ENTERPORT OF SUPPLIER (2) MULTIPLE CONSTRUCTION SUPPLIER (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION (2) MULTIPLE CONSTRUCTION AND CLAN OF (2) MULTIPLE CONSTRUCTION	DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:11/8/2018 FORM APPROVED OMB NO. 0938-0391
PREMIER ESTATES OF CINCINNAT-RIVERSIDE ILLUSTRIAL_STREET Or information on the munity humanics plants currents that deficiency, plants currents that curving home or the state survey gureys. (COLD DREFN TAG) ON JD PREPN TAG SUMMARY STATEMENT OF DEPETCINCENE SEACH DEPETCINCENT SHALE DEP	DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING	(X3) DATE SURVEY COMPLETED
 (A4) ID PREFIX TAG (SUMMARY YATATINATION OF DIFICINCIES (GACH DEPICINCY MIST BL PRECEDED BY FULL REGULATORY OR LSC DEPITYPYIN (NORMATION) F 0550 F 0550 F mediately cell the resident, the resident of actors, and a family member of situations tragger/definition. Bit and the first firs			315 LILIEN	THAL STREET
 F 0530 Level of harm - Minimal Market be resident, the resident, the resident, the RENE TED TO DEVETED CONSTDENTIAL ITY** 		SUMMARY STATEMENT OF D	DEFICIENCIES (EACH DEFICIENCY MUST	
Level of harm - Minimal harm or potential for actual harm or potential for actual harm **NOTE-TEEMS IN BRACKETS HÄVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, Abuse Prevention, Identification, Investigation, and Reporting Policy and treview of list of residents on insulin, the facility failed to prevent misappropriation of insulin medication. This affected two (#32 and #48) known and one unknown Resident. Staff took the other residents insulin to use for Resident #3. This had the potential to affect ten (#10, #14, #33, #30, #37, #44, #51, #55, #59, #62) additional Residents prescribed insulin at the facility. The census was 59. Findings include: 1. Medical record review revealed Resident #32 was admitted to the facility on [DATE] with a reentry date of 05/17/17. [DIAGNOSES REDACTED].#32 was independent with all activities of daily living (ADL'S). Review of the physician orders [REDACTED].#32 was prescribed [MEDICATION NAME] (for diabetes mellitus) insulin inject 1 units subcutaneous (SQ) every morning. 2. Medical record review revealed Resident #48 was admitted to the facility on [DATE] with a reentry date of 04/11/17 with [DIAGNOSES REDACTED].#48 was independent with all ADL's. Review of the physician orders [REDACTED].#48 was admitted to the facility on [DATE] at 7:30 P.M. with [DIAGNOSES REDACTED]. 0. daily at bedtime. 3. Closed medical record review revealed Resident #3 was admitted to the facility on [DATE] at 7:30 P.M. with [DIAGNOSES REDACTED]. 0. Review of the ab-hour plan of care effective 04/27/18 at 4:11 P.M. revealed Resident #3 had a confused mental status, was disoriented times three, and non-verbal. Resident #3 received a tube feeding through a gastric tube and was totally dependent upon staff with all activities of daily	F 0580 Level of harm - Minimal harm or potential for actual harm	OR LSC IDENTIFYING INFOR! Immediately tell the resident, th (injury/decline/room, etc.) that **NOTE- TERMS IN BRACKET Based on closed medical review a prescribed insulin. Resident #3 m registered HI. The physcian was 1 for diabetic care and treatment. T Findings include: Closed medical record review rever REDACTED]. Review of the admission physiciat A.M. and 9:00 P.M. Review of the Medication Admini NAME] eight units was administered at 9: indicated [REDACTED].M. and 9: 9:00 P.M. Review of the nursing progress not NAME]pen wasn't delivered as st [MEDICATION NAME]in a vial was notified and a new order was obta subcutaneous (SQ) at 6:00 A.M. and 9:00 P.M. There administration. Review of the nursing progress not kicking, and screaming. Blood su order for eight units of [MEDICAY yet. Review of the 48-hour plan of car disoriented times three, and non-v dependent upon staff with all acti blood sugar monitoring. Behavion Review of the nursing progress not the family due to unusual sedation units of [MEDICATION NAME] normal saline at 100 ml per hour insulin sliding scale, hold [MEDI range. Interview on [DATE] at 1:08 P.M residents blood sugar be assessed thrashed about. Resident #3's blot insulin and didn't have any routin notified and ordered 10 units of [] call back with the results, intravec coverage in addition to routine in Resident #3 never had any insulin obtained from another resident bu	MATION) e resident's doctor, and a family member of a affect the resident. S' HAVE BEEN EDITED TO PROTECT CON nd staff interviews, the facility failed to notify to issed three doses of her prescribed insulin and a not notified of the first missed dose. This affects he census was 59. ealed Resident #3 was admitted to the facility on n orders [REDACTED].#3 was prescribed [ME istration Record [REDACTED].M. or on [DAT 00 P.M. on [DATE] at which time Resident #3 9:00 P.M. and on [DATE] at 6:00 A.M. Residen the dated [DATE] at 3:00 P.M. revealed pharma ated on the shipment detail form. Pharmacy rep instead of the pen and pharmacy reported a net wined to change the [MEDICATION NAME] per e was no documentation the physcian was notifi- ted dated [DATE] at 11:54 P.M. revealed Reside gar was tested and results were HI. Medical Do TION NAME] was obtained as the [MEDICATION NAME] was obtained as the [MEDICATION NAME] was obtained and registered HI. new, recheck blood sugar in two hours and call via intravenous line, fingerstick blood sugar eve CATION NAME] bolus tube feeding until fing . with LPN #91 reported on [DATE] around 3:4 as it was unusual for the resident to sleep so m od sugar was obtained and registered HI. LPN # e blood sugar monitoring ordered so it had not MEDICATION NAME] bolus tube feeding until fing . with LPN #91 reported on [DATE] around 3:4 as it was unusual for the resident to sleep so m do sugar was obtained and registered HI. LPN # e blood sugar monitoring ordered so it had not MEDICATION NAME] bolus tube feeding until fing . with LPN #91 reported on [DATE] around 3:4 as it was unusual for the resident to sleep so m do sugar was obtained and registered HI. LPN # e blood sugar monitoring ordered so it had not MEDICATION NAME] bolus tube feeding until fing . with LPN #91 reported on [DATE] around 3:4 as it was unusual for the resident to sleep so m to sugar was obtained and registered HI. LPN # e blood sugar monitoring ordered so it had not MEDICATION NAME] bolus tube feeding until fing . with LPN #91 w	situations VFIDENTIALITY** the physcian that a resident did not have after missing the insulin her blood sugar ed one (#3) of five Residents reviewed an [DATE] at 7:30 P.M. with [DIAGNOSES EDICATION NAME]eight units twice daily at 6:00 E] at 6:00 A.M. and at 9:00 P.M [MEDICATION 's blood sugar was documented as HI. The MAR nt #3 expired prior to the dose due on [DATE] at rcy was contacted due to the [MEDICATION orded it would be delivered tonight. Requested w physician order [REDACTED].M., the physician en to [MEDICATION NAME]eight units ied the [MEDICATION NAME]was not available for ent #3 was resistive to all care, combative, ctor (MD) #125 was notified and a one time TION NAME]hadn't been delivered from pharmacy lent #3 had a confused mental status, was wagh a gastric tube and was totally EDICATION NAME]and didn't have any routine nt #3 was assessed at 3:45 P.M. upon request of The physician was notified and ordered 10 1 physician with results, administer one bag of ery six hours and cover with Humalog restrick blood sugar was back within normal 45 P.M., Resident #3's family requested the uch and reported the resident typically #91 reported Resident #3 received routine been obtained prior. The physician was nediately, recheck the blood sugar in two hours and s four times daily with sliding insulin LPN #91 on [DATE] at 9:21 A.M. reported n to the facility. The [MEDICATION NAME]was ident it was obtained. LPN #91 denied
	Level of harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKET Based on medical record review, s review of list of residents on insu affected two (#32 and #48) know This had the potential to affect tei insulin at the facility. The census Findings include: 1. Medical record review revealed [DIAGNOSES REDACTED],#37 Review of the physician orders [R units subcutaneous (SQ) every m 2. Medical record review revealed [DIAGNOSES REDACTED],#47 Review of the physician orders [R SQ daily at bedtime. 3. Closed medical record review r REDACTED]. Review of the 48-hour plan of car disoriented times three, and non- dependent upon staff with all acti blood sugar monitoring. Behavion Review of the admission physician A.M. and 9:00 P.M. Review of the Medication Admini on	S HAVE BEEN EDITED TO PROTECT CON staff interviews, Abuse Prevention, Identificatio in, the facility failed to prevent misappropriati n and one unknown Resident. Staff took the oth (#10, #14, #33, #30, #37, #44, #51, #55, #59, was 59. Resident #32 was admitted to the facility on [I 2 was independent with all activities of daily liv EDACTED].#32 was prescribed [MEDICATIC orning. Resident #48 was admitted to the facility on [I 8 was independent with all ADL's. EDACTED].#48 was prescribed [MEDICATIC orning. Resident #48 was admitted to the facility on [I 8 was independent with all ADL's. EDACTED].#48 was prescribed [MEDICATIC evealed Resident #3 was admitted to the facility e effective 04/27/18 at 4:11 P.M. revealed Resi verbal. Resident #3 received a tube feeding thro vities of daily living. Resident #3 received [ME r was combative and severely agitated. n orders [REDACTED].#3 was prescribed [MEDICATIO	 WFIDENTIALITY** m, Investigation, and Reporting Policy and on of insulin medication. This ther residents insulin to use for Resident #3. #62) additional Residents prescribed DATE] with a reentry date of 05/17/17. Ving (ADL's). DN NAME] (for diabetes mellitus) insulin inject 10 DATE] with a reentry date of 04/11/17 with DN NAME] (for diabetes mellitus) insulin 22 units y on [DATE] at 7:30 P.M. with [DIAGNOSES dent #3 had a confused mental status, was using a gastric tube and was totally EDICATION NAME]eight units twice daily at 6:00 NNAME] eight units was administered at 9:00 P.M.

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.

CENTERS FOR MEDICARE a	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:11/8/2018 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/23/2018
AME OF PROVIDER OF SU	365925 PPLIER	STREET ADDRES	S, CITY, STATE, ZIP
REMIER ESTATES OF CIN	NCINNATI-RIVERSIDE	315 LILIENTHAL CINCINNATI, OH	
0	· ·	cy, please contact the nursing home or the state survey	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MUST BE PR MATION)	RECEDED BY FULL REGULATORY
F 0602 Level of harm - Minimal harm or potential for actual	kicking, and screaming. Blood su order for eight units of [MEDICA	te dated 04/26/18 at 11:54 P.M. revealed Resident #3 gar was tested and results were HI. Medical Doctor (M TION NAME] was obtained as the [MEDICATION N	(ID) #125 was notified and a onetime
harm Residents Affected - Few	of the family due to unusual sedat 10 units of [MEDICATION NAM normal saline at 100 milliliter (ml	te dated 04/28/18 at 4:00 P.M. revealed Resident #3 w ion. Blood sugar was obtained and registered HI. The fE]now, recheck blood sugar in two hours and call phy) per hour via intravenous line, fingerstick blood suga Id [MEDICATION NAME] bolus tube feeding until f	physician was notified and ordered ysician with results, administer one bag of r every six hours and cover with
	Interview on 05/12/18 at 1:08 P.M residents blood sugar be assessed typically thrashed about. Resident routine insulin and didn't have any was notified and ordered 10 units and call back with the results, intr insulin coverage in addition to ror reported Resident #3 never had an NAME]was obtained from anothe Interviews on 05/16/18 at 7:02 P.M from pharmacy while at the facili to the residents [MEDICATION 1 of [MEDICATION NAME], whit reported it was then discovered R full of Resident #48's [MEDICATI Review of the facility Abuse, Prev misappropriation of resident prop permanent use of a resident's belo	I. with LPN #91 reported on 04/28/18 around 3:45 P.M. as it was unusual for the resident to sleep so much and #3's blood sugar was obtained and registered HI. LPN yroutine blood sugar monitoring ordered so it had not of [MEDICATION NAME]to be administered immed avenous fluids, and routine fingerstick blood sugars for time insulin twice daily. An additional interview with yr usulin delivered from the pharmacy during admission resident but LPN #91 was unable to recall from whit . and 05/17/18 at 5:42 A.M. with LPN #93 reported 11 y. A fingerstick blood sugar was obtained on 04/26/13 VAME]being unavailable. The physician was notified th LPN #93 reported of LPN #93 reported mas borrowed from Resident #3. ention, Identification, Investigation, and Reporting PC enty was defined as the deliberate misplacement, explorings or money without the resident's consent. estidents (#10, #14, #32, #33, #37, #40, #44, #48, #51.	d the family reported the resident N #91 reported Resident #3 received been obtained prior. The physician diately, recheck the blood sugar in two hours our times daily with sliding LPN #91 on 05/17/18 at 9:21 A.M. ion to the facility. The [MEDICATION ch resident it was obtained. Resident #3 never received any insulin 8, based upon nursing judgement, due and ordered a one time dose of eights units 2 for administration to Resident #3. LPN #93 orted she would have LPN #95 fill syringes blicy revised 04/01/17 revealed oitation, or wrongful temporary or
F 0678		ding CPR, prior to the arrival of emergency medica	al
Level of harm - Immediate jeopardy	**NOTE- TERMS IN BRACKET	orders and the resident's advance directives. S HAVE BEEN EDITED TO PROTECT CONFIDENT view, review of hospital records, staff and emergency	
Residents Affected - Few	facility failed to ensure one reside in condition and received cardiop respirations, or blood pressure. TI unresponsive with deteriorating v arrived at the facility and found ti for death. The facility identified 4 On [DATE] at 4:37 P.M., Regiona 7:10 P.M. when Resident #3 was (%) and respirations were eight to family's request. The residents' m paramedics arrived at 7:25 P.M. F Immediate Jeopardy was removed On [DATE] at 10:00 A.M., the D Registered Nurses (RNs) on adva completed on [DATE] at 3:30 P.M. had not been educated, including On [DATE] a 100% audit was co #78, after EMT Lieutenant #50 b noted at the time of the audit. Review of the medical records fo Interviews were conducted on [D #201, LPN's #94, #97, #230 and # monitoring for a change in condit The DON or designee will monit times a week for 90 days and diss quality assurance committee mon	or advanced directives on new admissions and or resic uss during clinical review Monday through Friday. An thly for three months. Facility will also review all new	priately monitored for a change DICAL CONDITION], without a pulse, was not monitored once she became ergency medical services (EMS) d one (#3) of three residents reviewed "ull Code status. ed Immediate Jeopardy began on [DATE] at an oxygen saturation at 72 percent , nine-one-one (911) was called at the n [MEDICAL CONDITION] when the 3 P.M. ed the following corrective actions: Licensed Practical Nurses (LPNs) and condition. All education was he facility that staff were working who #76 and Social Service Coordinator (SSC) not being correct. No issues were aled no CPR concerns were identified. "E] between 5:28 P.M. and 5:38 P.M. of RN ledgeable on advanced directives and dents with a change in code status five udit results will be reviewed with the <i>r</i> admission records the following
	Although the Immediate Jeopardy with potential for more than mini- monitoring their corrective action Findings include: Closed medical record review rever REDACTED]. Review of the 48-hour plan of card disoriented times three, and non- dependent upon staff with all acti- routine blood sugar monitoring. T Review of the hospital discharge i diagnosed with [REDACTED]. R and was prescribed [MEDICATIC hospitalized , prior to admission t A.M.; 245 mg/dL on [DATE] at 1 [DATE] at 4:48 P.M.; 123 mg/dL A.M. Advanced directives were d Review of the admission physicial (1.2 calories per ml) tube feeding eight units twice daily at 6:00 A.M. (DNRCC) was written on the phy Review of the Medication Admini NAME], eight units was administered at 9:00 P.I 600 mg/dL). Review of the nursing progress no kicking, and screaming. Blood su notified and a one-time order for	ng clinical review Monday through Friday, amd this w was removed, the facility remains out of compliance a mal harm that is not Immediate Jeopardy) as the facilit plan to ensure on-going compliance. eaded Resident #3 was admitted to the facility on [DAT e effective [DATE] at 4:11 P.M. revealed Resident #3 rerbal. Resident #3 received a tube feeding through a g vities of daily living. Resident #3 received [MEDICA 'he residents' behavior was documented as combative instructions revealed Resident #3 was admitted to the seident #3 had a history of [REDACTED]. Resident # DN NAME], eight units twice daily for diabetes. Bloot o the facility, included: 400 mg/dL on [DATE] at 9:22 2:49 P.M.; 32 mg/dL on [DATE] at 4:27 P.M.; 29 mg on [DATE] at 5:05 P.M.; 194 mg/dL on [DATE] at 7 ocumented as pre-existing Do Not Resuscitate (DNR) torders [REDACTED].#3 was prescribed nothing by five times a day until [MEDICATION NAME] HN at . and 9:00 P.M. There were no orders for blood glucc sician order [REDACTED].M. nor on [DATE] at 0 d. on [DATE] at which time Resident #3's blood suga te dated [DATE] at 11:54 P.M. revealed Resident #3 yagr was tested and results were HI. Medical Doctor (N eight units of [MEDICATION NAME] was obtained a There was no further monitoring of blood sugars to er	at a Severity Level 2 (No actual harm ty is still in the process of FE] at 7:30 P.M. with [DIAGNOSES had a confused mental status, was gastric tube and was totally TION NAMEJand did not have any and severely agitated. nospital from [DATE] to [DATE] and 43 was an insulin dependent brittle diabetic d sugar results in the past 24 hours while 5 A.M.; 453 mg/dL on [DATE] at 11:06 //dL on [DATE] at 31 P.M.; 77 mg/dL on :48 P.M.; and 188 mg/dL on [DATE] at 6:4' , notify physician for order. mouth, 240 milliliters (ml) of Glucerna trived, and [MEDICATION NAME] insulin ose monitoring. DNR Comfort Care 6:00 A.M or 9:00 P.M. [MEDICATION ur was documented as HI (greater than was resistive to all care, combative, /D) #125 (the on-call physician) was as the [MEDICATION NAME]hadn't been

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STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2018
CORRECTION	NUMBER 365925		
NAME OF PROVIDER OF SU		STREET AI	DDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF CI	NCINNATI-RIVERSIDE		NTHAL STREET ATI, OH 45204
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the stat	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		T BE PRECEDED BY FULL REGULATORY
F 0678	(continued from page 2)	i	
Level of harm - Immediate jeopardy	the family due to unusual sedatio ordered 10 units of [MEDICATIO MD #130 ordered to administer of	n. The resident's blood sugar was obtained and ON NAME]now, recheck blood sugar in two h one bag of normal saline at 100 ml per hour via	nours and call physician with results. Additionally, a intravenous line, fingerstick blood sugar
Residents Affected - Few	fingerstick blood sugar was back remained HL A message was left Review of the nursing progress no nurse regarding current medical of Resident #3 was a Full Code. Aw #3 was assessed and had a respira slightly to verbal prompts, and ra At 7:10 P.M., the family once ag	umalog insulin sliding scale. The bolus tube fe within normal range. Resident #3's fingerstick for MD #130, awaiting a return call. the dated [DATE] at 9:15 P.M. revealed at 6:45 condition. The day shift nurse reported Resider aiting call back from physician for continued l tion rate of 12 breaths per minute, skin was pa dial pulse rate was 62 beats per minute. Contir ain requested the nurse assess the resident. The o 10 per minute. Oxygen was applied at five li	c blood sugar was rechecked at 6:15 P.M. and 5 P.M. report was received from the day shift nt #3's family informed facility staff that HI blood sugar results. At 7:00 P.M., Resident ale and cool, eyes were open, head moved nued to wait for call back from physician. e assessment revealed oxygen saturation was
	Resident #3 be transported to the arrived at the facility and Resider cardiopulmonary resuscitation (C expired at 7:53 P.M., see below). Review of the paramedic incident unresponsive, not breathing resid	hospital. Nine-one-one (911) was notified, me tt #3's respirations were slow and shallow. Rep PR) and pronounced Resident #3 expired at 7: report dated [DATE] revealed the unit was dis- ent. Upon arrival at 7:25 P.M., Resident #3 was	essage was left for the physician, EMT's port was given to the EMTs. The EMTs began :35 P.M., (per paramedic report Resident #3 spatched at 7:20 P.M. for an unconscious, as unresponsive, without any spontaneous
	respirations, in [MEDICAL CON pronounced dead at 7:53 P.M. Interview on [DATE] at 1:08 P.M resident's blood sugar be assessed thrashed about. Resident #3's bloo insulin and didn' have any routin and ordered 10 units of [MEDICA with the results, intravenous fluid in addition to routine insulin twic message was left for MD #130 to Interview on [DATE] at 4:13 P.M (DATE] around 7:10 P.M. at whi #3 was a Full Code and requested the facility, EMS assessed Reside Resident #3's long acting insul MD #125 reported upon admissic already on routine blood sugar of Interview on [DATE] at 12:14 P.M unresponsive and having trouble the family, nobody was monitorin blood sugar of HI, over 600 mg/d a signed authorization form in the reported attempts were made to r the scene. Interview on [DATE] at 4:50 P.M necessarily review all accompany Interview on [DATE] at 4:50 P.M netwiew on [DATE] at 6:02 P.M admissions were seen within the would have been seen within the staff in morning meeting and this An additional interview on [DATE] of the family, Resident #3 was ur resident be transported to the hos family, and then out into the hall after the oxygen was applied as e Review of the Blood Glucose Mo	IDITION], with a blood sugar which registered . with LPN #91 revealed on [DATE] around 3 l as it was unusual for the resident to sleep so 1 od sugar was obtained and registered HL LPN e blood sugar monitoring ordered so it had not ATION NAME]to be administered immediatel is, and routine fingerstick blood sugar was reche call the facility. . with RNC #75 revealed the facility did not h ician of any HI or LO blood sugar results. . with LPN #93 revealed Resident #3's family ch time oxygen was applied due to low oxygen the resident be transported to the hospital. Ni in #3, began CPR, and pronounced the resider urrival of EMS at the facility or CPR would ha t 10:50 A.M. with MD #125, he stated he was in wasn't available so an order was given to su on, Resident #3 should have had blood sugar m tecks. . with RDT Lieutenant #50 revealed services breathing. Upon arrival to the facility, the LPN g or doing anything for the resident, and Resis L. The medical record had a sticker which ind the resolut #3 for 30 minutes without succ . with RNC #76 revealed orders were transcrift ring hospital records. . with LPC #76 revealed orders were transcrift ring hospital records. . with RNC #76 revealed orders were transcrift ring hospital records. . with RNC #76 revealed a physician was in the edays. Resident #3 had not been seen by a ph next day or two. The protocol was for all new did not occur for Resident #3. E] at 7:02 P.M. with LPN #93 revealed on [D <i>A</i> ad started vomiting around lunchtime. Upon a responsive, oxygen saturation levels were dro pital. Nine-one-one was called, LPN #93 reported the verything happened so rapidly, but reported R nitoring System User's Guide revealed a test re or healthcare professional should be contacte	d HI. CPR was initiated by EMS and Resident #3 was B:45 P.M., Resident #3's family requested the much and reported the resident typically #91 reported Resident #3 received routine t been obtained prior. MD #130 was notified ly, recheck the blood sugar in two hours and call back mes daily with sliding insulin coverage excked around 6:00 P.M. and remained HI. A have any policies related to diabetic requested the residents breathing be assessed on n saturation level. The family reported Resident ine-one-one was called. Upon EMS arrival to nt dead in the facility. LPN #93 reported two been initiated. the on-call physician and was contacted on [DATE] ubstitute with another long acting insulin. nonitoring ordered, and assumed the resident was s were requested on [DATE] for a resident who was N #93 was at the far end of the room with ident #3 was in [MEDICAL CONDITION] with a licated Resident #3 was a DNR but there was not sident was a Full Code. EMT Lieutenant #50 ress and the resident was pronounced dead at bed by a nurse upon admission who does not the facility at least every two weeks. New ysician since admission to the facility but admission charts to be reviewed by clinical ATE] around 6:30 P.M. report was received from the assessment, around 7:10 P.M., at the request opping rapidly, and the family requested the t back into the resident's orom to talk to the she did not have time to reassess Resident #3 resident #3 was breathing when last assessed. esult of HI indicated blood glucose reading was
F 0684 Level of harm - Immediate jeopardy Residents Affected - Few	gais. ***NOTE- TERMS IN BRACKET Based on closed medical record re review of the paramedic incident failed to ensure one resident recei Jeopardy when Resident #3 did n were not routinely monitored, and This affected one (#3) of five resi residents prescribed insulin for di On [DATE] at 4:37 P.M., Regiona 7:30 P.M. when Resident #3 was revealed Resident #3 was a britth hours prior to admission to the fa insulin, eight units subcutaneous available for administration on [I registered HI, above 600 mg/dL. administer [MEDICATION NAM pharmacy. The facility failed to f effective. Resident #3's blood sug blood sugar on [DATE] at 3:45 P notified and 10 units of [MEDIC. line, the tube feeding was placed every six hours with Humalog im: results telephoned to the physicia left for MD #130. On [DATE] at	report, and review of the blood glucose monitived appropriate monitoring and treatment for or receive ordered insulin for over 24 hours aft d Resident #3 became unresponsive and expire idents reviewed with insulin dependent diabete abetes. The facility census was 59. al Nurse Consultants (RNCs) #75 and #76 wer admitted to the facility without any plan in plae diabetic, received a tube feeding and nothing cilty ranged from 29 milligrams per deciliter (SQ), was prescribed twice daily at 6:00 A.M. DATE] and [DATE]. On [DATE] at 9:00 P.M., DATE] and [DATE]. On glate as the [MED] urther monitor Resident #3's blood sugar to en gar was not monitored again until the family received. The second second monitored again until the family received. The second se	DNFIDENTIALITY** hergency medical technician (EMT) interviews, toring system user's guide, the facility [REDACTED]. This resulted in Immediate ther admission to the facility, blood sugars ed at the facility three days after admission. es. The facility three days after admission. es. The facility identified a total of 12 re notified Immediate Jeopardy began on [DATE] at ace to monitor her JODM. Hospital records by mouth, and blood sugars for the 24 (mg/dL) to 453 mg/dL. [MEDICATION NAME] and 9:00 P.M. The [MEDICATION NAME]Mass not , Resident #3's blood sugar was obtained and cian) was contacted and an order was obtained to IICATION NAMEJstill had not been delivered by usure the administered treatment was equested the nurse assess the resident's e blood sugar results measured HI. MD #130 was ly, normal saline was administered via an intravenous nal range, routine blood sugars were ordered was to be repeated in two hours with the 6:15 P.M. and remained HI. A message was e nurse to assess Resident #3's breathing.

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:11/8/2018 FORM APPROVED
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/23/2018
	365925		
AME OF PROVIDER OF SU REMIER ESTATES OF CI		STREET ADDR 315 LILIENTH	RESS, CITY, STATE, ZIP IAL STREET
		CINCINNATI,	OH 45204
X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST BE	, , ,
E 0694	OR LSC IDENTIFYING INFOR	MATION)	
F 0684		the family's request. Resident #3 was in [MEDICA	AL CONDITION] when the paramedics arrived
Level of harm - Immediate jeopardy		oved on [DATE] at 3:30 P.M. when the facility im	
Residents Affected - Few	Registered Nurses (RNs) on diab	Director of Nursing (DON) began educating all faci etic care and monitoring. All education was compl hem staff were working who had not been educate ident #3.	eted on [DATE] at 3:30 P.M. by RNC #75 and
	residents to ensure orders were in • Review of the medical records for	5 and #76, and Social Service Coordinator (SSC) # place for blood sugar monitoring. There were no is or Residents #10, #32, #48 and #55 who were insul d of the monitoring of blood sugars.	issues noted at the time of the audit.
	Interviews were conducted on [I #201, LPN's #94, #97, #230 and The DON or designee will moni sugar results and parameters, and Monday through Friday. Audit re months. Facility will also review	DATE] between 6:42 P.M. and 6:52 P.M. and on [I #234 and STNA's #62 and #69 revealed all were kn tor diabetic care of residents including medication physician notification five times a week for 90 da sults will be reviewed with the Quality Assessment all new admission records the following business of	nowledgeable on diabetic care and monitoring. orders, availability of medication, blood ys and discuss during clinical review t & Assurance Committee monthly for three
	with potential for more than mini monitoring their corrective action	nd this will be ongoing. v was removed, the facility remained out of complia imal harm that is not Immediate Jeopardy) as the fa h plan to ensure on-going compliance.	ance at a Severity Level 2 (No actual harm cility is still in the process of
		ealed Resident #3 was admitted to the facility on []	DATE] at 7:30 P.M. with [DIAGNOSES
	disoriented times three, and non- dependent upon staff with all acti routine blood sugar monitoring. T Review of the hospital discharge i diagnosed with [REDACTED]. F and was prescribed [MEDICATI hospitalized, prior to admission A.M.; 245 mg/dL on [DATE] at [DATE] at 4:48 P.M.; 123 mg/dI	e effective [DATE] at 4:11 P.M. revealed Resident verbal. Resident #3 received a tube feeding througl ivities of daily living. Resident #3 received [MEDI The residents' behavior was documented as combat instructions revealed Resident #3 was admitted to t Resident #3 had a history of [REDACTED]. Reside ON NAME], eight units twice daily for diabetes. B to the facility, included: 400 mg/dL on [DATE] at 1 12:49 P.M.; 32 mg/dL on [DATE] at 4:27 P.M.; 29 on [DATE] at 5:05 P.M.; 194 mg/dL on [DATE]	h a gastric tube and was totally CATION NAMEJand did not have any ive and severely agitated. the hospital from [DATE] to [DATE] and ent #3 was an insulin dependent brittle diabetic lood sugar results in the past 24 hours while 9:25 A.M.; 453 mg/dL on [DATE] at 11:06 9 mg/dL on [DATE] at 4:31 P.M.; 77 mg/dL on
	(1.2 calories per ml) tube feeding units twice daily at 6:00 A.M. and Review of the Medication Admin	n orders [REDACTED].#3 was prescribed nothing five times a day until the Two Cal HN arrived, an d 9:00 P.M. There were no orders for blood glucos istration Record [REDACTED].M. nor on [DATE]	d [MEDICATION NAME] insulin, eight e monitoring.
		:00 P.M. on [DATE] at which time Resident #3's b	lood sugar was documented as HI (greater
	kicking, and screaming. Blood su	ote dated [DATE] at 11:54 P.M. revealed Resident agar was tested and results were HI. MD #125 was] was obtained as the [MEDICATION NAME]had	notified and a onetime order for eight
	any further monitoring of blood s Review of the nursing progress nc the family due to unusual sedatio ordered 10 units of [MEDICATIO MD #130 ordered to administer of every six hours and cover with H fingerstick blood sugar was back	sugars to ensure effectiveness of the insulin given. the dated [DATE] at 4:00 P.M. revealed Resident # n. The resident's blood sugar was obtained and reg ON NAME]now, recheck blood sugar in two hours one bag of normal saline at 100 ml per hour via intr umalog insulin sliding scale. The bolus tube feedir within normal range. Resident #3's fingerstick blo for the physician, awaiting a return call.	istered HI. MD #130 was notified and s and call physician with results. Additionally, ravenous line, fingerstick blood sugar g was ordered to be held until the
	Review of the nursing progress nor respiration rate of 12 breaths per and radial pulse rate was 62 beats P.M., the family once again requir was 72 % and respirations were e Resident #3 be transported to the	to the physician, awaining a fertuin can. to the dated [DATE] at 9:15 P.M. revealed at 7:00 P.M minute, skin was pale and cool, eyes were open, he s per minute. Facility staff continued to wait for a sested the nurse assess Resident #3. The assessment eight to 10 per minute. Oxygen was applied at five hospital. Nine-one-one (911) was notified, EMT's PR) and pronounced the resident expired at 7:35 P	ead moved slightly to verbal prompts, all back from the physician. At 7:10 r revealed Resident #3's oxygen saturation liters per minute. The family requested arrived at the facility and began
	P.M., see below). Review of the paramedic incident unresponsive, not breathing resid	report dated [DATE] revealed the unit was dispate ent. Upon arrival at 7:25 P.M., Resident #3 was un IDITION], with a blood sugar which registered HI.	ched at 7:20 P.M. for an unconscious, uresponsive, without any spontaneous
	Resident #3 was pronounced dea Interview on [DATE] at 1:08 P.M resident's blood sugar be assessed typically thrashed about. Residen routine insulin and didn't have an notified and ordered 10 units of [call back with the results, intrave		P.M., Resident #3's family requested the h and the family reported the resident LPN #91 reported Resident #3 received not been obtained prior. MD #130 was liately, recheck the blood sugar in two hours ar our times daily with sliding insulin
	remained HI. A message was left Interview on [DATE] at 4:13 P.M management, just to notify the pl Interview on [DATE] at 9:11 P.M	for the physician to call the facility. I. with RNC #75 revealed the facility did not have a hysician of any HI or LO blood sugar results. I. with LPN #93 revealed Resident #3 was not on ra ar on the resident once, based upon nursing judgen	any policies related to diabetic outine blood sugar monitoring. LPN #93
	NAME]being unavailable. LPN # combative behavior as it was extr During an interview on [DATE] a as Resident #3's long acting insul MD #125 reported upon admissio	#93 reported she assumed routine blood sugar mon remely difficult to even administer the insulin. It 10:50 A.M. with MD #125 he stated he was the c in wasn't available so an order was given to substit on, Resident #3 should have had blood sugar monit	itoring was not ordered due to Resident #3's on-call physician and was contacted on [DATE tute with another long acting insulin.
	unresponsive and having trouble family, nobody was monitoring ti mg/dL. EMT Lieutenant #50 repo was pronounced dead at the scene	M. with EMT Lieutenant #50 revealed services were breathing. Upon arrival to the facility, LPN #93 we he resident, and Resident #3 was in [MEDICAL CO orted attempts were made to revive Resident #3 for e.	as at the far end of the room with the ONDITION] with a blood sugar of HI, over 60 r 30 minutes without success and the resident
	necessarily review all accompany Interview on [DATE] at 6:02 P.M admissions were seen within three	. with RNC #75 revealed a physician was in the fare days. Resident #3 had not been seen by a physici	cility at least every two weeks. New an since admission to the facility but
		next day or two. The protocol was for all new adm	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:11/8/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 365925	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2018
NAME OF PROVIDER OF SU			DRESS, CITY, STATE, ZIP
PREMIER ESTATES OF CI		CINCINNA	THAL STREET FI, OH 45204
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I	cy, please contact the nursing home or the state DEFICIENCIES (EACH DEFICIENCY MUST	
F 0684	OR LSC IDENTIFYING INFORM (continued from page 4)	MATION)	
Level of harm - Immediate jeopardy	Review of the Blood Glucose Mo	nitoring System User's Guide revealed a test res or healthcare professional should be contacted plaint Number OH 802.	
Residents Affected - Few			
		ery day to meet the needs of every resident; a h shift.	and have a
Level of harm - Minimal harm or potential for actual harm	minutes, and review of Resident	d staff interviews, review of employee timeshee Census and Conditions of Residents the facility	failed to ensure sufficient staffing levels
Level of harm - Minimal harm or potential for actual harm Residents Affected - Many Residents #48 and #50 stopped and informe waiting to receive his night medications. Of mild behavior disturbances revealed one LF and call lights were answered within 10 mi Observation during a facility tour on 05/12/1 and two STNA's on the fourth floor. Reside lights. Interview on 05/12/18 at 6-41 A.M. with ST staffed with two STNA's. Interview on 05/12/18 at 6-42 A.M. with ST staffed with two STNA's. Interview on 05/12/18 at 10-40 A.M. with R staffed with two STNA's. Interview on 05/12/18 at 10-39 A.M. with R care timely. Interview on 05/12/18 at 10:56 A.M. with R STNA for the entire facility. Interview on 05/12/18 at 10:56 A.M. with R STNA for the entire facility. Interview on 05/12/18 at 10:56 A.M. with R STNA for the entire facility. Interview on 05/12/18 at 12:50 A.M. with R so as STNA on the floor. Interview on 05/12/18 at 12:50 A.M. with R care timely. Interview on 05/17/18 at 12:12 P.M. with R so as STNA for the entire facility. Interview on 05/17/18 at 12:12 P.M. with RS one STNA on the floor. Interview on 05/17/18 at 12:12 P.M. with ST upon staffing levels. Interview on 05/17/18 at 12:12 P.M. with ST upon staffing levels. Interview on 05/17/18 at 12:12 P.M. with ST upon staffing levels. Interview on 05/17/18 at 12:12 P.M. with ST upon staffing levels. Interview on 05/17/18 at 12:12 P.M. with ST upon staffing levels. Interview on 05/17/18 at 12:12 P.M. with ST upon staffing levels. Interview on 05/17/18 at 12:12 P.M. with L1 another day or shift. Review of table staffing sheets for 05/02/18 for 05/05/18 at 00/06/18 the to inaccuraci and one STNA on the DoN reviewed the timesheet facility did not have any registered nurse (R inaccurate and did not reflect the staff work Interview on 05/17/18 at 12:25 P.M. with L1 another day or shift. Review of CMS Resident Census and Cond required the assistance of on or two staff ar		 lents. This had the potential to affect all 59 residents. This had the potential to affect all 59 resident (STNA) on the third floor with 30 skilled and diaformed the surveyor the facility needed mointons. Observation at 10:04 P.M. of the fourthled one LPN and two STNA's with a census of 2 hin 10 minutes. on 05/12/18 at 6:14 A.M. revealed one LPN and on 05/12/18 at 6:14 A.M. revealed one LPN and row STNA's with a census of 2 hin 10 minutes. 1. with STNA #65 reported the ability to complete the STNA #67 reported only two out of 29 relys). STNA #67 reported residents functioning the to face of a meals. STNA #67 reported on 05/2/18 bille to meet the needs of all the residents where M. with Resident #128 reported the facility did n M. with Resident #14 reported there wasn't enored at night, having to wait up to an hour for a be bedpan. Resident #14 reported staffing was mot. L with LPN #97 reported many nights there was ime LPN #97 provided care as much as possible mequired two person assistance, LPN #97 res M. with STNA #69 reported sometimes resident M. with LPN #94 reported sometimes resident M. with the Director of Nursing (DON) reported timesheets, daily staffing sheets, and confirme ported the Administrator managed staffing resp g minutes dated 01/30/18 to 04/24/18 revealed 7/18, and 04/24/18. and Conditions of Residents completed by the facility resident sequired the administrator managed staffing resp g minutes dated 01/30/18 to 04/24/18 revealed for transferring, 42 residents required the assift for dressing, and 57 residents required the	dents at the facility. d one Licensed Practical Nurse (LPN) and long term care residents. During the tour restaff. Resident #59 reported he was still floor unit with residents with memory and 29 residents. Residents received needed care d two STNA's on the third floor and one LPN e and there weren't any unanswered call et assigned job duties if appropriately residents on the fourth floor were independent level varied daily and there could be 06/18, there was only one STNA for the entire a staffing fell below two STNA's on the entire staffing for the facility to provide timely depan and then an additional 30 minutes rea problem at night when there was only one staff and the facility to provide timely depan and then an additional 30 minutes rea problem at night when there was only entire to bed and if there wasn't enought stri a STNA assigned to the floor including on ender the circumstances. When asked how care sponded, I do the best I can. to third receive showers as scheduled dependent fing levels, resident showers may be moved to et of timesheets provided by the facility 59 residents and two LPN's (#97, #94) until 06/18 with a census of 59 residents. The daily stiffing sheet for 05/08/18 was out. d there wasn't an RN who worked at the fourbilities up until a few days ago. documented complaints about slow call light for eating, forty residents sistance of one or two staff and six sistance of one or two staff and six sistance of one or two staff and two sistance of one or two staff and two
Level of harm - Minimal harm or potential for actual harm		d staff interviews, review of employee timeshee Census and Conditions of Residents the facility	
Residents Affected - Many	eight hours daily at the facility to residents at the facility. Findings include: Observation during an initial tour one State tested Nursing Assistan Residents #48 and #50 stopped au waiting to receive his night mediu mild behavior disturbances revea and call lights were answered tim Observation during a facility tour and two STNA's on the fourth flo lights. Interview on 05/12/18 at 6:41 A.M staffed with two STNA's. Interview on 05/12/18 at 6:42 A.M with activities of daily living (AI anywhere from one to nine reside facility and reported it was impos	meet the care needs of the residents. This had the of the facility on 05/08/18 at 9:34 P.M. revealed t (STNA) on the third floor with 30 skilled and d informed the surveyor the facility needed mo- rations. Observation at 10:04 P.M. of the fourth led one LPN and two STNA's with a census of 2 ely, within 10 minutes. on 05/12/18 at 6:14 A.M. revealed one LPN and or. Residents were being provided morning card 1. with STNA #65 reported the ability to compl 1. with STNA #67 reported only two out of 29 r V2's). STNA #67 reported residents functioning nts to feed at meals. STNA #67 reported on 05/ sible to meet the needs of all the residents wher	he potential to affect all 59 d one Licensed Practical Nurse (LPN) and long term care residents. During the tour ore staff. Resident #59 reported he was still floor unit with residents with memory and 29 residents. Residents received needed care d two STNA's on the third floor and one LPN e and there weren't any unanswered call ete assigned job duties if appropriately residents on the fourth floor were independent level varied daily and there could be 06/18, there was only one STNA for the entire n staffing fell below two STNA's on the
FORM CMS-2567(02-99) Previous Versions Obsolete	Event ID: YL1011	Facility ID: 365925	If continuation sheet Page 5 of 9

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:11/8/2018 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 365925	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2018
AME OF PROVIDER OF SU REMIER ESTATES OF CI	PPLIER	STREET ADDI 315 LILIENTH CINCINNATI	
	1 · · ·	cy, please contact the nursing home or the state su	irvey agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MUST BI MATION)	E PRECEDED BY FULL REGULATORY
F 0727	(continued from page 5) floor.		
Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/12/18 at 10:39 A. care timely. Interview on 05/12/18 at 10:40 A. STNA for the entire facility. Interview on 05/12/18 at 10:56 A.	M. with Resident #28 reported the facility did not M. with Resident #31 reported he received medica M. with Resident #14 reported there wasn't enoug d at night, having to wait up to an hour for a bedp	ations late and one night there was only one the staff in the facility to provide timely
	one STNA on the floor. Interview on 05/12/18 at 1:25 P.M provide needed care. Resident #11 help, he remained where he was a Interview on 05/16/18 at 6:42 P.M 05/05/18 and 05/06/18 at which ti was provided to the residents whi Interview on 05/17/18 at 12:12 P.J the residents due to poor staffing Interview on 05/17/18 at 12:48 P.J upon staffing levels. Interview on 05/17/18 at 12:58 P.J another day or shift. Review of daily staffing sheets for for 05/05/18 and 05/06/18 due to and one STNA (#55) from 7:45 P 11:00 P.M., and (#132) at 10:30 H facility did not have any registere inaccurate and did not reflect the Interview on 05/17/18 at 12:25 P.J 05/06/18. The DON reviewed the facility on 05/06/18. The DON re	L. with LPN #97 reported many nights there wasn' me LPN #97 provided care as much as possible um required two person assistance. LPN #97 respt M. with STNA #69 reported inability to complete levels. M. with STNA #62 reported sometimes residents of M. with LPN #94 reported dependent upon staffin 05/02/18 to 05/08/18 and review of the third set of inaccuracies discovered by the surveyor revealed M. to 10:50 P.M. on 05/05/18 with a census of 55 P.M.) and one STNA (#65) for night shift on 05/06 d nurse (RN) hours on 05/06/18. Review of the d staff working in the building during the initial tou M. with the Director of Nursing (DON) reported s timesheets, daily staffing sheets, and confirmed t ported the Administrator managed staffing respon g minutes dated 01/30/18 to 04/24/18 revealed do 7/18, and 04/24/18.	ways have enough staff at night to nair to bed and if there wasn't enough 't an STNA assigned to the floor including on inder the circumstances. When asked how care onded, I do the best I can. assigned job duties and meet the needs of didn't receive showers as scheduled dependent g levels, resident showers may be moved to of timesheets provided by the facility insufficient staffing of one LPN (#97) 9 residents and two LPN's (#97, #94) until 6/18 with a census of 59 residents. The aily staffing sheet for 05/08/18 was r. the did not work at the facility on here wasn't an RN who worked at the sibilities up until a few days ago. cumented complaints about slow call light sitify on 05/12/18 revealed nine residents taff for eating, forty residents sistance of one or two staff and six tance of one or two staff and six
F 0729 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	2 years, receive retraining. ***NOTE- TERMS IN BRACKET Based on observation, interview, r ensure employees were qualified Nursing Assistants reviewed and Findings include: Observation during an initial tour providing care to residents on the Review of the daily staffing sheet original copy provided did not int and from 7:00 P.M. to 11:00 P.M Review of timesheet for [DATE] I Interview on [DATE] at 5:00 P.M and worked both floors since [DA his STNA registry was never revi to work as an STNA. Review of Nurse Aide Registry re received in the past 24 months, ar	dated [DATE], after requesting a correct copy to a clude STNA #63, revealed STNA #63 worked from	IDENTIALITY** the Aide Registry the facility failed to his affected one (#63) of 16 State tested acility. TNA #63 was working as an STNA and reflect whom was observed on tour as the m 2:00 P.M. to 7:00 P.M. on the third floor acid STNA #63 had been employed at the facility redentials on [DATE] and it was discovered terminated on [DATE] due to being unqualified a [DATE] as no work verification had been
F 0755		to meet the needs of each resident and employ	v or obtain
Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on closed medical review, s ensure prescribed medications we diabetic care and treatment. The of Findings include: Closed medical record review rever REDACTED]. Review of the admission physician A.M. and 9:00 P.M. Review of the Medication Admini NAME] eight units was administered at 9: indicated [REDACTED].M. and 9 9:00 P.M. Review of the nursing progress no NAME]pen wasn't delivered as st	S HAVE BEEN EDITED TO PROTECT CONFI taff and pharmacy interviews, and review of phar re available for administration. This affected one	macy shipment detail the facility failed to (#3) of five Residents reviewed for [DATE] at 7:30 P.M. with [DIAGNOSES [CATION NAME]eight units twice daily at 6:00 at 6:00 A.M. and at 9:00 P.M [MEDICATION plood sugar was documented as HI. The MAR #3 expired prior to the dose due on [DATE] at was contacted due to the [MEDICATION ted it would be delivered tonight. Requested
	was notified and a new order was obta subcutaneous (SQ) at 6:00 A.M. and 9:00 P.M. Review of the nursing progress not kicking, and screaming. Blood su order for eight units of [MEDICA yet. Review of the 48-hour plan of card disoriented times three, and non	ined to change the [MEDICATION NAME] pen te dated [DATE] at 11:54 P.M. revealed Resident gar was tested and results were HI. Medical Doct TION NAME] was obtained as the [MEDICATIG e effective [DATE] at 4:11 P.M. revealed Residen rerbal. Resident #3 received a tube feeding throug vities of daily living. Resident #3 received [MEDI was combative and severely agitated. te dated [DATE] at 4:00 P.M. revealed Resident #	to [MEDICATION NAME]eight units #3 was resistive to all care, combative, or (MD) #125 was notified and a one time ON NAME]hadn't been delivered from pharmac at #3 had a confused mental status, was the a gastric tube and was totally ICATION NAME]and didn't have any routine
ORM CMS-2567(02-99) revious Versions Obsolete	Event ID: YL1011	Facility ID: 365925	If continuation sheet Page 6 of 9

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 365925	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2018
AME OF PROVIDER OF SU	JPPLIER	STREET ADDRE	ESS, CITY, STATE, ZIP
REMIER ESTATES OF CI	NCINNATI-RIVERSIDE	315 LILIENTHA	
or information on the nursing	home's plan to correct this deficient	CINCINNATI, C	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D	DEFICIENCIES (EACH DEFICIENCY MUST BE	, , , ,
F 0755 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	In normal saline at 100 ml per hour via intravenous line, fingerstick blood sugar every six hours and cover with Humalog insulin sliding scale, hold [MEDICATION NAME] bolus tube feeding until fingerstick blood sugar was back within normal range.		visician with results, administer one bag of six hours and cover with Humalog ick blood sugar was back within normal .M., Resident #3's family requested the and reported the resident typically reported Resident #3 received routine n obtained prior. The physician was ately, recheck the blood sugar in two hours and ar times daily with sliding insulin 1 #91 on [DATE] at 9:21 A.M. reported the facility. The [MEDICATION NAME]was ti t was obtained. oharmacy never delivered any insulin for d the pharmacy shipment detail dated delivered but the DON reported interviewing the ulin for Resident #3. Per the DON, he shipment. This was also documented in DICATION NAME] Flextouch pens were rted Resident #3 never received any insulin fE], based upon nursing judgement, due to and ordered a one time dose of eights units of 2 for administration to Resident #3. LPN #93 reported she would have LPN #95 fill syringes vealed [MEDICATION NAME] and oral is medications were delivered on [DATE]. 1 in the shipment and pharmacy was notified the demail pharmacy to investigate the

F 0760	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
Level of harm - Actual harm	Based on closed medical review, staff and pharmacy interviews, review of pharmacy shipment detail and review of the blood glucose monitoring system user's guide, the facility failed to ensure residents were free of significant medication errors.
	This resulted in actual harm to Resident #3 who missed three doses of her prescribed insulin and after missing the insulin
Residents Affected - Few	doses her blood sugar registerd HI. This affected one (#3) of five Residents reviewed for diabetic care and treatment. The census was 59.
	Findings include:
	Closed medical record review revealed Resident #3 was admitted to the facility on [DATE] at 7:30 P.M. with [DIAGNOSES REDACTED].
	Review of the admission physician orders [REDACTED].#3 was prescribed [MEDICATION NAME]eight units twice daily at 6:00
	A.M. and 9:00 P.M.
	Review of the Medication Administration Record [REDACTED].M. or on [DATE] at 6:00 A.M. and at 9:00 P.M [MEDICATION NAME]
	eight units was administered at 9:00 P.M. on [DATE] at which time Resident #3's blood sugar was documented as HI. The MAR indicated [REDACTED].M. and 9:00 P.M. and on [DATE] at 6:00 A.M. Resident #3 expired prior to the dose due on [DATE] at 9:00 P.M.
	Review of the nursing progress note dated [DATE] at 3:00 P.M. revealed pharmacy was contacted due to the [MEDICATION NAME]pen wasn't delivered as stated on the shipment detail form. Pharmacy reported it would be delivered tonight. Requested [MEDICATION NAME]in a vial instead of the pen and pharmacy reported a new physician order [REDACTED].M., the physician was
	notified and a new order was obtained to change the [MEDICATION NAME] pen to [MEDICATION NAME]eight units subcutaneous (SQ)
	at 6:00 A.M. and 9:00 P.M. Review of the nursing progress note dated [DATE] at 11:54 P.M. revealed Resident #3 was resistive to all care, combative,
	kicking, and screaming. Blood sugar was tested and results were HI. Medical Doctor (MD) #125 was notified and a one time order for eight units of [MEDICATION NAME] was obtained as the [MEDICATION NAME]hadn't been delivered from pharmacy
	yet. Review of the 48-hour plan of care effective [DATE] at 4:11 P.M. revealed Resident #3 had a confused mental status, was
	disoriented times three, and non-verbal. Resident #3 received a tube feeding through a gastric tube and was totally dependent upon staff with all activities of daily living. Resident #3 received [MEDICATION NAME] and didn't have any routine
	blood sugar monitoring. Behavior was combative and severely agitated.
	Review of the nursing progress note dated [DATE] at 4:00 P.M. revealed Resident #3 was assessed at 3:45 P.M. upon request of the family due to unusual sedation. Blood sugar was obtained and registered HI. The physician was notified and ordered 10
	units of [MEDICATION NAME]now, recheck blood sugar in two hours and call physician with results, administer one bag of normal saline at 100 ml per hour via intravenous line, fingerstick blood sugar every six hours and cover with Humalog insulin sliding scale, hold [MEDICATION NAME] bolus tube feeding until fingerstick blood sugar was back within normal
	range.
	Interview on [DATE] at 1:08 P.M. with LPN #91 reported on [DATE] around 3:45 P.M., Resident #3's family requested the residents blood sugar be assessed as it was unusual for the resident to sleep so much and reported the resident typically
	thrashed about. Resident #3's blood sugar was obtained and registered HI. LPN #91 reported Resident #3 received routine insulin and didn't have any routine blood sugar monitoring ordered so it had not been obtained prior. The physician was
	notified and ordered 10 units of [MEDICATION NAME] to be administered immediately, recheck the blood sugar in two hours and
	call back with the results, intravenous fluids, and routine fingerstick blood sugars four times daily with sliding insulin coverage in addition to routine insulin twice daily. An additional interview with LPN #91 on [DATE] at 9:21 A.M. reported
	Resident #3 never had any insulin delivered from the pharmacy during admission to the facility. The [MEDICATION NAME] was
	obtained from another resident but LPN #91 was unable to recall from which resident it was obtained. Interview on [DATE] at 2:47 P.M. with the Director of Nursing (DON) reported the pharmacy never delivered any insulin for
	Resident #3 and it was not available in the facility emergency box. The DON reported the pharmacy shipment detail dated
	[DATE] at 2:34 P.M. indicated three [MEDICATION NAME] flextouch pens were delivered but the DON reported interviewing the nurse on duty whom received the shipment and the shipment did not include any insulin for Resident #3. Per the DON,
	Pharmacy was immediately contacted and informed the insulin was not included in the shipment. This was also documented in
	Resident #3's nursing progress notes. Review of pharmacy shipment detail dated [DATE] at 2:34 P.M. revealed three [MEDICATION NAME] Flextouch pens were
	delivered for Resident #3.
	Interviews on [DATE] at 7:02 P.M. and on [DATE] at 5:42 A.M. with LPN #93 reported Resident #3 never received any insulin
	from pharmacy while at the facility. A fingerstick blood sugar was obtained on [DATE], based upon nursing judgement, due to the residents [MEDICATION NAME]being unavailable. The physician was notified and ordered a one time dose of eights units of
	[MEDICATION NAME], which LPN #93 reported was borrowed from Resident #32 for administration to Resident #3. LPN #93
	reported it was then discovered Resident #48 received [MEDICATION NAME]and reported she would have LPN #95 fill syringes full of Resident #48's [MEDICATION NAME]for administration to Resident #3.
FORM CMS-2567(02-99) Previous Versions Obsolete	Event ID: YL1011 Facility ID: 365925 If continuation sheet Page 7 of 9

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:11/8/2018 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 365925	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	FION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/23/2018
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, ST.	ATE, ZIP
PREMIER ESTATES OF CL	NCINNATI-RIVERSIDE		315 LILIENTHAL STREET CINCINNATI, OH 45204	
	home's plan to correct this deficien			VELLI DECLI ATODV
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED B	I FULL REGULATOR I
F 0760 Level of harm - Actual harm	(continued from page 7) Interview on [DATE] at 2:51 P.M medications were delivered to the Upon informing Pharmacist #710 about	e facility for Resident #3 on [DA]	E] and intravenous medications v	vere delivered on [DATE].
Residents Affected - Few	this error, Pharmacist #710 report issue, and inform the surveyor ab Pharmacist as of [DATE]. Review of the Blood Glucose Mo above 600 mg/dL and a physiciar This is an incidental deficiency ar	out the results of the investigation nitoring System User's Guide revo or healthcare professional should	 No further information was pro- ealed a test result of HI indicated d be contacted immediately. 	vided by the blood glucose reading was
F 0842 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	This is an incidental deficiency ar Safeguard resident-identifiable resident that are in accordance **NOTE- TERMS IN BRACKET Based on closed medical record re information. This affected one (# Findings include: Closed medical record review rev REDACTED]. Review of the hospital discharge i diagnosed with [REDACTED]. R and was prescribed [MEDICATI hospitalized, prior to admission of A.M.; 245 mg/dL on [DATE] at [DATE] at 4:48 P.M.; 123 mg/dL A.M. Review of the admission physicia tube feeding five times a day unti- A.M. and 9:00 P.M. There weren't any Review of the medication adminis [DATE] at 9:00 P.M. and on [DA on [DATE] at which time Resident f- sugar checks dated [DATE] comp documented on the MAR). Resul- fingerstick blood sugar MAR for P.M. results were 426, on [DATE] Review of the nursing progress na kicking, and screaming. Blood su order for eight units of [MEDICAZ yet. There wasn't any further monitori Review of the Alshour plan of can disoriented times three, and non- dependent upon staff with all acti- blood sugar monitoring. Behavio Review of the nursing progress na discinented times three, and non- dependent upon staff with all acti- blood sugar monitoring. Behavio Review of the nursing progress na discine tat of 12 breaths per and radial pulse rate was 62 beats nore again requested the rurse as eight to 10 per minute. Oxygen w the hospital. 911 was notified. RD Review of paramedic incident rep unresponsive, not breathing resid respirations, in [MEDICAL CON Resident #3 was pronounced dead Interview on [DATE] at 1:08 P.M. Review of paramedic incident rep unresponsive, not breathing resid netwident expired the rurse as eight to 10 per minute. Oxygen w the hospital. 911 was notified, and ordered two hours and call back with the sliding insulin coverage in additi- physician was notified and ordered two hours and call back with the sliding insulin coverage in additi- physician tay is combative behavion Interview on [DATE] at 1:19 P.M obtained	d was discovered during the cour information and/or maintain m with accepted professional stan TS HAVE BEEN EDITED TO PF view and staff interviews the faci 3) of nine residents reviewed duri ealed Resident #3 was admitted to nstructions revealed Resident #3 tesident #3 had a history of [RED DN NAME] eight units twice dail to the facility, included: 400 mg/d 12:49 P.M.; 32 mg/dL on [DATE] on [DATE] at 5:05 P.M.; 194 m; n orders [REDACTED].#3 was pl 1 [MEDICATION NAME] HN an orders for blood glucose monitoris stration record (MAR) revealed [N TTE] at 6:00 A.M. an 9:00 P.M. [P 43's blood sugar was documented oleted three times daily at 9:00 A. to were recorded without any nurse [DATE] at 9:00 P.M. were 301. 6] 21 at 9:00 A.M. results were 358, at the dated [DATE] at 11:54 P.M. re gar was tested and results were H TION NAME] was obtained as the arg of blood sugars to ensure effect the effective [DATE] at 4:11 P.M. re wersal. Resident #3 received a tub vities of daily living. Resident #3 r was combative and severely agil the dated [DATE] at 4:00 P.M. rev n. Blood sugar was obtained as the as rechecked and faily living. Resident #3 r was combative and severely agil the dated [DATE] at 9:15 P.M. rev minute, skin was pale and cool, e per minute. Continued to wait for sess the Resident #3 received a tub vities of daily living. Resident #3 r was combative and severely agil the dated [DATE] at 9:15 P.M. rev minute, skin was pale and cool, e per minute. Continued to wait for sess the Resident A3 received Resident ort dated [DATE] revealed the un ent. Upon arrival at 7:25 P.M., Ref DITION], with a blood sugar wh at 7:53 P.M. with Licensed Practical Nurse (10 ours of [MEDICATION NA results, intravenous line, fingerstick b CATION NAME] was obtained and ref ro on the resident only once, based ava alft for the physician of call re with Regional Nurse Consultant ust notify the physician of call re with Regional Nurse Consultant ust was emnitoring the resident, at M. with	se of the investigation of Čompla edical records on each dards. COTECT CONFIDENTIALITY** ility failed to ensure medical recor- ng the survey. The census was 59 o the facility on [DATE] at 7:30 P was admitted to the hospital from ACTED]. Resident #3 was an ins y for diabetes. Blood sugar result L on [DATE] at 9:25 A.M.; 453 r [at 4:27 P.M.; 29 mg/dL on [DATE] g/dL on [DATE] at 7:48 P.M.; and rescribed nothing by mouth, 240 r rived, and [MEDICATION NAME] mg. MEDICATION NAME]was not an MEDICATION NAME]was not an MEDICATION NAME]was not an MEDICATION NAME]was not an MEDICATION NAME] eight uni- as HI. Review of an additional M M., 12:00 P.M., and 9:00 P.M. (T ess initials or signatures. The resu On [DATE] at 12:00 P.M. results v ind on [DATE] at 2:00 P.M. results v ind On [DATE] at 2:00 P.M. results v ind on [DATE] at 12:00 P.M. results v ind a full fuguritif higherstick blood sugar vealed Resident #3 was assessed a registered HI. The physician was 2 wore open, head moved slight r call back from physician was 7 wey were open, head moved slight r call back from physician was 7 wey swere open, head moved slight r call back from physician was 7 wey swere open, head moved slight r call back from physician was rest hours and call physician was 7 wey swere open, head moved slight r call back from physician was rest hours and registered HI. CPR was initiat LPN) #91 reported on [DATE] ar was not on routine blood sugar so the fingerstick blood sugar so the finger	* rds contained accurate
	Interview on [DATE] at 2:09 P.M daily fingerstick blood sugar resu resident denied obtaining routine coincide with the result documen fingerstick blood sugar MAR can terminated and not able to be que	Its when routine blood sugars were fingerstick blood sugars, and the ted in the progress notes and on a me from, she just provided the sur-	re not ordered, the nurses providin recorded result for 9:00 P.M. on [nother MAR. RNC #75 reported s	ng care for the DATE] did not she did not know where the

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NAME OF PROVIDER OF SU		STREET AI	DDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF CI	NCINNATI-RIVERSIDE	315 LILIEN CINCINNA	NTHAL STREET TI, OH 45204
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		BE PRECEDED BY FULL REGULATORY
F 0842	(continued from page 8)		
Level of harm - Minimal harm or potential for actual harm	This is an incidental deficiency an	d was discovered during the course of the inve	sstigation of Complaint Number OH 802.
Residents Affected - Few F 0868		d Assurance group have the required memt	bers and meet at
Level of harm - Minimal	least quarterly		
harm or potential for actual harm	meeting was conducted quarterly	interview, the facility failed to ensure a quality . This had the potential to affect all 59 resident	assessment and assurance committee s at the facility.
Residents Affected - Many	Interview on 05/17/18 at 9:50 A.M assessment and assurance commi	A. with Clinical Regional Manger #75 reported ttee meeting being conducted in (YEAR). scovered during the course of investigation of 1	