STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365952	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley Road Maumee, OH 43537

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on medical record review and staff interview, the facility failed to ensure residents who were being discharged from Medicare Part A services received timely notification. This affected three (#25, #49, and #104) of three residents reviewed for beneficiary notices. The facility census was 44. Findings include: 1. Review of the medical record for Resident #25 revealed an admitted [DATE]. Review of the Notice of Medicare Non-Coverage (NOMNC) for Resident #25 revealed his services would end on 11/23/24. Further review revealed Resident #25 was notified his services were ending via a telephone call on 11/22/24. 2. Review of the medical record for Resident #49 revealed an admitted [DATE] and a discharge date of [DATE]. Review of the NOMNC for Resident #49 revealed her services ended on 12/11/24. Further review revealed Resident #49 was notified on 12/10/24 regarding the end of her services. 3. Review of the medical record for Resident #104 revealed an admitted [DATE] and a discharge date of [DATE]. Review of the NOMNC for Resident #104 revealed her services ended on 09/14/24. Further review revealed Resident #104 was notified on 09/13/24 regarding the end of her services. Interview on 12/18/24 at 10:15 A.M. with Business Office Manager (BOM) #706 confirmed Resident #25, Resident #49, and Resident #104's NOMNCs for were given 24 hours in advance of the end of services rather than the required 48 hour notification. BOM #706 stated she worked in two buildings and was not always able to provide NOMNC documents timely.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, review of self-reported incidents (SRIs) and facility investigation, review of a witness statement, and staff interview, the facility failed to ensure residents were free from abuse. This affected two (#7 and #23) of three residents reviewed for abuse. The facility census was 44. Findings include: 1. Review of the medical record revealed Resident #7 was admitted on [DATE]. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of an unspecified cerebral artery, unspecified dementia, schizoaffective disorder bipolar type, essential hypertension, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was moderately cognitively impaired. 2. Review of the medical record revealed Resident #39 was admitted on [DATE]. Diagnoses included dislocation of the C1/C2 cervical vertebrae, atherosclerotic heart disease of native coronary, Parkinson's disease, chronic viral hepatitis C, schizoaffective disorder bipolar type, and asymptomatic human immunodeficiency virus (HIV) infection status. Review of the MDS assessment dated [DATE] revealed Resident #39 was cognitively intact. Review of an SRI dated 11/07/24 revealed Resident #7 and Resident #39 were involved in an altercation in their shared bedroom. Licensed Practical Nurse (LPN) #702 was the only witness to the incident stating Resident #39 was in the doorway of the resident room and Resident #7 was behind him waiting to get out. LPN #702 asked Resident #39 to move out of the doorway so Resident #7 could get out of the room. Resident #39 became upset and yelled, You stinky mother (expletive), you could have asked me to move, at Resident #7. Resident #7 responded, (expletive) you mother (expletive). Resident #39 then stood from the wheelchair, walked over to Resident #7, and began to hit him in the head and chest in addition to kicking him in the legs. Both residents were immediately separated from each other and assessed. There were no injuries noted to either resident, vital signs were within normal limits, and both residents denied pain or discomfort. Both residents were interviewed immediately following the incident. Resident #7 stated Resident #39 was always mean to him and he just used him as a punching bag. Resident #39 stated he does not like Resident #7 adding that he smells and was glad he hit him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement dated 11/07/24, written by LPN #702, revealed during the morning medication pass, the writer witnessed two residents (#7 and #39) have a verbal and physical altercation. Resident #39 was sitting in the doorway of his bedroom and Resident #7 was behind him waiting to get out. LPN #702 asked Resident #39 to move aside so Resident #7 could get out of the room. Resident #39 then yelled at Resident #7, calling him an expletive name and telling him he could have asked him to move. Resident #7 then cursed at Resident #39. Resident #39 then got out of his wheelchair and walked to Resident #7 and began hitting him in the head and chest and kicking him in his legs. Resident #7 did not hit back and attempted to wheel back from Resident #39. LPN #702 verbally encouraged the residents to stop and Resident #39 was assisted back into his wheelchair. Review of the physical aggression received documentation dated 11/07/24 revealed Resident #7 was hit in the face and chest multiple times and kicked in the legs by another resident (#39). Review of the physical aggressive initiated documentation dated 11/07/24 revealed Resident #39 was in the doorway of his room when LPN #702 asked the resident to move aside so his roommate (#7) could get through to exit the room. Resident #39 then began yelling at his roommate, got out of his wheelchair, and began hitting his roommate in the chest and face and kicking the roommate in the legs. The roommate attempted to back away from the resident. LPN #702 verbally intervened and assisted the resident back into his wheelchair and separating the two residents. Resident #39 continued to verbally attack Resident #7 as he was leaving the room. Resident #39 stated he did not like his roommate and he stunk, adding he does not care that he verbally and physically attacked his roommate. Interview on 12/17/24 at 11:58 A.M. with the Director of Nursing (DON) verified resident-to-resident abuse occur between Resident #7 and Resident #39 on 11/07/24.

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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** 41528 Based on medical record review, resident interview, staff interview, and facility policy review, the facility failed implement ordered interventions to aid in producing a bowel movement. This affected one (#15) of one residents reviewed for bowel and bladder. The facility census was 44. Findings include: Review of the medical record revealed Resident #15 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease, muscle wasting and atrophy, chronic pulmonary edema, heart failure, dyspnea, hypotension, polyneuropathy, essential hypertensive, chronic systolic heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was moderately cognitively impaired, was always incontinent of bowel, and received hospice services. Review of the care plan dated 07/15/24 revealed Resident #15 was at risk for pain due to disease process and interventions included to monitor for side effects of pain medication including to observe for constipation. Review of a physician order dated 09/11/24 revealed an order for the laxative Glycolax powder with instructions to give 17 grams by mouth as needed for constipation. Observation and interview on 12/16/24 at 3:09 P.M. revealed Resident #15 was laying in bed and stated he was constipated. Review of the bowel function tracking dated 12/06/24 to 12/13/24 revealed Resident #15 did not have a bowel movement documented during that time frame. Review of the December 2024 medication administration record revealed from 12/06/24 to 12/13/24 Resident #15 was not provided any as needed medication for constipation. Interview on 12/17/24 at 11:57 A.M. with the Director of Nursing (DON) verified Resident #15 had an eight (8)consecutive day time frame with no documented bowel movement. The DON stated when Resident #15 began hospice services all routine orders ended and the medical record system did not provide notification for intervention. Interview on 12/17/24 at 1:46 P.M. with Hospice Registered Nurse (RN) #704 verified no knowledge of Resident #15's lack of bowel movements for 8 days. Hospice RN #704 stated the facility would have needed to call the hospice provider so the physician could have given orders for treatment. Review of the policy bowel disorders clinical protocol, dated September 2017, revealed the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms which may include an alteration in bowel movements. The physician will identify and order pertinent cause-specific and symptomatic interventions.

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F 0686 Level of Harm - Minimal harm or potential for 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** 31638 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure wound care was completed timely and as ordered. This affected one (#9) of two residents reviewed for wound care. The facility census was 44. Findings included: Review of Resident #9's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, congestive heart failure, and malnutrition. The resident was admitted to hospice on 11/12/24. Review of Resident #9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a low cognitive function. The resident was dependent for all activities of daily living except eating. The resident was also dependent on staff for rolling left and right. Review of Resident #9's current care plan revealed she had the potential for skin impairment related to fragile skin, impaired mobility, and incontinence. The resident had a stage two (partial-thickness skin loss with exposed dermis) sacral pressure wound. The goal was for the resident to maintain clean and intact skin by the review date. Review of Resident #9's medical record revealed a physician order dated 12/05/24 for staff to cleanse the right dorsal foot with wound cleanser, apply a honey based medication, and cover with bordered foam dressing every day shift for wound care. Review of an additional physician order dated 12/11/24 revealed staff were to cleanse the sacral wound area with soap and water and pat dry, mix collagen fibers and zinc (at bedside) together and apply to area, cover area with an abdominal pad, and do not use tape. The wound dressing was to be complete twice daily and as needed. Observation of wound care was completed on 12/17/24 at 9:15 AM with Assistant Director of Nursing (ADON) #515. The dressing to Resident #9's right dorsal foot was dated 12/15/25 which revealed the wound care was not completed on 12/16/24. Interview with ADON #515 on 12/17/24 at 9:16 A.M. verified Resident #9's right dorsal foot dressing was not changed as ordered. ADON #515 also confirmed certified nurse aides (CNAs) provided care earlier that morning and removed the resident's sacral dressing in preparation for wound care. Observation of Resident #9's sacral wound on 12/17/24 at approximately 9:17 A.M. revealed ADON #515 mixed the collagen fibers and zinc ointment at bedside in a small plastic cup and the consistency of the mixture was sand-like. ADON #515 attempted to apply the mixture to the resident's wound, but approximately 50 percent (%) of the sand-like mixture fell off the resident's wound. ADON #515 then covered the wound with the abdominal pad. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Wound Care Certified Nurse Practitioner (WCCNP) #705 on 12/18/24 10:10 A.M. revealed Resident #9 had a wound previously on her sacrum and and it reopened recently. WCCNP #705 stated the collagen fiber and zinc ointment should be a paste consistency when mixed to cover the entire open area of the sacrum. WCCNP #705 verified she would rewrite Resident #9's wound care order to ensure the entire wound was covered with the collagen fiber and zinc ointment mixture to ensure wound protection and healing. Review of the facility policy titled, Wound Care, revised October 2010, revealed staff are to review the resident's care plan to assess for any special needs of the resident. Additionally, staff are to mark tape with initials, time, and date and apply it to the dressing. Staff are to verify there is a physician's order for the procedure.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44815 Based on observation, resident and staff interview, review of medical records, review of a behavior contract, review of facility equipment logs, and review of facility policies, the facility failed to ensure emergency crash carts were completely stocked per facility policy. This had the potential to affect 33 (#1, #3, #4, #5, #10, #12, #13, #14, #16, #17, #18, #19, #20, #21, #23, #24, #27, #28, #29, #30, #31, #32, #33, #35, #38, #39, #40, #41, #44, #45, #46, #48, and #50) residents identified by the facility as being full code (the resident wishes to receive resuscitation and all live saving measures in the event of a cardiac or respiratory arrest). In addition, the facility failed to ensure smoking materials were stored safely for one (#28) of one residents reviewed for smoking and failed to ensure one (#43) of one residents reviewed for accidents and hazards was transferred with the appropriate level of assistance to prevent falls. The facility census was 44. Findings Include: 1. Interview and observation on 12/18/24 at 2:21 P.M. of the emergency crash cart at the North nurse's station with Licensed Practical Nurse (LPN) #702 revealed no oxygen tubing and no oxygen mask were available in the cart. Additionally, LPN #702 confirmed the oxygen tank was empty, but stated the regulator needed to be adjusted to show if there was oxygen available. Continued observation on 12/18/24 at 2:27 P.M. revealed LPN #702 and Registered Nurse (RN) #515 attempting to adjust the regulator and determine if oxygen was in the tank. Interview on 12/18/24 at 2:29 P.M. with RN #515 confirmed they could not determine if the oxygen tank located with the crash cart contained oxygen. RN #515 stated if she needed oxygen she would go to the closet located inside the dining room to get another tank. Interview and observation on 12/18/24 at 2:33 P.M. with RN #515 of the crash cart at the South nurse's station revealed no oxygen tank was with the cart. RN #515 confirmed no oxygen tank was with the cart. Continued observation on 12/18/24 at 2:33 P.M. revealed RN #515 could not unlock or open the crash cart. Corporate Risk Management Nurse (CRMN) #700 approached the cart and attempted to open it. After several attempts, CRMN #700 was able to turn the key and successfully open the cart. CRMN #700 noted something was jammed against the inside lock causing the delay in accessing the cart. CRMN #700 demonstrated hidden levers on every drawer required sliding before the drawers would open. Observation and interview on 12/18/24 at 3:53 P.M. with LPN #701 revealed she could not open the crash cart at the South nurse's station. LPN #701 turned the key but was unable to open the drawers of the cart. LPN #701 further confirmed she could not find the crash cart checklist. LPN #701 stated she previously worked in the facility on night shift and stated the night shift nurse was responsible for conducting a nightly inventory on the crash cart. Interview on 12/19/24 at 9:02 A.M. with the Director of Nursing (DON) confirmed she could not find the crash cart book for the South nurse's station crash cart. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the document titled, Crash Cart Equipment, revealed a list of all items to be included in the crash cart. Review of the Crash Cart Equipment form from the notebook with the North nurse's station crash cart revealed all items were present in the crash cart on 12/16/24, including an oxygen mask and a full oxygen tank. Review of the policy titled, Emergency Crash Cart, copyright 2024, revealed the emergency crash cart is checked every 24 hours and after every use. Additionally, equipment/supplies used from the emergency crash cart are noted and replaced promptly. 2. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses of heart disease, congestive heart failure, and depression. Review of the comprehensive admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had intact cognition and used tobacco. Review of the current care plan revealed Resident #28 was a smoker. Interventions included storing Resident #28's smoking supplies at the nursing station. Review of a progress note dated 10/11/24 at 4:27 P.M. revealed Resident #28 was educated on the smoking policy. Further review revealed Resident #28's cigarettes and lighter were confiscated and placed in the smoke box. Review of a progress note dated 10/11/24 at 5:39 P.M. revealed Resident #28 was educated to smoke only in designated areas and smoking materials were not to be kept in his room. Further review revealed Resident #28 stated understanding and agreed to give cigarettes to the nurse to be locked up. Interview on 12/16/24 at 9:26 A.M. with Resident #28 revealed he kept his cigarettes and lighter in his pocket. Concurrent observation revealed a cigarette pack in Resident #28's left pocket. Further observation revealed a cigarette burn in his jacket and another on his pants. Observation on 12/17/24 at 10:08 A.M. revealed Resident #28 lying in bed watching television. A cigarette pack was on his bedside table. Concurrent interview with Resident #28 stated he was allowed to keep his cigarettes and lighter in his room because he was allowed to smoke independently. Interview on 12/19/24 at 11:25 P.M. with Social Services Director (SSD) #643 revealed she was familiar with Resident #28. SSD #643 stated Resident #28 should not have cigarettes or lighters in his room. Interview on 12/19/24 at 11:29 A.M. with SSD #643 and Resident #28 revealed Resident #28 confirmed he had cigarettes and lighters in his room. Resident #28 gave permission to look in a shopping bag hanging from the arm of his wheelchair. Observation with SSD #643 confirmed two packs of cigarettes were in the bag. Continued observation revealed Resident #28 removing two lighters from his jacket pockets and handing them to SSD #643. Review of the Behavior Contract for Resident #28, signed 12/11/24, revealed Resident #28 understood cigarettes and smoking materials (i.e., lighters) may not be kept on his person. 49742 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, hypothyroidism, anxiety disorder, dysphagia, cachexia, and dementia. Review of the most quarterly recent MDS assessment dated [DATE] revealed the resident was rarely/never understood. Further review of the MDS assessment revealed the resident was dependent for all functional care areas. Review of the most recent care plan for Resident #43 revealed she required a mechanical lift with two staff assistance for transfers. Observation on 12/18/24 at 1:09 P.M. revealed one staff member, Certified Nurse Aide (CNA) #601, was transferring Resident #43 from her Broda chair (a chair that provides comfort, support, positioning, and mobility) to her bed unassisted by another staff member and without a mechanical lift. An interview on 12/18/24 at 1:11 P.M. with CNA #601 confirmed she transferred Resident #43 from her Broda chair to her bed unassisted from another staff member and without a Mechanical Lift. An interview on 12/18/24 at 1:19 P.M. with MDS RN #517 confirmed Resident #43's plan of care revealed the resident required a mechanical lift with two staff assistance for transfers. This deficiency represents non-compliance investigated under Complaint Number OH00160151.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, staff interview, medical record review, review of a medication manufacturer package insert, the facility failed to ensure residents received insulin as ordered which resulted in a significant medication error. This affected one (#13) of three residents observed during medication administration. The facility identified 10 residents with orders for insulin in a facility census of 44. Findings Include: Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included epilepsy, iron deficiency anemia, heart failure, primary osteoarthritis, insomnia, hyperlipidemia, hypertension, atrial fibrillation, type two diabetes mellitus, post-traumatic stress disorder, and major depressive disorder. Review of Resident #13's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #13's current physician orders as of 12/18/24 revealed the resident was to receive Novolog insulin eight (8) units subcutaneously (SQ) before meals for blood sugar control. Review of an additional order for Novolog insulin per sliding scale was to be administered SQ with meals and at bed time. Observation and interview on 12/18/24 at 8:14 A.M. of Licensed Practical Nurse (LPN) #701 administering medication for Resident #13 revealed the nurse obtained a blood glucose level for Resident #13 of 224 milligrams per deciliter (mg/dL), which required four (4) units of Novolog insulin from the sliding scale order. LPN #701 stated she would be administering 12 units total of Novolog insulin to Resident #13. LPN #701 then was observed to attach an administration needle to the insulin administration pen, turned the dose selector dial to 12 units, and proceed to administer the insulin to Resident #13 without first priming the Novolog insulin administration pen. Interview on 12/18/24 at 8:37 A.M. with LPN #701 confirmed she administered the ordered 12 units of Novolog insulin to Resident #13, but did not prime the pen needle prior to administration. Review of the Novolog FlexPen package insert, dated 2023, revealed before each injection, to avoid injecting air and ensure proper dosing, turn the dose selector to two (2), hold the Novolog FlexPen with the needle pointing up, and press the push button all the way in until the dose selector returns to zero (0). A drop of insulin should be seen at the tip of the needle. The dose selector then can be dialed to the correct dose of insulin for administration. Review of the facility policy titled, Administering Medications, revised 2012, revealed medications will be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Master Complaint Number OH00160513 and Complaint Number OH00160203.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, staff interview, medical record review, review of medication manufacturer package inserts, and review of facility policy, the facility failed to ensure that insulin was labeled appropriately. This affected two (#17 and #46) of 10 residents with orders for insulin. The facility census was 44. Findings Include: 1. Review of Resident #17's medical record revealed an admitted [DATE]. Diagnoses included nonrheumatic aortic stenosis, hyperlipidemia, type two diabetes mellitus, hypertension, mild protein-calorie malnutrition, obstructive sleep apnea, major depressive disorder, anxiety disorder, insomnia, and bilateral primary osteoarthritis. Review of Resident #17's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] the resident was cognitively intact. Observation on 12/16/24 at 9:11 A.M. of a medication cart on the South Hall revealed a Basaglar insulin KwikPen that was open and approximately one-quarter used. There was no date documented on the Basaglar insulin KwikPen indicating when it was opened. Interview on 12/16/24 at 9:13 A.M. with Licensed Practical Nurse (LPN) #551 confirmed the Basaglar insulin KwikPen was for Resident #17. LPN #551 verified the pen had been used and was not labeled with a date that it was first opened. Review of the manufacturer's package insert for Basaglar KwikPen revealed that when the pen is stored at room temperature after opening it should be thrown away after 28 days. 2. Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, diabetes mellitus type II, major depressive disorder, glaucoma, hyperlipidemia, hypertension, and muscle weakness. Review of Resident #46's admission MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired. Observation on 12/16/24 at 10:05 A.M. of a second medication cart revealed an open vial of Humalog insulin for Resident #46. There was no date documented on the vial of Humalog insulin indicating when it was opened. Interview on 12/16/24 at 10:07 A.M. with LPN #551 confirmed the vial of Humalog insulin for Resident #46 was open and was not labeled with a date that it was opened. (continued on next page)

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	365952	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley Road Maumee, OH 43537

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer's package insert for Humalog insulin revealed that when stored at room temperature, after opening Humalog insulin can only be used for a total of 28 days. Review of the facility policy titled, Storage of Medication, revised April 2007, revealed the facility shall store all drugs and biologicals in a safe manner. When opening a multi-dose container, the date opened shall be recorded on the container. This deficiency represents non-compliance investigated under Complaint Number OH00160203.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure medication administration was accurately documented. This affected one (#24) of four residents reviewed for medication administration. The facility census was 44. Findings include: Review of the medical record for Resident #24 revealed an admitted [DATE] with a diagnosis of type II diabetes mellitus. Review of the admission comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had intact cognition. Review of a physician order dated 09/05/24 revealed Resident #24 received insulin glargine solution 100 units per milliliter with instructions to inject 45 units subcutaneously (SQ) every morning and at bedtime for diabetes. Review of the medication administration record (MAR) for Resident #24 revealed insulin glargine was scheduled to be given at 7:00 A.M. and was administered on 12/17/24 at 7:54 A.M. Further review revealed Resident #24's blood glucose level was 164 milligrams per deciliter (mg/dL). Interview on 12/17/24 at approximately 8:30 A.M. with Certified Nurse Aide (CNA) #591 revealed Resident #24 requested medication after she finished her breakfast. Observation on 12/17/24 at approximately 8:31 A.M. revealed CNA #591 notified Licensed Practical Nurse (LPN) #702 of Resident #24's request for her scheduled insulin injection. Observation on 12/17/24 at approximately 8:32 A.M. revealed LPN #702 removing an insulin pen from the medication cart and walking toward Resident #24's room. Interview on 12/17/24 at 8:34 A.M. with LPN #702 confirmed she was carrying Resident #24's insulin glargine and planned to administer it. LPN #702 confirmed she documented Resident #24 received the insulin glargine earlier, but decided to not administer it until Resident #24 finished eating breakfast. Interview on 12/17/24 at 8:48 A.M. with Corporate Risk Management Nurse #700 confirmed LPN #702's documentation indicated Resident #24 received 45 units of insulin glargine on 12/17/24 at 7:54 A.M. Review of the policy, Administering Medications, revised 12/2012, revealed the individual administering the medication will record in the resident's medical record the date and time the medication was administered.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, staff interview, medical record review, and review of the Centers for Medicare and Medicaid Services (CMS) Provider History Profile document, the facility failed to have an effective quality assurance and performance improvement (QAPI) program to address repeated deficiencies identified during four consecutive comprehensive surveys. This had the potential to affected all 44 residents in the facility. The census was 44. Findings include: Review of the CMS Provider History Profile document, with Certification and Survey Provider Enhanced Reporting (CASPER) system data, last updated 12/10/24, revealed the facility was issued a deficiency for not administering medications as ordered resulting in significant medication errors on the three previous comprehensive surveys in August 2023, January 2024, and 07/18/24. During the current comprehensive survey, with exit date 12/19/24, the facility was cited for significant medication errors for the four consecutive comprehensive survey. Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included epilepsy, iron deficiency anemia, heart failure, primary osteoarthritis, insomnia, hyperlipidemia, hypertension, atrial fibrillation, type two diabetes mellitus, post-traumatic stress disorder, and major depressive disorder. Review of Resident #13's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #13's current physician orders as of 12/18/24 revealed the resident was to receive Novolog insulin eight (8) units subcutaneously (SQ) before meals for blood sugar control. Review of an additional order for Novolog insulin per sliding scale was to be administered SQ with meals and at bed time. Observation and interview on 12/18/24 at 8:14 A.M. of Licensed Practical Nurse (LPN) #701 administering medication for Resident #13 revealed the nurse obtained a blood glucose level for Resident #13 of 224 milligrams per deciliter (mg/dL), which required four (4) units of Novolog insulin from the sliding scale order. LPN #701 stated she would be administering 12 units total of Novolog insulin to Resident #13. LPN #701 then was observed to attach an administration needle to the insulin administration pen, turned the dose selector dial to 12 units, and proceed to administer the insulin to Resident #13 without first priming the Novolog insulin administration pen. Interview on 12/18/24 at 8:37 A.M. with LPN #701 confirmed she administered the ordered 12 units of Novolog insulin to Resident #13, but did not prime the pen needle prior to administration. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Novolog FlexPen package insert, dated 2023, revealed before each injection, to avoid injecting air and ensure proper dosing, turn the dose selector to two (2), hold the Novolog FlexPen with the needle pointing up, and press the push button all the way in until the dose selector returns to zero (0). A drop of insulin should be seen at the tip of the needle. The dose selector then can be dialed to the correct dose of insulin for administration. Review of the facility policy titled, Administering Medications, revised 2012, revealed medications will be administered in a safe and timely manner, and as prescribed.

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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** 31638 Based on observation, staff interview, medical record review, review of a medication package insert, and review of facility policies, the facility failed to ensure water temperature testing was completed as part of the facility Legionella prevention program. In addition, the facility failed to ensure staff wore proper personal protective equipment during resident care for a resident (#13) on enhanced barrier precautions and failed to cleanse a resident's (#24) insulin dispensing pen prior to affixing a needle for administration. This deficient practice had the potential to affect all 44 residents residing in the facility. The facility census was 44. Findings Include: 1. Review of the facility water temperature logs on 12/19/24 at 8:35 A.M. revealed water temperature testing was absent from 10/01/24 through 12/19/24. Interview with Maintenance Supervisor #631 on 12/19/24 at 8:40 A.M. revealed he had been employed at the facility for a short time and was unaware of the Legionella policy. Interview with Regional Director of Operations #703 on 12/19/24 at 9:10 P.M. verified the facility failed to complete Legionella water temperature testing timely. Review of the facility policy titled, Legionella Surveillance and Detection, revised September 2022, revealed the facility is committed to the prevention, detection and control of water-borne contaminates, including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. 44815 2. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses of a pressure ulcer and colostomy status. Review of the admission comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had intact cognition. Additional review reviewed Resident #24 had an indwelling catheter and an ostomy (an artificial opening into an organ of the body). Review of the physician order dated 09/19/24 revealed Resident #24 was in enhanced barrier precautions (EBP) for wounds and an indwelling catheter. Observation on 12/16/24 at approximately 2:40 P.M. revealed Resident #24 had a sign next to her doorframe indicating the resident was on EBP. The sign advised staff to wear a gown and gloves when changing briefs or assisting with toileting. Under the sign was a plastic set of drawers with personal protective equipment (PPE), including blue disposable gowns and disposable gloves. Interview on 12/17/24 at approximately 7:40 A.M. with Licensed Practical Nurse (LPN) #702 revealed staff were in Resident #24's room providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 12/17/24 at 7:44 A.M. revealed Certified Nurse Aide (CNA) #591 exiting Resident #24's room carrying bags of soiled items. No blue items were observed in the bags. Concurrent interview with CNA #591 revealed she just finished providing colostomy care to Resident #24. CNA #591 stated she only wore gloves while providing the care. CNA #591 confirmed Resident #24 was in EBP and CNA #591 should have worn a disposable gown while providing colostomy care to Resident #24. Review of the policy, Policy on Disease-Specific Isolation/Precautions, dated 04/01/24, revealed enhanced barrier precautions include the use of personal protective equipment, gowns and gloves, during high contact resident care activities. 49742 3. Review of the facility electronic medical record for Resident #13 revealed an admitted [DATE] with diagnoses including epilepsy, iron deficiency anemia, heart failure, primary osteoarthritis, insomnia, hyperlipidemia, hypertension atrial fibrillation, type two diabetes mellitus post-traumatic stress disorder, and major depressive disorder. Review of Resident #13's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact. Observation and interview on 12/18/24 at 8:14 A.M. of Licensed Practical Nurse (LPN) #701 administering medication for Resident #13 revealed the nurse obtained a blood glucose level for Resident #13 of 224 milligrams per deciliter (mg/dL). LPN #701 stated she would be administering 12 units of Novolog insulin to Resident #13. At this time, LPN #701 was observed to attach a needled to the end of the Novolog insulin administration pen without first wiping the rubber stopper at the tip with an alcohol swab and administered the insulin to Resident #13. Interview on 12/18/24 at 8:37 A.M. with LPN #701 confirmed she did not wipe the rubber stopper of the Novolog insulin pen with an alcohol swab prior to attaching a needle. Review of the Novolog FlexPen package insert, dated 2023, revealed when preparing the Novolog FlexPen for administration, first wipe the rubber stopper with an alcohol swab prior to attaching the needle. Review of the facility policy titled, Administering Medications, revised December 2012, revealed staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolations, etc.) for the administration of medications.