STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366279	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosary Care Center	6832 Convent Boulevard Sylvania, OH 43560

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on record review, staff interview, and review of policy, the facility failed to notify the family when a resident experienced a change in condition requiring a medication change. This affected one (#62) of one resident reviewed for notification of changes. The facility census was 71. Findings include: Review of the electronic medical record for Resident #62 revealed an admitted [DATE], with diagnoses including chronic respiratory failure with hypoxia, hypertension (HTN), other post-traumatic urethral stricture, chronic kidney disease (CKD), hyperkalemia, heart failure, diverticulum of bladder, acidosis, anxiety, atherosclerotic heart disease of native coronary artery without angina pectoris, atrial fibrillation (a. fib), hypothyroidism, neuromuscular dysfunction of bladder, generalized muscle weakness, need for assistance with personal care, cognitive communication deficit, oral dysphagia, and difficulty in walking. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 12, indicating the resident had relatively cognition intact. Review of the medical record for Resident #62 revealed a urine culture dated 12/23/24 which resulted >100, 000 colony-forming units per milliliter (cfu/ml). Review of the electronic medical record revealed a physician order dated 12/23/24, for Macrobid (an antibiotic used to treat UTI's) Oral Capsule 100 milligrams, to be administered twice daily for seven days. Review of the electronic medical record for Resident #62 revealed no documented evidence of the family for Resident #62 being notified of the positive UTI urine test or Resident #62 being started on oral antibiotics to treat her UTI. Interview on 01/07/24 at 9:20 A.M. with Licensed Practical Nurse (LPN) #123 verified the medical record contains no evidence of the family of Resident #62 being notified of her change in condition or treatment. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Change in Condition, revised February 2021, revealed the facility promptly (within 24 hours) notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident interview, staff interview, and policy review, the facility failed to ensure medications were taken as self-administration assessments and according to policy. This affected two (#18 and #38) of two residents reviewed for self medication administration. The facility identified four residents participating in self medication administration in a facility census of 71. Findings include: 1. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with the diagnoses including: transient cerebral ischemic attack, atrial fibrillation, hypertension, osteoporosis, atrial flutter, chronic rhinitis and low back pain. Review of the most current Minimum Data Set (MDS) assessment dated [DATE], assessed Resident #18 with minimal hearing difficulty, highly impaired vision, intact cognition, utilized a walker for mobility, independent with activities of daily living, received scheduled pain medications, and received an anti-platelet medication. Review of Resident #18's independent medication administration plan of care dated 04/04/22 noted the following interventions: Complete self-administration assessment. Monitor for signs of decreased cognition or dexterity that may interfere with continued ability to self administer medications. Provide me a lock box for the storage of my medications. Review of physician orders dated 07/26/22 revealed a physician order initiated for a Self medication assessment every 90 days. Review of the medical record identified a self medication evaluation completed on 01/17/24 indicating Resident #18 was assessed and self-administration of medication is granted and a physician's order is obtained. Review of a self-administration of medication assessment was completed on 07/22/24, indicating Resident #18 was approved for self administration of medications. No documentation contained in the medical record revealed evidence self medication evaluations were completed every 90 days. The record also lacked a physician order for self medication administration. Observation on 01/06/25 at 9:44 A.M., discovered a daily self medication container ([NAME]) on the overbed table at the foot of the bed. Interview with Resident #18, at the time, revealed medications were placed into the medication [NAME]. Observation with the resident noted medications placed inside each daily compartment marked Sunday through Saturday. Inside each day of the week identified multiple of the same medication tablet placed under each day of the week. The medications taken daily were not placed together. The resident was unable to provide documentation indicated when medications were administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/06/25 at 9:45 A.M., with Registered Nurse (RN) #143 revealed she was unaware Resident #18 utilized a medication [NAME], unaware what medications the resident took or when she took the medications. No documentation was maintained indicating the facility or resident were recording medications were taken daily. Interview on 01/07/25 at 11:10 A.M., with Licensed Practical Nurse (LPN) #130 and LPN #138 unit manager verified no documentation or verification was recorded when Resident #18 medications were self administered. Review of the policy titled Self-Administration of Medications Policy, revised February 2021, revealed if it is deemed safe and appropriate for a resident to self administer medications, it is documented in the medical record and the care plan. The decision that a resident can self-administer medications is re-assessed periodically based on changes in the residents medical or decision making skills. For self administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken. If the resident is able and willing to take responsibility for documenting self-administration of medications, the resident is instructed on how to complete a record indicating the administration of the medication. 2. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with the diagnoses including: paraplegia, spina bifida, neuromuscular bladder, urinary incontinence, edema, systemic inflammatory response syndrome, cervicalgia, and pain to right and left shoulder. Review of the most current MDS assessment dated [DATE], assessed Resident #38 with intact cognition, utilized a wheelchair for mobility, independent with activities of daily living, incontinent of bowel and bladder, received regular diet with no weight loss, and at risk for pressure ulcer development with no current skin breakdown. Review of the nursing plan of care initiated 04/18/24, regarding Resident #38 preference to self-administer medications included interventions for the following: I will safely administer medications as my physician has ordered. Assess ability to self-administer medications as needed. Educate regarding the dosage, frequency and side effects of medication(s). Monitor me for signs of decreased cognition or dexterity that may interfere with continued ability to self administer medications. Notify physician as needed if I am unable/do not follow medication orders. Provide me a lock box for the storage of my medications if needed. Provide me with medication administration assistance as needed. Review of a physician order dated 08/13/19 noted self medication assessment to be completed quarterly. Review of self medication evaluation dated 07/17/24 revealed self medication granted. Physicians order obtained. Further review of the record revealed no evidence of a physician order contained in the medical record for the resident to self administer medications. The most recent self medication assessment prior to 07/17/24 was dated 10/21/23 and lacked further evidence self medication assessments were being completed every 90 days. Interview with Resident #38 on 01/06/25 at 2:44 P.M., revealed he had not been provided with the medication Methenamine for the past 4 days. Resident #38 stated he reported the medication was not available to the nurse. Observation inside a locked cabinet noted Multiple blister pack cards or medications. The medication Methenamine Hippurate was not contained inside the cabinet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/25 at 7:48 A.M., interview with Licensed Practical Nurse (LPN) #130 and LPN #138 revealed Resident #38 medication Methenamine was ordered twice since 12/19/24 and the resident it had not been delivered to the facility. LPN #130 and LPN #138 confirmed they were unaware when medications needed refilled unless a resident request a refill. In addition they stated no documentation was being maintained indicating self medication approved residents were consuming medications as ordered. Observation on 01/07/25 at 7:54 A.M., with Resident #38 revealed the night nurse provided him with a medication card containing Methenamine early that morning. Observation inside the locked cabinet in the resident room discovered a medication card labeled Methenamine one (1) Gram (GM) with the fill date of 01/06/25. Review of pharmacy delivery manifest noted a card containing 14 tablets each of Resident #38 Methenamine one (1) Gram (GM) were delivered on 11/12/24, 11/25/24, 12/17/24, 01/06/25. Interview on 01/08/24 at 9:45 A.M., with the Director of Nursing (DON) obtained a list of four residents residing in the facility, assessed to self administer medications (#8, #18, #38, #53). Review of the policy titled Self-Administration of Medications Policy, revised February 2021, revealed if it is deemed safe and appropriate for a resident to self administer medications, it is documented in the medical record and the care plan. The decision that a resident can self-administer medications is re-assessed periodically based on changes in the residents medical or decision making skills. For self administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken. If the resident is able and willing to take responsibility for documenting self-administration of medications, the resident is instructed on how to complete a record indicating the administration of the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 15816 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered as ordered by the physician, and within prescribed time frames, resulting in a medication error rate above five percent (%). A total of 2 medication errors were observed out of 32 opportunities for a medication administrations calculating an error rate of 6.25%. This affected two (#12, #40) of three residents observed during medication administration. The facility census was 71. Findings include: 1. Observation on 01/07/25 at 7:27 A.M., noted Licensed Practical Nurse (LPN) #130 to obtain Resident #12 medications from the medication cart. LPN #130 stated Lamotrigine 200 milligrams (mg) was not available in the facility or in the contingency box supply. The medication would have to be omitted and ordered from the pharmacy. LPN #130 proceeded to Resident #12 room and administered the available medications. Review of the medical record revealed a physician order dated 04/05/22 for the administration of Lamotrigine one 200 mg tablet twice daily for Seizures. Review of the medication administration record (MAR) revealed Lamotrigine one 200 mg was scheduled for the prescribed times twice daily at 7:30 A.M. and 7:30 P.M. Interview on 01/07/25 at 10:35 A.M., with LPN #130 verified the medication Lamotrigine was not available in the facility and the dose was not administered. 2. Observation on 01/07/24 at 8:38 A.M., noted Licensed Practical Nurse (LPN) #154 preparing Resident #40 medications for administration. As medications were obtained from the medication cart LPN #154 stated Resident #40 medication Januvia 50 milligrams (mg) was not available in the medication cart. LPN #154 proceeded to review the contents of the facility contingency medication storage and stated the medication was not available in the facility stating the medication would not be administered. LPN #154 proceeded to administered Resident #40 available medications. Review of the medical record revealed a physician order dated 09/25/23 for the administration of Januvia 50 mg once daily for Diabetes Mellitus. Review of the medication administration record (MAR) Januvia 50 mg was scheduled for the prescribed times once daily at 8:00 A.M. Interview on 01/07/25 at 8:45 A.M., with LPN #154 verified the medication Januvia was not available in the facility and the dose was not administered. Review of the policy titled Medication Administration, effective 09/12/24, revealed medications are administered in accordance with written orders of the prescriber. A schedule of routine dose administration times is established by the community and utilized on the administration records. Medications are administered within 60 minutes of scheduled time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered as ordered by the physician and within prescribed time frames, resulting in delay in administration of anticonvulsant medication, anti-diabetic medication, anti-dementia medication and anti-psychotic medication. This affected four (#12, #36 #40, #66) of eight residents reviewed for medication administration. The facility census was 71. Findings include: 1. Observation on 01/07/25 at 7:27 A.M., noted Licensed Practical Nurse (LPN) #130 to obtain Resident #12 medications from the medication cart. LPN #130 stated Lamotrigine 200 milligrams (mg) was not available in the facility or in the contingency box supply. The medication would have to be omitted and ordered from the pharmacy. LPN #130 proceeded to Resident #12 room and administered the available medications. Review of the medical record revealed a physician order dated 04/05/22 for the administration of Lamotrigine one 200 mg tablet twice daily for Seizures. Review of the medication administration record (MAR) revealed Lamotrigine one 200 mg was scheduled for the prescribed times twice daily at 7:30 A.M. and 7:30 P.M. Interview on 01/07/25 at 10:35 A.M., with LPN #130 verified the medication Lamotrigine was not available in the facility and the dose was not administered. 2. Observation on 01/07/24 at 8:38 A.M., noted Licensed Practical Nurse (LPN) #154 preparing Resident #40 medications for administration. As medications were obtained from the medication cart LPN #154 stated Resident #40 medication Januvia 50 milligrams (mg) was not available in the medication cart. LPN #154 proceeded to review the contents of the facility contingency medication storage and stated the medication was not available in the facility stating the medication would not be administered. LPN #154 proceeded to administered Resident #40 available medications. Review of the medical record revealed a physician order dated 09/25/23 for the administration of Januvia 50 mg once daily for Diabetes Mellitus. Review of the medication administration record (MAR) Januvia 50 mg was scheduled for the prescribed times once daily at 8:00 A.M. Interview on 01/07/25 at 8:45 A.M., with LPN #154 verified the medication Januvia was not available in the facility and the dose was not administered. Review of the policy titled Medication Administration, effective 09/12/24, revealed medications are administered in accordance with written orders of the prescriber. A schedule of routine dose administration times is established by the community and utilized on the administration records. Medications are administered within 60 minutes of scheduled time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44815 3. Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses depression, vascular dementia, and anxiety. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #36 had impaired cognition and received antipsychotic medications on a routine basis. Review of the current physician order dated 01/02/25 revealed Resident #36 received Seroquel 50 milligrams (mg), one tablet by mouth in the evening for depression, dementia, and anxiety. Review of the January 2025, medication administration record (MAR) for Resident #36 revealed a 9 was marked in the administration box on 01/05/25, 01/06/25, and 01/07/25. Further review of the MAR revealed 9 indicated the nurse wrote a progress note. Review of a nurse's progress note dated 01/05/25 revealed the Seroquel was not available and the facility was awaiting delivery from the pharmacy. Review of a nurse's progress note dated 01/06/25 revealed the facility was awaiting shipment of the medication from the pharmacy. Review of a nurse's progress note dated 01/07/25 revealed the facility was awaiting shipment of the medication from the pharmacy. Interview on 01/09/25 at 10:09 A.M., with the DON confirmed Resident #36 did not receive Seroquel as ordered by the physician on 01/05/25, 01/06/025, and 01/07/25. The DON stated Seroquel was received from the pharmacy on 01/08/25. 4. Review of the medical record for Resident #66 revealed an admitted [DATE] with diagnoses of vascular dementia and Alzheimer's disease. Review of the initial comprehensive MDS assessment dated [DATE] revealed Resident #66 was rarely/never understood. Review of the physician order dated 11/09/24 revealed Resident #66 should receive galantamine hydrobromide ER (extended release) oral capsule, 24 mg, one capsule by mouth once daily for Alzheimer's disease. Review of the MAR for November 2024 revealed a 9 documented in the administration box for galantamine hydrobromideER on [DATE] and 11/10/24. Further review of the MAR revealed 9 indicated the nurse wrote a progress note. Review of the nurse's progress notes revealed no note dated 11/09/24. Additional review revealed a progress note dated 11/10/24 indicating the medication was on order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/09/25 at 10:09 A.M., with the DON confirmed Resident #66 did not receive galantamine hydrobromide ER for two days after admission, as ordered by the physician. The DON further provided evidence the medication was delivered to the facility on [DATE]. Further interview with the DON revealed the facility used one pharmacy and provided the pharmacy a list of medications required for each resident upon admission. The DON stated the pharmacy was also able to drop-ship (send more quickly) medications as requested by the facility.

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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. 44815 Based on observation, staff interview, and review of policy, the facility failed to ensure staff practiced appropriate hand hygiene during meal service and ensured food was free from contamination. This had the potential to affect all residents in the facility except Resident #1 who was identified to not eat food by mouth. The facility census was 71. Findings include: Observations on 01/07/25, beginning at 3:56 P.M., revealed [NAME] #182 taking temperatures of food items before meal service. [NAME] #182 wore disposable gloves while touching the thermometer, serving utensils, a pen and paperwork, lids covering food items, and then picked up a pork chop with his left hand and inserted the thermometer into the pork chop. [NAME] #182 determined the temperature was not adequate and touched three additional pork chops before determining the food temperature was adequate. Interview on 01/07/25 at 4:05 P.M., with [NAME] #182 confirmed he touched multiple surfaces with his disposable gloves before touching ready-to-eat pork chops. Observation and interview on 01/07/25 at approximately 4:07 P.M., with [NAME] #182 confirmed a single hair was in the pork chops. The hair was approximately six inches long. [NAME] #182 removed the hair from the pork chops and threw the hair in the trash. [NAME] #182 did not discard or replace any pork chops. 2. Observation during meal service on 01/07/25 at 4:36 P.M., with Dietary Director (DD) #165 revealed he was plating meal trays while wearing disposable gloves. DD #165 touched serving utensils, plates, plate warmers, meal tickets and lids to the steam table while wearing disposable gloves. DD #165 then picked up a dinner roll with his gloved hand without performing hand hygiene or changing gloves. Concurrent interview with DD #165 confirmed he touched a ready-to-eat dinner roll with his gloved hand after touching multiple kitchen surfaces and should have washed his hands and changed gloves before touching the dinner roll. 3. Observation during meal service on 01/07/25 at approximately 4:42 P.M., revealed Dietary Aide (DA) #121 wearing disposable gloves and dissembling a prepared hamburger. DA #121 placed the hamburger patty on a plate and placed the plate in a microwave. DA #121 then changed her disposable gloves. Further observation revealed DA #121 opened the microwave wearing disposable gloves, removed the plate from the microwave, and reassembled the burger and provided it to Resident #38. Interview on 01/07/25 at 4:44 P.M., with DA #121 confirmed she did not change her disposable gloves after opening the microwave and before reassembling Resident #38's hamburger. Review of the undated policy titled, Food Safety Requirements - Use and Storage of Food and Beverage, Food Procurement, revealed staff were responsible to adhere to food safety requirements, including preventing cross-contamination between food contact surfaces and ready-to-eat foods, and preventing physical contamination of food including hair.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44815 Based on observation, staff interview, and review of policy, the facility failed to doff and appropriately store soiled personal protective equipment (PPE). This had the potential to affect all 23 residents on the second floor (#2, #3, #5, #10, #14, #15, #19, #22, #23, #24, #27, #29, #35, #36, #44, #51, #56, #62, #64, #66, #67, #70, and #71). The facility census was 71. Findings include: Observation on 01/06/25 at approximately 10:45 A.M., revealed Certified Nursing Aide (CNA) #116 removing PPE in the doorway of Resident #10's room and placing it in a trash can located in the hallway outside Resident #10's room. Concurrent interview with CNA #116 confirmed Resident #10 was on Enhanced Barrier Precautions (EBP) and required staff to wear PPE while providing personal care. CNA #116 further confirmed the process was to remove PPE in the doorway and place in a trash can located in the hallway outside of the room. Observation on 01/06/25 at 2:48 P.M., revealed a trash can outside Resident #36's room. Concurrent interview with Licensed Practical Nurse (LPN) #160 confirmed Resident #36 was on EBP and the trash can for soiled PPE was located in the hallway outside his room. LPN #160 further stated the process was to keep trash cans for soiled PPE outside each resident's room, in the common hallway. Observation on 01/07/25 at approximately 11:00 A.M., revealed no trash cans in the hallway outside residents rooms who were identified to require EBP. Interview on 01/07/25 at 11:04 A.M., with LPN #123 confirmed eight residents (#3, #5, #10, #19, #23, #27, #36, and #56) on the second floor were on EBP. Further interview with LPN #123 confirmed all residents trash cans were kept outside the rooms for soiled PPE until 01/06/25. LPN #123 stated the facility reviewed the policy for EBP and determined the trash cans should be kept inside the room and staff should doff soiled PPE inside the room. LPN #123 further confirmed all trash can were inside each resident's room who were on EBP. Review of the policy titled, Enhanced Barrier Precautions Policy, dated 04/01/24, revealed a trash can would be positioned inside the resident's room for discarding PPE prior to exit of the room.