STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365974	A. Building B. Wing	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Quaker Heights	514 West High Street Waynesville, OH 45068

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on record review and interview, the facility failed to have clear documentation of advanced directives in the electronic medical record. This affected four (Residents #9, #10,#13 and #25) of five residents reviewed for advanced directives. The facility census was 56. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE]. Review of Resident #9's medical records revealed a DNR order form signed by physician on 03/15/21 for an order of Do Not Resuscitate Comfort Care Arrest, (DNR- CCA). There was also a physician order for a code status of Do Not Resuscitate Comfort Care, (DNRCC) dated 08/29/23. 2. Review of the medical record for Resident #10 revealed an admitted [DATE]. Review of Resident's #10 medical records revealed Resident #10 had a physician order for a code status of Do Not Resuscitate Comfort Care Arrest, (DNRCC-A) dated 10/12/21 and a non-dated DNR order form with the words FULL CODE written in large back letters across the form. 30802 3. Review of the medical record for Resident #13 revealed an admitted [DATE]. Review of the electronic record revealed an order for DNRCC, but there was no copy of a signed advanced directive in the electronic record. There was no paper record for the resident. 4. Review of the medical record for Resident #25 revealed and admitted [DATE]. Review of the electronic record revealed a physician order for DNRCC, but there was no advanced directives form on the electronic record. There was no paper record for the resident. During interview on 11/02/23 at 2:45 P.M., Nurse #10 verified the conflicting information as noted above. She stated the copy of the signed advanced directives was kept in a binder at the nurses station with all the others. It was not scanned into the resident's electronic record and the residents did not have a paper record.

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on record review and interview, the facility failed to ensure the Ombudsman was notified when residents were discharged to the hospital. This affected one (Resident #33) of two residents reviewed for discharges. The facility census was 56. Findings include: Review of the medical record for Resident #36 revealed an admission 04/09/20. Review of the medical record for Resident #33, revealed the resident was sent to the hospital and admitted on [DATE]. There was no documentation the Ombudsman was notified of the resident's transfer to the hospital. During an interview on 11/06/23 at 11:00 A.M., Social Service Designee, (SSD) #16 stated notification to the Ombudsman had not been completed for Resident #33 or any other residents who had discharged between November 2022 and October 2023.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on record review and interview, the facility failed to complete a comprehensive assessment after a significant change in condition for one (Resident #354) of three residents sampled. The facility census was 56. Findings include: Review of the medical record of Resident #354 revealed an admitted [DATE] and diagnosis of diabetes, metabolic encephalopathy, and cognitive communication deficit and cerebrovascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #354 had severely impaired cognition. Review of Resident #354 physician orders revealed the resident received hospice services starting 08/23/23. Review of significant change MDS dated [DATE] revealed Resident #354 was clinically assessed due to a change in status for starting hospice services. During interview on 11/02/23 at 3:00 P.M. the Director of Nursing, (DON) verified Resident #354 changed to hospice services on 08/23/23 and did not receive a significant change comprehensive assessment until 10/26/23. The DON verified the significant change MDS was late and should have been completed 14 days after the start of hospice services.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30802 Based on record review and staff interview, the facility failed to ensure all Minimum Data Set (MDS) assessments were transmitted within 14 days after being completed. This affected two (Residents #19 and #46) of two residents reviewed for MDS assessments. The facility census was 56. Findings include: 1. Review of the record for Resident #19 revealed an admitted [DATE]. He had a quarterly Minimum Data Set (MDS) assessment dated [DATE]. This assessment stated production accepted but did not say it was completed. 2. Review of the record for Resident #46 revealed and admitted [DATE]. He had a quarterly Minimum Data Set (MDS) assessment dated [DATE]. The assessment stated production accepted but did not say completed. During interview on 11/06/23 at 2:57 PM, the administrator verified the above assessments were not submitted.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on record review, interview, and policy review, the facility failed to refer a resident with a serious mental disorder and dementia to the appropriate State-designated authority for a Preadmission and Resident Review (PASRR) Level II assessment/determination. This affected one (Resident #34) of one resident reviewed for PASRR. The facility census was 56. Findings include: Review of the medical record for Resident #34 revealed an admitted [DATE]. Review of Resident #34's PASRR from a previous healthcare facility, dated 03/05/21, indicated the resident had no indications of serious mental illness, therefore, a PASRR Level II review was not warranted/completed. Resident #34 was admitted to the current facility with diagnoses is of adjustment disorder with mixed anxiety and depressed mood, unspecified dementia, mood disorder due to known physiological condition, and nonpsychotic mental disorder. No updated PASRR was completed upon admission with diagnoses to indicate mental health disorders were present. During interview 11/01/23 2:58 P.M., the Director of Nursing and Staff #16 verified that an updated or new PASRR should have been completed upon admission with diagnosis of mental health disorders and dementia. It was verified the current PASRR, dated 03/05/21, indicated that Resident #34 did not have any mental health disorders or dementia, which was an inaccurate representation of Resident #34 current medical diagnosis. Because of the inaccuracy, Resident #34 was not referred to the appropriate State-designated authority for a Level II resident review. Review of the facility policy titled Preadmission Screening and Annual Resident Review, dated 09/14/23, stated to refer all levels II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44083 Based on record review and interview, the facility failed to initiate and update care plans for residents. This affected three (Residents #5, #354 and #48) of 21 residents whose care plans were reviewed The facility census was 56. Findings include: 1. Review of the medical record for Resident #5 revealed an admitted [DATE] and diagnoses including malignant pancreatic cancer, dysphagia, Alzheimer's disease, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had moderately impaired cognition. Resident #5 had an advanced dysphagia diet ordered on 10/10/23 with no new texture change orders since 10/10/23. Review of social service progress notes dated 11/01/23 as late entry of 10/18/23 at 11:56 A.M. documented Resident #5's dentures had been broken. Review of Resident #5's plan of care had been updated with new problems, goals and interventions on 09/17/23. There were no interventions to address Resident #5 had broken dentures as of 10/18/23. Review of the progress notes documented by Registered Dietitian (RD) #16 dated 10/31/23 revealed no revised assessment, or plan care interventions addressing Resident #5's broken dentures. Observation on 10/31/23 at 12:21 P.M lunch meal Resident #35 received chopped lettuce. During interview at this time, Resident #5 stated she could not eat the chopped lettuce due to her lower dentures being broken for a couple of weeks. During observation on 11/01/23 at 8:18 A.M., Resident #5 did not eat the omelet served at breakfast meal. During interview at this time, Resident #35 stated she could not eat the omelet served at breakfast without her lower dentures. During interview on 11/02/23 at 3:00 P.M., the Director of Nursing, (DON) verified there was no new problem areas, goals or interventions to Resident #5's plan of care when her dentures were discovered broken on 10/18/23. 2. Review of the medical record for Resident #354 revealed an admitted [DATE] and diagnoses including diabetes, metabolic encephalopathy, and cognitive communication deficit and cerebrovascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #354 had severely impaired cognition. The skin risk assessment dated [DATE] revealed the resident was at risk for skin breakdown. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the initial plan of care date 08/01/23 and care plans through 11/02/23 revealed no skin problems, goals or interventions for the identified risk of skin breakdown. During interview on 11/02/23 at 3:00 P.M., the Director of Nursing, (DON) verified Resident #354 did not have a care plan area for risk of skin breakdown from date of admission of 07/31/23 to 11/03/23, when the care plan was updated. 47988 3. Review of Resident #48's medical record revealed an admission to the facility on [DATE], with diagnoses including pressure ulcer of sacral region stage four, pressure ulcer of right and left heel, muscle weakness, bacteremia, lymphedema, metabolic encephalopathy, hydrocele, retention of urine, type two diabetes mellitus, obstructive pulmonary disease, and morbid obesity. Review of Resident #48's quarterly Minimum Data Set (MDS) assessment, dated 09/13/23, documented the resident was severely cognitively impaired. Resident #48 was dependent for toilet hygiene, an indwelling urinary catheter was present and was frequently incontinent of bowel. Review of Resident #48's physician orders revealed an order dated 06/07/23 for an indwelling urinary catheter for diagnosis of bilateral hydrocele, change bag every 30 days and as needed and to change the catheter securement device every seven days. Review of Resident #48 comprehensive plan of care dated 06/13/23, revealed no information related to Resident #48 having a urinary catheter or for the care of a urinary catheter. During an interview on 11/06/23 at 3:15 P.M., the Director of Nursing verified there was no plan of care developed to address Resident #48's indwelling urinary catheter. Review of the facility policy titled Comprehensive Person-Centered Care Planning, dated 09/14/23, revealed the plan of care is centered on the residents needs including measurable objectives and time frames and must be re-evaluated with each comprehensive assessment and significant change assessment.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on record review, observation and interview, the facility failed to prepare food in a form designed to meet the resident's individual needs. This affected three (Residents #4, #5 and #354) of three residents sampled. The facility census was 56. Findings include: 1. Review of the medical record of Resident #4 revealed an admitted [DATE] and diagnoses including dementia, diabetes, dysphagia, and chronic obstructive pulmonary disease. Resident #4 received hospice services starting 08/01/23. Resident #4's diet order included an advanced dysphagia diet, an eight-ounce supplement three times a day and four-ounce supplement with lunch due to malnutrition risk. Review of the nutritional plan of care dated 07/03/23, completed by Registered Dietitian, (RD) #64, revealed Resident #4 omitted food groups and was to be served fortified oatmeal at breakfast and supper. Review of Resident #4 meal ticket dated 11/06/23 revealed the resident was to receive six ounces of fortified oatmeal at breakfast and supper meals. The meals consisted of fortified cereal and beverages. Review of the fortified cereal recipe revealed the cereal preparation required six ounces of oatmeal, nine tablespoons whole milk, three quarters teaspoon powdered milk, three eighths teaspoons sugar, and 0.01 pound of butter. During observation on 11/01/23 at 8:01 A.M., during the breakfast tray line service, Diet Manager (DM) #57 was instructing Diet Aide (DA) #63 in how to prepare the fortified cereal. There was no recipe available. During interview on 11/01/23 at 8:33 A.M., DA #63 verified the meal ticket of Resident #4 listed fortified cereal at the breakfast meal as the main entree. DA #63 verified he was instructed by DM #57 during tray line in how to prepare Resident #4's fortified cereal. DA #63 verified he did not prepare the fortified cereal with a recipe, using the ingredients and portions listed in the recipe. To six ounces of prepared oatmeal, DA #63 stated he added unknown amounts of butter, sugar, and milk. The powered milk and the ingredients portions were not followed as listed on the fortified recipe. During interview on 11/01/23 at 8:35 A.M., DM #57 verified the fortified cereal recipe was not available to DA #63 on 11/01/23 to prepare Resident #4's fortified cereal. DM #57 verified the recipe needed to be available and followed to ensure the resident received the nutritional value as planned by RD #64. DM #57 verified Resident #4 did not receive the recipe specified fortified cereal as listed on the meal ticket. 2. Review of the medical record of Resident #5 revealed an admitted [DATE] and diagnoses including malignant pancreatic cancer, dysphagia, Alzheimer's disease, and depression. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #5's diet order included advanced dysphagia diet, and four ounces of a supplement once a day for adequate protein and energy intake. Review of the meal ticket of Resident #5 dated 11/06/23 revealed the resident was to receive four ounces of supplement on the lunch meal tray service. Observation on 10/31/23 at 12:21 P.M. of Resident #5 lunch meal tray revealed no four-ounce supplement was on the meal tray. During interview at this time, Resident #5 stated she was to receive a supplement on the lunch meal tray, she liked the supplement, as she could not eat some of the foods. During interview on 10/31/23 at 12:22 P.M., Licensed Practical Nurse, (LPN) #32 verified Resident #5 did not receive the four ounces of supplement on the meal tray form the kitchen meal service. 3. Review of the medical record of Resident #354 revealed an admitted [DATE] and diagnosis of diabetes, metabolic encephalopathy, and cognitive communication deficit and cerebrovascular disease. Review of the diet orders for Resident #354 revealed puree diet, and a supplement eight ounces twice a day to aide in blood sugar management. Review of Resident #354 meal ticket 11/02/23 revealed a notation of no juice at the breakfast meal. Review of the Registered Dietitian, (RD) #64 progress notes dated 11/01/23 revealed Resident #354 family representative discouraged juice due to the diagnosis of diabetes. The resident did not receive juice while at home to assist in blood sugar control. The family preferred other beverages be offered and lastly if the resident persisted, the juice to be offered in moderation. During observation on 11/02/23 at 8:30 A.M. in the main dining room, Resident #354 received eight ounces of juice from Activity Assistant (AA) #5. Resident #354 was not observed to ask for the juice. The breakfast meal ticket was printed in bold no juice. During interview on 11/02/23 at 8:32 A.M., AA #5 verified Resident #354's breakfast meal ticket had listed in bold, no juice. AA #5 stated Resident #354 cannot verbally ask for juice, type or how much, so she served him cranberry juice in the water glass size at the breakfast meal. She stated she did not know why no juice was listed on the meal ticket and had not confirmed with nurses or the RD #64 as to why no juice was listed on the meal ticket. AA #5 verified she did not know his medical or swallowing diagnosis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44083 Based on record review, observation and interview, the facility failed to store foods in accordance with professional standards for food service safety. This had the potential to affect 56 residents who received food from the kitchen. The facility census was 56. Findings include: Observation of the Kitchen on 10/31/23 form 8:35 A.M. to 9:05 A.M. revealed the following: 1. In the reach in refrigerator: a. a large bag of lettuce appearing brown and watery dated 10/26/23. b. a bag of hot dogs and ham dated 10/26/23. c. a bag of apparent cheese with no date or label. d. open container whole milk with no date 2. In the milk cooler: a. a four by six inch spillage of milk on the bottom of the cooler with milk cartons stored above. 3. In dry storage and prep area: a. the meal slicer blade had brown colored debris and was uncovered. b. a package of spaghetti opened and unsealed on the storage shelf. 3. In the main kitchen area: a. on a shelf under the food preparation table, there was an aerosol can of a cleaning chemical stored with bags of foods. b. an opened bag of gravy mix with no open date. 4. In the mop and chemical storage room: a. soiled towels and soiled cleaning cloths were on the floor, measuring two by three feet wide. During interview on 10/31/23 at 9:05 A.M., Diet Manager, (DM) #57 verified the above observations. DM #57 verified foods should be labeled and dated, equipment cleaned and covered, soiled cleaning cloths stored off the floor, and chemicals should not be stored near food preparation areas. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Food Storage: Dry Goods, dated September 2017, revealed all packaged food items will be properly sealed. Toxic material will not be stored with food. All items will be stored at least six inches above the floor. Review of the facility policy titled Food Storage: Cold Food, dated April 2018, revealed all foods will be labeled and dated, and arranged to prevent cross contamination.