STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365714	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Leonard Hcc	8100 Clyo Road Centerville, OH 45458

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, policy review, and staff interview the facility failed to ensure the comprehensive care plan included a vision and hearing plan for Resident #107 and a indwelling urinary catheter for Resident #95. This affected two (Resident #95 and #107) of six residents reviewed for care plans. The facility census was 112. Findings include: 1. Review of medical record for Resident #107 revealed admitted [DATE]. Diagnoses included macular degeneration of the right eye and hearing loss, unspecified ear. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #107 had impaired cognition. His vision was documented as impaired, and his hearing was documented as adequate. Review of Resident #107's care plan revealed there was no documentation of a hearing or vision concern. Interview on 07/15/24 at 11:44 A.M. with Resident #107 revealed he did have an issue with his hearing, and he was blind in his right eye. Interview on 07/18/24 at 2:08 P.M. with MDS Nurse #214 verified there was no care plan in place for Resident #107's hearing and vision concern. 48570 2. Review of the medical record for Resident #95 revealed an admitted [DATE]. Diagnosis included benign prostatic hyperplasia with lower urinary tract symptoms. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders for Resident #95's indwelling urinary catheter revealed an order dated 01/21/24 for a privacy bag at all times every shift for dignity, irrigate with 60 cubic centimeters (cc) of normal saline (NS) for leaking or non-functioning every 12 hours as needed, may change as needed when unable to irrigate every 12 hours as needed for dysuria, change collection bag with sediment or as needed every shift. An order dated 03/01/24 to change the urine collection bag every two months on day shift An order dated 03/14/24 may use leg bag when out of bed as tolerated every shift. An order dated 05/01/24 for a catheter strap to leg as tolerated every shift. Review of Resident #95's care plan revealed no documentation on the resident's indwelling urinary catheter. Interview on 07/17/24 at 3:14 P.M. with Assistant Director of Nursing (ADON) #1 confirmed Resident #95 had a indwelling urinary catheter and verified Resident #95's plan of care did not include the care and services of the indwelling urinary catheter. Review of the facility policy titled Comprehensive Care Plan dated 10/24/22 revealed the facility would develop a comprehensive and person-centered care plan for each resident that included measurable objectives and time frames.

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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** 44069 Based on record review, staff interview, and policy review, the facility failed to ensure fall interventions were timely added to the care plan. This affected one (#66) of five residents reviewed for falls. The facility census was 112. Findings include: Review of the medical record for Resident #66 revealed an admitted [DATE]. Diagnoses included dementia, congestive heart failure, anxiety disease, chronic kidney disease, delusional disorders, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 had severely impaired cognition. Review of the interdisciplinary team (IDT) note dated 07/10/24 revealed Resident #66 had a fall on 06/17/24 in her room and was found in front of her wheelchair. The new intervention was to place Dycem in the wheelchair. The IDT note dated 07/11/24 revealed Resident #66 had a fall on 06/21/24 in her room and was found near her bed. The new intervention was a fall mat to the side of the bed. Review of the plan of care revised on 07/15/24 revealed Resident #66 was at risk for falls and injury related to confusion, incontinence, psychoactive drug use, anxiety, insomnia, impaired mobility, gout, peripheral vascular disease, and neuropathy. Interventions included fall mat to side of bed while in bed, which was initiated on 06/21/24 and added to the care plan on 07/16/24, low bed, place Dycem to wheelchair, which was initiated on 06/17/24 and added to the care plan on 07/10/24, ensure appropriate footwear when out of bed, and make sure floor/path is clutter free and properly lighted. Interview on 07/18/24 at 1:34 P.M. with the Director of Nursing (DON) confirmed the new fall interventions for Resident #66 were not added to Resident #66's care plan timely. Review of the facility policy titled Fall Prevention Program, revised 07/17/24, revealed the facility would review the resident's care plan and update as indicated.

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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 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** 44076 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the physician treatment orders were followed and implemented timely for the residents. This affected two (Residents #60 and #108) of two residents reviewed for un-pressure related skin conditions. The facility census was 112. Findings include: 1. Review of the medical record for Resident #60 revealed admitted [DATE]. Diagnoses included encounter for orthopedic aftercare, infection and inflammatory reaction due to internal joint prosthesis and vascular dementia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had significantly impaired cognition. Review of the care plan revealed Resident #60 had skin breakdown due to right hip surgical incision. Interventions included to administer treatments as ordered and for enhanced barrier precautions. Review of the physician orders dated 06/18/24 revealed an order to cleanse the right hip surgical site with normal saline, pat dry and apply dry dressing daily and as needed. Observation and interview on 07/18/24 at 11:52 A.M. with Licensed Practical Nurse (LPN) #107 and Infection Control Preventionist #3 revealed they were going to complete a wound treatment for Resident #60. Upon exposing the right hip of Resident #60, the dry dressing was dated 07/15/24. LPN #107 verified this date was three days old and LPN #107 verified the physician order was to change the dressing daily. 48570 2. Review of the medical record for Resident #108 revealed an admitted [DATE] with diagnoses of hypertensive heart disease without heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #108 had severe cognitive impairment. Review of [NAME] Wound Initial Wound Evaluation and Management summary dated 07/16/24 revealed Resident #108 had a wound of the left, lower, lateral shin due to infection and a wound of the right, upper, medial calf due to infection. The resident developed cellulitis, has chronic issues with lower extremity (LE) edema, and developed multiple blisters. The dressing treatment plan was to apply Alginate calcium with silver apply once daily for 30 days and apply gauze roll (kerlix) 4.5 inch, apply once daily for 30 days. Review of Resident #108's physician orders for July 2024 revealed there were no treatment orders initiated to apply calcium alginate with silver, apply once daily for 30 days and to apply kerlix daily for 30 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/18/24 at 10:00 A.M. with Assistant Director of Nursing (ADON) #1 confirmed the wound rounds completed on 07/16/24 had physician orders to change the treatments to resident's right lower extremity and left lower extremity and confirmed the physician orders were not initiated for Resident #108.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, observations, interviews, review of the information from the National Pressure Ulcer Advisory Panel (NPUAP), and policy review, the facility failed to ensure timely treatments and interventions were done for a resident's pressure ulcer. This resulted in actual harm when Resident #95's pressure ulcer to his left heel deteriorated in condition and developed osteomyelitis from the delay in treatment. This affected one (Resident #95) of two residents reviewed for pressure wounds. The facility census was 112. Findings include: Review of the medical record for Resident #95 revealed an admitted [DATE]. Diagnoses included acute kidney failure, peripheral vascular disease, and pressure ulcer of sacral region, unspecified stage. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 had moderate cognitive impairment. Resident #95 was dependent on staff for toileting, bathing and transfers and required substantial assistance from staff for bed mobility. Resident #95 did not have any rejection of care during the look-back period of the assessment. Review of the plan of care created on 05/21/24 revealed Resident #95 had a pressure ulcer to the left heel related to recent medical diagnoses and noncompliance with off-loading area. Intervention included wearing off-loading boots as tolerated. Review of the Skin Observation Tool assessment dated [DATE] revealed Resident #95 had a wound to the left heel, and it was a deep tissue injury (DTI) (purple or maroon area of discolored intact skin due to damage of underlying soft tissue). There were no measurements present. Review of the Treatment Administration Record (TAR) for May 2024 revealed on 05/17/24, skin preparation to the left heel was applied once daily through 05/21/24. Review of the [NAME] Wound Evaluation and Management Summary dated 05/21/24 revealed Resident #95 had a pressure area to the left heel, and it was an unstageable (slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar) due to necrosis measuring 3.0 centimeter (cm) in length by 3.0 cm in width by 0.1 cm in depth. Physician #213 ordered treatment changed to Alginate calcium w/silver apply once daily, foam silicone bordered dressing and apply once daily for 30 days. The recommendation was to float heels in bed and wear pressure off-loading boots. Review of the TAR revealed there was no treatment applied to the wound on 05/22/24 and the new treatment was not implemented until two days later on 05/23/24. This treatment remained in place until 06/19/24 and there was one missed treatment to the left heel on 06/03/24. Review of the physician order dated 06/14/24 revealed an order for two-view x-ray of the left heel due to an odor on the left heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the progress note dated 06/14/24 at 11:49 A.M. revealed Resident #95 had a positive x-ray confirming the resident had osteomyelitis in the left heel. Review of the radiology results report dated 06/14/24 revealed the conclusion of the x-ray was suspect posterior calcaneal osteomyelitis. Review of the [NAME] Wound Evaluation and Management Summary dated 06/18/24 revealed a pressure area to left heel was presenting at a stage IV measuring 4.0 cm in length by 4.0 cm wide by 0.2 cm in depth. Physician #213 ordered treatment changed to cleanse with normal saline, dampen gauze with 0.25% Dakin's solution, then pack wound with Dakin's dampened gauze. Cover with abdominal pad and wrap with kerlix every day. Further review of the TAR and physician orders revealed the treatment was not changed until two days later on 06/20/24. On 06/28/24, there was an order for Doxycycline Monohydrate (antibiotic) 100 milligrams (mg) capsule, administer one capsule by mouth two times a day for osteomyelitis until 07/28/24. This order was 14 days after the initial diagnosis of osteomyelitis on 06/14/24. Review of the TAR for July 2024 revealed there were two missed treatments to the left heel on 07/05/24 and 07/07/24. The treatment to the left heel was to cleanse with normal saline, dampen gauze with 0.25% Dakin's solution, then pack wound with Dakin's dampened gauze. Cover with abdominal pad and wrap with kerlix every day was not documented as being done. Review of the Skin Observation Tool assessment dated [DATE] revealed the wound to left heel presented as a stage IV pressure wound full thickness wound and measured 3.5 cm in depth by 3.0 cm length by 0.2 cm in depth. The surface area was 10.50 cm. Observation and interview on 07/15/24 at 10:27 A.M. revealed Resident #95 was lying in bed with bilateral heels laying directly on his mattress and the heels were not floating off the mattress and he was not wearing any pressure off-loading boots. There was a low air loss mattress in place. The left heel wound had gauze wrap present. Observations on 07/15/24 at 1:39 P.M. and 3:17 P.M. and on 07/16/24 at 9:00 A.M., 12:22 P.M., and 3:46 P.M. revealed Resident #95 continued to lay in bed with bilateral heels laying on the mattress and the heels were not floating off the mattress and he was not wearing any pressure off-loading boots. Interview on 07/17/24 at 3:14 P.M. with Assistant Director of Nursing (ADON) #22 confirmed there was not a physician order to float bilateral heels in bed or for pressure off-loading boots as noted on the [NAME] Wound Evaluation and Management Summary dated 05/21/24. ADON #22 confirmed there was no documentation that Resident #95's heels have been floated or that pressure off-loading boots had been implemented. ADON #22 confirmed Resident #95's treatment of osteomyelitis which was diagnosed on [DATE] was not implemented until 06/28/24. ADON #22 stated the facility was behind on reviewing the wounds' recommendations and transcribing accordingly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Telephone interview on 07/17/24 at 3:39 P.M. with Physician #213 confirmed Resident #95 has a stage IV pressure area to the left heel. Physician #213 confirmed Resident #95 had arterial doppler in November 2023 and the vascular studies were normal. Physician #213 stated she was surprised Resident #95 ended up with a stage IV wound and osteomyelitis in the left heel. Physician #213 confirmed Resident #95 was to wear pressure off-loading boots. Review of the Wound Treatment Management policy dated 11/23/22 revealed it is the policy of the facility to promote wound healing for various types of wounds, and to provide evidence-based treatments in accordance with current standards of practice and physician orders. Review of the information from the NPUAP revealed a deep tissue pressure injury is intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage Three or Stage Four). Do not use deep tissue pressure injury to describe vascular, traumatic, neuropathic, or dermatologic conditions. Further review of the NPUAP revealed staff should assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices, implement interventions to ensure that the heels are free from the bed and use heel offloading devices or polyurethane foam dressings on individuals at high-risk for heel ulcers.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, observations, staff interview, and policy review, the facility failed to ensure physician orders for oxygen administration were followed. This affected one (Resident #7) of one resident reviewed for respiratory care. The facility census was 112. Findings include: Review of the medical record of Resident #7 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact, was dependent on staff assistance for activities of daily living, and utilized oxygen therapy. Review of the care plan revealed Resident #7 has oxygen therapy related to COPD, chronic respiratory failure with hypoxia, obstructive sleep apnea, congestive heart failure, and morbid obesity. Intervention included providing oxygen as ordered. Review of Resident #7's physician order dated 07/18/23 revealed an order to administer oxygen at two to three liters per minute per nasal cannula to keep saturations greater than 90% every shift for shortness of breath (SOB) related to COPD. Observation on 07/15/24 at 2:11 P.M. revealed Resident #7's oxygen level was set on 3.5 to four liters. Subsequent observation on 07/16/24 at 3:14 P.M. revealed Resident #7's oxygen level set to four liters. Interview on 07/16/24 at 3:15 P.M. with Assistant Director of Nursing (ADON) #1 confirmed Resident #7's oxygen was set at four liters per minute via nasal cannula and should not be set that high. ADON #1 confirmed Resident #7's oxygen should be set at two to three liters per minute per nasal cannula. Review of the Oxygen Administration policy dated 10/2010 revealed the purpose is to provide safe oxygen administration and verify that there is a physician's order for the procedure.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, resident and staff interviews, and policy review, the facility failed to schedule dental services for teeth extractions per physician orders for a resident. This affected one (Resident# 54) of one resident reviewed for dental services. The facility census was 112. Findings include: Review of the medical record for Resident #54 revealed an admitted [DATE] with diagnoses of major depressive disorder and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was cognitively intact and required substantial assistance with oral hygiene. Resident #7 did not have broken or loosely fitting full or partial dentures and did not have mouth or facial pain, discomfort or difficulty with chewing. Review of the physician orders dated 12/14/23 revealed an order for Resident #54 to have order to extract broken teeth and root tips. The resident was planned for upper complete denture and lower partial. Resident #54 would like to keep tooth #17 and #22 to #27 for partial support. Please see scheduler to set up appointment. There was an additional order dated 02/21/24 to please contact Cleveland Dental Institute and schedule appointment for Resident #54 to extract broken teeth and root tips and the resident would like to keep tooth #17 and #22 to #27. The physician cleared Resident #54 to have local anesthesia and discontinue when done. Review of the care plan dated 04/08/24 revealed Resident #54 was at risk for oral/dental health problems to rule out partial dentures. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered and monitor for signs and symptoms of oral/dental problems needing attention: pain (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth, and lesions. Interview on 07/15/24 at 9:50 A.M. with Resident #54 revealed she had broken teeth that needs removed and had a consultation done 02/02/24. Resident #54 stated there had been no follow up since February 2024 and reported she has pain with movement and touching of the areas. Interview on 07/17/24 at 10:40 A.M. with Administrative Assistant/Scheduler (AA/S) #20 confirmed she schedules appointments for the residents. AA/S #20 stated she was not aware an appointment needed scheduled to have Resident #54's teeth extracted. AA/S #20 stated no one gave her the paperwork to schedule the appointment and verified Resident #54 has not been scheduled or sent out to have teeth extracted. Review of the Dental Services policy, undated, revealed routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and care plan.

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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** 44076 Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure proper enhanced barrier precautions (EBP) were followed for Resident #60 and the facility failed to ensure gloves were worn when administering eye drops for Resident #26. The facility census was 112. Findings include: 1. Review of the medical record for Resident #60 revealed admitted [DATE]. Diagnoses included encounter for orthopedic aftercare and infection and inflammatory reaction due to internal joint prosthesis. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had significantly impaired cognition. Review of the care plan dated 06/27/24 revealed Resident #60 had skin breakdown due to right hip surgical incision. Interventions included to administer treatments as ordered and EBP. Observation on 07/18/24 at 11:51 A.M. revealed there was a sign taped on the door of Resident #60's room which documented EBP were required. This included the need for gloves and gowns for high resident contact. Just inside the room to the right of the doorway was a plastic cabinet with three drawers which contained gloves and disposable yellow gowns. Observation and interview on 07/18/24 at 11:52 A.M. with Licensed Practical Nurse (LPN) #107 and Infection Control Preventionist (ICP) #3 revealed they entered Resident #60's room to complete wound treatment. LPN #107 washed her hands and donned gloves. LPN #107 did not don a gown. LPN #107 proceeded to assist Resident #60 to pull down her pants, unfasten her incontinent product and expose her dressing. After removing the dressing using proper procedure, she provided wound treatment and redressed the wound. During an interview directly following the wound treatment, LPN #107 acknowledged Resident #60 required EBP but denied knowledge of the need for any other Personal Protective Equipment (PPE) except her gloves. Interview on 07/18/24 at 12:23 P.M. with ICP #3 revealed a gown was required during the wound treatment for Resident #60 and verified LPN #107 did not wear a gown to perform wound treatment on Resident #60. Review of the undated facility policy titled Enhanced Barrier Precautions documented it was the policy of the facility to implement EBP for the prevention of transmission of multidrug-resistant organisms. Staff were expected to comply with all designated precautions. 48570 2. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of the physician orders revealed an order for Artificial Tears one drop in each eye daily. Observation on 07/17/24 at 8:46 A.M. revealed Licensed Practical Nurse (LPN) #110 administered Resident #26's Artificial Tears one drop in each eye without wearing gloves. (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 07/17/24 at 8:54 A.M. with LPN #110 confirmed she did not use gloves to administer Resident #26's Artificial Tears one drop in each eye.

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	365714	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Leonard Hcc	8100 Clyo Road Centerville, OH 45458

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 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** 44069 Based on record review, staff interview, and policy review, the facility failed to ensure influenza and pneumococcal immunizations were offered to residents. This affected four (#19, #51, #66, and #74) out of five residents reviewed for immunizations. The facility census was 112. Findings include: 1. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included other sequela of cerebral infarction and type two diabetes mellitus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had severely impaired cognition. Further review of the medical record revealed no evidence that the facility offered the pneumococcal immunization or provided education to the resident or resident representative. Interview on 07/18/24 at 1:30 P.M. with the Director of Nursing verified the lack of immunization documentation for Resident #19. 2. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition. Further review of the medical record revealed no evidence that the facility offered the pneumococcal immunization or provided education to the resident or resident representative. Interview on 07/18/24 at 1:30 P.M. with the Director of Nursing verified the lack of immunization documentation for Resident #51. 3. Review of the medical record for Resident #66 revealed an admitted [DATE]. Diagnoses included dementia, congestive heart failure, and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 had severely impaired cognition. Further review of the medical record revealed no evidence that the facility offered the influenza or pneumococcal immunization or provided education to the resident or resident representative. Interview on 07/18/24 at 1:30 P.M. with the Director of Nursing verified the lack of immunization documentation for Resident #66. 4. Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included congestive heart failure, asthma, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 had intact cognition. Further review of the medical record revealed no evidence that the facility offered the influenza or pneumococcal immunization or provided education to the resident or resident representative. Interview on 07/18/24 at 1:30 P.M. with the Director of Nursing verified the lack of immunization documentation for Resident #74. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365714	A. Building B. Wing	07/18/2024

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St Leonard Hcc	8100 Clyo Road Centerville, OH 45458

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Influenza Exposure Control, dated 03/01/23, revealed the current season's influenza vaccine would be offered to residents. Review of the facility policy titled Pneumococcal Vaccine, dated 03/02/23, revealed each resident would be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365714	A. Building B. Wing	07/18/2024

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, staff interview, and policy review, the facility failed to ensure COVID-19 immunizations were offered to residents. This affected three (#19, #66, and #74) out of five residents reviewed for immunizations. The facility census was 112. Findings include: 1. Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus and hypertensive heart disease with heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had severely impaired cognition. Further review of the medical record revealed no evidence that the facility offered the COVID-19 vaccine or provided education to the resident or resident representative. Interview on 07/18/24 at 1:30 P.M. with the Director of Nursing verified the lack of immunization documentation for Resident #19. 2. Review of the medical record for Resident #66 revealed an admitted [DATE]. Diagnoses included dementia, congestive heart failure, atrial fibrillation, and pulmonary hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 had severely impaired cognition. Further review of the medical record revealed no evidence that the facility offered the COVID-19 vaccine or provided education to the resident or resident representative. Interview on 07/18/24 at 1:30 P.M. with the Director of Nursing verified the lack of immunization documentation for Resident #66. 3. Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included congestive heart failure and asthma. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 had intact cognition. Further review of the medical record revealed no evidence that the facility offered the COVID-19 vaccine or provided education to the resident or resident representative. Interview on 07/18/24 at 1:30 P.M. with the Director of Nursing verified the lack of immunization documentation for Resident #74. Review of the facility policy titled COVID-19 Vaccination, revised 05/09/23, revealed COVID-19 vaccinations would be offered to residents when available unless medically contraindicated, the resident has already been immunized, or refuses the vaccine.