pharmacy for emergency approval to use the E box. The DON acknowledged the medications were administered the next day but did not know reason for delay. Review of the facility's undated policy titled Pain Management revealed pain assessments should be completed at admission and periodically as needed. Incorporate a resident interview in the pain assessment as well as observations regarding pain characteristics. Notify the physician and as appropriate obtain an order for pain medication and notify physician if ordered medications for pain are not effective. 2. Review of the medical record for Resident #149 revealed an admitted [DATE]. Diagnoses included dementia with Lewy bodies, acute embolism with thrombosis of right popliteal vein. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #149 was cognitively intact. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders dated 08/26/22 revealed Resident #149 was ordered Azelastine HCl Solution 0.15 percent (%) two sprays in each nostril at bedtime for allergies. Review of the medication administration review (MAR) from 08/26/22 to 09/07/22 revealed Azelastine HCl Solution 0.15 % two sprays in each nostril at bedtime was not administered on 08/26/22, 08/27/22, 08/29/22, 08/31/22, 09/01/22 and 09/06/22. The code marked on the MAR said, other-see nursing note. Review of the progress notes dated 08/26/22 to 09/07/22 revealed there was no documentation related to Azelastine HCl Solution not being administered to Resident #149. Interview with Resident #149 and family member revealed they have requested home medications be added to his physician orders and provided while at the facility including the allergy medication Azelastine HCl solution. Resident #149 reported he was not consistently getting this medication. Interview on 09/12/22 at 3:34 P.M. with the Director of Nursing (DON) and Administrator revealed Resident #149's wife was bringing in the Azeleastine HCL solution medication to provide to Resident #149 and when she did not provide it, Resident #149 would not receive it. They confirmed it was not being administered as physician ordered. Review of the facility's undated policy titled Automated Dispensing Machine for First Dose and Emergency Medications revealed the community may use automated dispensing system for the first dose and emergency medications when permitted. The pharmacy must provide authorization for emergency use medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, review of the facility's policy, staff interviews, review of online resources at Center for Medicaid and Medicare Services (CMS) and Centers for Disease Control and Prevention (CDC), and record review, the facility failed to maintain infection control protocols and wear the appropriate Personal Protective Equipment (PPE) in resident rooms that were in quarantine to prevent the potential spread of COVID-19. This affected one (Residents #160) of two residents reviewed for transmission based precautions (TBP). This had the potential to affect all 45 residents residing in the facility. Findings include: Review of the medical record for Resident #160 revealed an admitted [DATE]. Diagnoses included gangrene, kidney failure atrial fibrillation, and heart disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 was cognitively intact and required extensive assistance of one staff member for mobility. Review of the physician's orders dated 09/06/22 at 1:33 P.M. revealed Resident #160 was placed in quarantine for 10 days due to vaccination status. This physician order was four days after Resident #160 was admitted to the facility. Observation on 09/06/22 at 12:38 P.M. revealed State tested Nursing Aide (STNA) #42 entered Resident #160's room wearing a surgical mask and face shield for PPE. Resident #160 was having a hard time understanding STNA #160, so STNA #42 removed her mask. Interview on 09/06/22 at 1:25 P.M. with the Director of Nursing (DON) revealed Resident #160 should be in quarantine due to being unvaccinated for COVID-19 and a new admission. The DON verified Resident #160 had not been in placed in quarantine upon admission on 09/02/22. The DON verified Resident #160 went four days without being in quarantine and was placed in quarantine on 09/06/22 after surveyor intervention. The DON confirmed staff should be wearing N-95, gown, gloves, and a face shield when entering Resident #160's room. Observation and interview on 09/08/22 at 5:37 P.M. with STNA #39 revealed staff wore surgical mask into a Resident #160's room. STNA #39 confirmed isolation boxes do not have N-95 masks in them and staff were to place a second surgical mask over their original surgical mask and remove the second mask upon exit from the resident's room. Review of an online resource from CMS titled COVID-19 Nursing Home Data at https://data.cms.gov/COVID-19/covid-19-nursing-home-data revealed the county in which the facility was situated was experiencing a high (red) community transmission rate of COVID 19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on an online resource per the CDC titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, last updated 02/02/22, revealed the recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic to implement source control measures. Source control refers to the use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control options for healthcare professionals include: A NIOSH-approved N95 or equivalent or higher-level respirator or a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators or a well-fitting facemask. Health Care Professionals (HCP) working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They should also, wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters. Review of the CDC guidance titled Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, last updated 02/02/22, revealed under the section titled New Admission and Residents who Leave the Facility, all residents who are not up to date with recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as described in the testing section. Review of the facility's policy titled Transmission Based Precautions, dated 05/01/22, revealed PPE should be maintained in the isolation carts including gowns, gloves, masks, etc. A notice should be posted to the door identifying CDC category of transmission based precautions and instructions to see the nurse prior to entering. [NAME] appropriate PPE prior to entering the environment.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45443 Based on medical record review, staff interview, and policy review, the facility failed to administer a pneumonia vaccine to a resident. This affected one (Resident #8) of five residents reviewed for immunizations. The facility census was 45. Findings include: Medical record review for Resident #8 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, tropical spastic paraplegia, and cerebral infarction. Further record review for Resident #8 revealed a consent for the pneumonia vaccine dated 09/29/20 by Resident #8's Power of Attorney (POA). Review of Resident #8's physician orders revealed there was no order to administer the pneumonia vaccine. Review of immunizations in Resident #8's electronic medical record revealed it was silent for documentation of the pneumonia vaccine. Interview on 09/12/22 at 12:44 P.M. with the Director of Nursing (DON) revealed the facility offers the pneumonia vaccine to residents. The facility reviews the residents' records periodically for pneumonia vaccine status and offers the vaccine if indicated. Subsequent interview on 09/12/22 at 2:17 P.M. with the DON revealed the facility was unable to provide evidence of historical pneumonia vaccine status for Resident #8. Review of the facility's undated policy titled Pneumoccocal Vaccine revealed the facility is to offer the pneumoccal vaccine immunizations to all residents as recommended by the Centers for Disease Control and Prevention (CDC). Residents should be evaluated for indications to receive the pneumonia vaccine upon admission and immunization records will be reviewed annually.