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 SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF CINCINNATI-RIVERSIDE	**315 LILIENTHAL STREET CINCINNATI, OH 45204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 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** Based on closed medical review and staff interviews, the facility failed to notify the physcian that a resident did not have prescribed insulin. Resident #3 missed three doses of her prescribed insulin and after missing the insulin her blood sugar registered HI. The physcian was not notified of the first missed dose. 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. There was no documentation the physcian was notified the [MEDICATION NAME]was not available for administration. 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. LPN #91 denied notifying a physcian prior to this time. This is an incidental deficiency and was discovered during the course of the investigation of Complaint Number OH 802.
F 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, Abuse Prevention, Identification, Investigation, and Reporting Policy and review 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 10 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 prescribed [MEDICATION NAME] (for diabetes mellitus) insulin 22 units SQ 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]. Review of the 48-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 living. Resident #3 received [MEDICATION NAME]and didn't have any routine blood sugar monitoring. Behavior was combative and severely agitated. 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]. [MEDICATION NAME] eight units was administered at 9:00 P.M. on 04/26/18 at which time Resident #3's blood sugar was documented as HI. The MAR indicated [REDACTED].M. on 04/28/18.

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

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.

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 SUPPLIER **PREMIER ESTATES OF CINCINNATI-RIVERSIDE**		STREET ADDRESS, CITY, STATE, ZIP **315 LILIENTHAL STREET CINCINNATI, OH 45204**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Review of the nursing progress note dated 04/26/18 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 onetime order for eight units of [MEDICATION NAME] was obtained as the [MEDICATION NAME]hadn't been delivered from pharmacy yet. Review of the nursing progress note dated 04/28/18 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 milliliter (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 05/12/18 at 1:08 P.M. with LPN #91 reported on 04/28/18 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 the family 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 05/17/18 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. Interviews on 05/16/18 at 7:02 P.M. and 05/17/18 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 04/26/18, 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. Review of the facility Abuse, Prevention, Identification, Investigation, and Reporting Policy revised 04/01/17 revealed misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The facility provided a list of 12 Residents (#10, #14, #32, #33, #37, #40, #44, #48, #51, #55, #59, and #62) currently prescribed insulin at the facility.
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospital records, staff and emergency medical technician (EMT) interviews, review of the paramedic incident report review, and review of the blood glucose monitoring system user's guide, the facility failed to ensure one resident, identified as having a Full Code status, was appropriately monitored for a change in condition and received cardiopulmonary resuscitation (CPR) immediately upon [MEDICAL CONDITION], without a pulse, respirations, or blood pressure. This resulted in Immediate Jeopardy when Resident #3 was not monitored once she became unresponsive with deteriorating vital signs and as a result did not receive CPR until emergency medical services (EMS) arrived at the facility and found the resident in [MEDICAL CONDITION]. This affected one (#3) of three residents reviewed for death. The facility identified 47 current residents who were designated as having a Full Code status. On [DATE] at 4:37 P.M., Regional Nurse Consultants (RNCs) #75 and #76 were notified Immediate Jeopardy began on [DATE] at 7:10 P.M. when Resident #3 was assessed at the request of the family. Resident #3 had an oxygen saturation at 72 percent (%) and respirations were eight to 10 per minute. Oxygen was applied and at 7:20 P.M., nine-one-one (911) was called at the family's request. The residents' medical status was not monitored and Resident #3 was in [MEDICAL CONDITION] when the paramedics arrived at 7:25 P.M. Resident #3 was pronounced dead at the facility at 7:53 P.M. Immediate Jeopardy was removed on [DATE] at 3:30 P.M. when the facility implemented the following corrective actions: · On [DATE] at 10:00 A.M., the Director of Nursing (DON) began educating all facility Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) on advanced directives and monitoring for changes in clinical condition. All education was completed on [DATE] at 3:30 P.M. by RNC #75 and #76, after the surveyor informed the facility that staff were working who had not been educated, including LPN #93 who was directly involved in the incident. · On [DATE] a 100% audit was completed on advanced directives of residents by RNC #76 and Social Service Coordinator (SSC) #78, after EMT Lieutenant #50 brought forth his concerns with the advanced directives not being correct. No issues were noted at the time of the audit. · Review of the medical records for Residents #4 and #5 who expired in the facility revealed no CPR concerns were identified. · Interviews were conducted on [DATE] between 6:42 P.M. and 6:52 P.M. and on [DATE] between 5:28 P.M. and 5:38 P.M. of RN #201, LPN's #94, #97, #230 and #234 and STNA's #62 and #69 revealed all were knowledgeable on advanced directives and monitoring for a change in condition. · The DON or designee will monitor advanced directives on new admissions and or residents with a change in code status five times a week for 90 days and discuss during clinical review Monday through Friday. Audit results will be reviewed with the quality assurance committee monthly for three months. Facility will also review all new admission records the following business day after admission during clinical review Monday through Friday, amd this will be ongoing. Although the Immediate Jeopardy was removed, the facility remains out of compliance at a Severity Level 2 (No actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of monitoring their corrective action plan to ensure on-going compliance. 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 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 did not have any routine blood sugar monitoring. The residents' behavior was documented as combative and severely agitated. Review of the hospital discharge instructions revealed Resident #3 was admitted to the hospital from [DATE] to [DATE] and diagnosed with [REDACTED]. Resident #3 had a history of [REDACTED]. Resident #3 was an insulin dependent brittle diabetic and was prescribed [MEDICATION NAME], eight units twice daily for diabetes. Blood sugar results in the past 24 hours while hospitalized , prior to admission to the facility, included: 400 mg/dL on [DATE] at 9:25 A.M.; 453 mg/dL on [DATE] at 11:06 A.M.; 245 mg/dL on [DATE] at 12:49 P.M.; 32 mg/dL on [DATE] at 4:27 P.M.; 29 mg/dL on [DATE] at 4:31 P.M.; 77 mg/dL on [DATE] at 4:48 P.M.; 123 mg/dL on [DATE] at 5:05 P.M.; 194 mg/dL on [DATE] at 7:48 P.M.; and 188 mg/dL on [DATE] at 6:47 A.M. Advanced directives were documented as pre-existing Do Not Resuscitate (DNR), notify physician for order. Review of the admission physician orders [REDACTED].#3 was prescribed nothing by mouth, 240 milliliters (ml) of Glucerna (1.2 calories per ml) tube feeding five times a day until [MEDICATION NAME] HN arrived, and [MEDICATION NAME] insulin, eight units twice daily at 6:00 A.M. and 9:00 P.M. There were no orders for blood glucose monitoring. DNR Comfort Care (DNRCC) was written on the physician order [REDACTED]. Review of the Medication Administration Record [REDACTED].M. nor on [DATE] at 6:00 A.M or 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 (greater than 600 mg/dL). 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 (the on-call physician) was notified and a one-time order for eight units of [MEDICATION NAME] was obtained as the [MEDICATION NAME]hadn't been delivered from the pharmacy yet. There was no further monitoring of blood sugars to ensure effectiveness of the insulin given.

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 SUPPLIER **PREMIER ESTATES OF CINCINNATI-RIVERSIDE**		STREET ADDRESS, CITY, STATE, ZIP **315 LILIENTHAL STREET CINCINNATI, OH 45204**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) 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. The resident's blood sugar was obtained and registered HI. MD #130 was notified and ordered 10 units of [MEDICATION NAME]now, recheck blood sugar in two hours and call physician with results. Additionally, MD #130 ordered to 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. The bolus tube feeding was ordered to be held until the fingerstick blood sugar was back within normal range. Resident #3's fingerstick blood sugar was rechecked at 6:15 P.M. and remained HI. A message was left for MD #130, awaiting a return call. Review of the nursing progress note dated [DATE] at 9:15 P.M. revealed at 6:45 P.M. report was received from the day shift nurse regarding current medical condition. The day shift nurse reported Resident #3's family informed facility staff that Resident #3 was a Full Code. Awaiting call back from physician for continued HI blood sugar results. At 7:00 P.M., Resident #3 was assessed and had a respiration rate of 12 breaths per minute, skin was pale and cool, eyes were open, head moved slightly to verbal prompts, and radial pulse rate was 62 beats per minute. Continued to wait for call back from physician. At 7:10 P.M., the family once again requested the nurse assess the resident. The assessment revealed oxygen saturation was 72 % and respiration were eight to 10 per minute. Oxygen was applied at five liters per minute. The family requested Resident #3 be transported to the hospital. Nine-one-one (911) was notified, message was left for the physician, EMT's arrived at the facility and Resident #3's respirations were slow and shallow. Report was given to the EMTs. The EMTs began cardiopulmonary resuscitation (CPR) and pronounced Resident #3 expired at 7:35 P.M., (per paramedic report Resident #3 expired at 7:53 P.M., see below). Review of the paramedic incident report dated [DATE] revealed the unit was dispatched at 7:20 P.M. for an unconscious, unresponsive, not breathing resident. Upon arrival at 7:25 P.M., Resident #3 was unresponsive, without any spontaneous respirations, in [MEDICAL CONDITION], with a blood sugar which registered HI. CPR was initiated by EMS and Resident #3 was pronounced dead at 7:53 P.M. Interview on [DATE] at 1:08 P.M. with LPN #91 revealed on [DATE] around 3:45 P.M., Resident #3's family requested the resident's 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. MD #130 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. The fingerstick blood sugar was rechecked around 6:00 P.M. and remained HI. A message was left for MD #130 to call the facility. Interview on [DATE] at 4:13 P.M. with RNC #75 revealed the facility did not have any policies related to diabetic management, just notify the physician of any HI or LO blood sugar results. Interview on [DATE] at 9:11 P.M. with LPN #93 revealed Resident #3's family requested the residents breathing be assessed on [DATE] around 7:10 P.M. at which time oxygen was applied due to low oxygen saturation level. The family reported Resident #3 was a Full Code and requested the resident be transported to the hospital. Nine-one-one was called. Upon EMS arrival to the facility, EMS assessed Resident #3, began CPR, and pronounced the resident dead in the facility. LPN #93 reported Resident #3 was breathing upon arrival of EMS at the facility or CPR would have been initiated. During an interview on [DATE] at 10:50 A.M. with MD #125, he stated he was the on-call physician and was contacted on [DATE] as Resident #3's long acting insulin wasn't available so an order was given to substitute with another long acting insulin. MD #125 reported upon admission, Resident #3 should have had blood sugar monitoring ordered, and assumed the resident was already on routine blood sugar checks. Interview on [DATE] at 12:14 P.M. with EMT Lieutenant #50 revealed services were requested on [DATE] for a resident who was unresponsive and having trouble breathing. Upon arrival to the facility, the LPN #93 was at the far end of the room with the family, nobody was monitoring or doing anything for the resident, and Resident #3 was in [MEDICAL CONDITION] with a blood sugar of HI, over 600 mg/dL. The medical record had a sticker which indicated Resident #3 was a DNR but there was not a signed authorization form in the medical record and LPN #93 reported the resident was a Full Code. EMT Lieutenant #50 reported attempts were made to revive Resident #3 for 30 minutes without success and the resident was pronounced dead at the scene. Interview on [DATE] at 4:50 P.M. with RNC #76 revealed orders were transcribed by a nurse upon admission who does not necessarily review all accompanying hospital records. Interview on [DATE] at 6:02 P.M. with RNC #75 revealed a physician was in the facility at least every two weeks. New admissions were seen within three days. Resident #3 had not been seen by a physician since admission to the facility but would have been seen within the next day or two. The protocol was for all new admission charts to be reviewed by clinical staff in morning meeting and this did not occur for Resident #3. An additional interview on [DATE] at 7:02 P.M. with LPN #93 revealed on [DATE] around 6:30 P.M. report was received from the off going nurse that Resident #3 had started vomiting around lunchtime. Upon assessment, around 7:10 P.M., at the request of the family, Resident #3 was unresponsive, oxygen saturation levels were dropping rapidly, and the family requested the resident be transported to the hospital. Nine-one-one was called, LPN #93 went back into the resident's room to talk to the family, and then out into the hall to direct EMS responders. LPN #93 reported she did not have time to reassess Resident #3 after the oxygen was applied as everything happened so rapidly, but reported Resident #3 was breathing when last assessed. Review of the Blood Glucose Monitoring System User's Guide revealed a test result of HI indicated blood glucose reading was above 600 mg/dL and a physician or healthcare professional should be contacted immediately. This deficiency substantiates Complaint Number OH 802.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospital records, staff and emergency medical technician (EMT) interviews, review of the paramedic incident report, and review of the blood glucose monitoring system user's guide, the facility failed to ensure one resident received appropriate monitoring and treatment for [REDACTED]. This resulted in Immediate Jeopardy when Resident #3 did not receive ordered insulin for over 24 hours after admission to the facility, blood sugars were not routinely monitored, and Resident #3 became unresponsive and expired at the facility three days after admission. This affected one (#3) of five residents reviewed with insulin dependent diabetes. The facility identified a total of 12 residents prescribed insulin for diabetes. The facility census was 59. On [DATE] at 4:37 P.M., Regional Nurse Consultants (RNCs) #75 and #76 were notified Immediate Jeopardy began on [DATE] at 7:30 P.M. when Resident #3 was admitted to the facility without any plan in place to monitor her JODM. Hospital records revealed Resident #3 was a brittle diabetic, received a tube feeding and nothing by mouth, and blood sugars for the 24 hours prior to admission to the facility ranged from 29 milligrams per deciliter (mg/dL) to 453 mg/dL. [MEDICATION NAME] insulin, eight units subcutaneous (SQ), was prescribed twice daily at 6:00 A.M. and 9:00 P.M. The [MEDICATION NAME]was not available for administration on [DATE] and [DATE]. On [DATE] at 9:00 P.M., Resident #3's blood sugar was obtained and registered HI, above 600 mg/dL. Medical Doctor (MD) #125 (the on-call physician) was contacted and an order was obtained to administer [MEDICATION NAME], eight units SQ for one dose, as the [MEDICATION NAME]still had not been delivered by pharmacy. The facility failed to further monitor Resident #3's blood sugar to ensure the administered treatment was effective. Resident #3's blood sugar was not monitored again until the family requested the nurse assess the resident's blood sugar on [DATE] at 3:45 P.M. as Resident #3 was unusually sedated. The blood sugar results measured HI. MD #130 was notified and 10 units of [MEDICATION NAME]was administered. Additionally, normal saline was administered via an intravenous line, the tube feeding was placed on hold until the blood sugar was within normal range, routine blood sugars were ordered every six hours with Humalog insulin sliding scale prescribed, and blood sugar was to be repeated in two hours with the results telephoned to the physician. Resident #3's blood sugar was rechecked at 6:15 P.M. and remained HI. A message was left for MD #130. On [DATE] at 7:10 P.M., the family once again requested the nurse to assess Resident #3's breathing. Resident #3's oxygen saturation was at 72 percent (%) and respirations were eight to 10 per minute. Oxygen was applied and

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 SUPPLIER **PREMIER ESTATES OF CINCINNATI-RIVERSIDE**	STREET ADDRESS, CITY, STATE, ZIP **315 LILIENTHAL STREET CINCINNATI, OH 45204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0684

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 3)
nine-one-one (911) was called at the family's request. Resident #3 was in [MEDICAL CONDITION] when the paramedics arrived and was pronounced expired at the facility at 7:53 P.M.
The Immediate Jeopardy was removed on [DATE] at 3:30 P.M. when the facility implemented the following corrective actions:
· On [DATE] at 10:00 A.M., the Director of Nursing (DON) began educating all facility Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) on diabetic care and monitoring. All education was completed on [DATE] at 3:30 P.M. by RNC #75 and #76 after the surveyor informed them staff were working who had not been educated, including LPN #93 who was directly involved with the incident of Resident #3.
· On [DATE], the DON, RNC #75 and #76, and Social Service Coordinator (SSC) #78 completed an audit of 100% of diabetic residents to ensure orders were in place for blood sugar monitoring. There were no issues noted at the time of the audit.
· Review of the medical records for Residents #10, #32, #48 and #55 who were insulin dependent diabetes revealed no concerns with the availability of insulin and of the monitoring of blood sugars.
· Interviews were conducted on [DATE] between 6:42 P.M. and 6:52 P.M. and on [DATE] between 5:28 P.M. and 5:38 P.M. of RN #201, LPN's #94, #97, #230 and #234 and STNA's #62 and #69 revealed all were knowledgeable on diabetic care and monitoring.
· The DON or designee will monitor diabetic care of residents including medication orders, availability of medication, blood sugar results and parameters, and physician notification five times a week for 90 days and discuss during clinical review Monday through Friday. Audit results will be reviewed with the Quality Assessment & Assurance Committee monthly for three months. Facility will also review all new admission records the following business day after admission during clinical review Monday through Friday and this will be ongoing.
Although the Immediate Jeopardy was removed, the facility remained out of compliance at a Severity Level 2 (No actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of monitoring their corrective action plan to ensure on-going compliance.
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 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 did not have any routine blood sugar monitoring. The residents' behavior was documented as combative and severely agitated.
Review of the hospital discharge instructions revealed Resident #3 was admitted to the hospital from [DATE] to [DATE] and diagnosed with [REDACTED]. Resident #3 had a history of [REDACTED]. Resident #3 was an insulin dependent brittle diabetic and was prescribed [MEDICATION NAME], eight units twice daily for diabetes. Blood sugar results in the past 24 hours while hospitalized , prior to admission to the facility, included: 400 mg/dL on [DATE] at 9:25 A.M.; 453 mg/dL on [DATE] at 11:06 A.M.; 245 mg/dL on [DATE] at 12:49 P.M.; 32 mg/dL on [DATE] at 4:27 P.M.; 29 mg/dL on [DATE] at 4:31 P.M.; 77 mg/dL on [DATE] at 4:48 P.M.; 123 mg/dL on [DATE] at 5:05 P.M.; 194 mg/dL on [DATE] at 7:48 P.M.; and 188 mg/dL on [DATE] at 6:47 A.M.
Review of the admission physician orders [REDACTED].#3 was prescribed nothing by mouth, 240 milliliters (ml) of Glucerna (1.2 calories per ml) tube feeding five times a day until the Two Cal HN arrived, and [MEDICATION NAME] insulin, eight units twice daily at 6:00 A.M. and 9:00 P.M. There were no orders for blood glucose monitoring.
Review of the Medication Administration Record [REDACTED].M. nor 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 (greater than 600 mg/dL).
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. MD #125 was notified and a onetime order for eight units of [MEDICATION NAME] was obtained as the [MEDICATION NAME]hadn't been delivered from the pharmacy yet. There was not
any further monitoring of blood sugars to ensure effectiveness of the insulin given.
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. The resident's blood sugar was obtained and registered HI. MD #130 was notified and ordered 10 units of [MEDICATION NAME]now, recheck blood sugar in two hours and call physician with results. Additionally, MD #130 ordered to 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. The bolus tube feeding was ordered to be held until the fingerstick blood sugar was back within normal range. Resident #3's fingerstick blood sugar was rechecked at 6:15 P.M. and remained HI. A message was left for the physician, awaiting a return call.
Review of the nursing progress note dated [DATE] at 9:15 P.M. revealed at 7:00 P.M., Resident #3 was assessed and had a respiration rate of 12 breaths per minute, skin was pale and cool, eyes were open, head moved slightly to verbal prompts, and radial pulse rate was 62 beats per minute. Facility staff continued to wait for a call back from the physician. At 7:10 P.M., the family once again requested the nurse assess Resident #3. The assessment revealed Resident #3's oxygen saturation was 72 % and respirations were eight to 10 per minute. Oxygen was applied at five liters per minute. The family requested Resident #3 be transported to the hospital. Nine-one-one (911) was notified, EMT's arrived at the facility and began cardiopulmonary resuscitation (CPR) and pronounced the resident expired at 7:35 P.M. (Paramedic report documented 7:53 P.M., see below).
Review of the paramedic incident report dated [DATE] revealed the unit was dispatched at 7:20 P.M. for an unconscious, unresponsive, not breathing resident. Upon arrival at 7:25 P.M., Resident #3 was unresponsive, without any spontaneous respirations, in [MEDICAL CONDITION], with a blood sugar which registered HI. CPR was initiated without success and Resident #3 was pronounced dead at 7:53 P.M.
Interview on [DATE] at 1:08 P.M. with LPN #91 revealed on [DATE] around 3:45 P.M., Resident #3's family requested the resident's blood sugar be assessed as it was unusual for the resident to sleep so much and the family 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. MD #130 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. The fingerstick blood sugar was rechecked around 6:00 P.M. and remained HI. A message was left for the physician to call the facility.
Interview on [DATE] at 4:13 P.M. with RNC #75 revealed the facility did not have any policies related to diabetic management, just to notify the physician of any HI or LO blood sugar results.
Interview on [DATE] at 9:11 P.M. with LPN #93 revealed Resident #3 was not on routine blood sugar monitoring. LPN #93 obtained a finger stick blood sugar on the resident once, based upon nursing judgement, due to the residents [MEDICATION NAME]being unavailable. LPN #93 reported she assumed routine blood sugar monitoring was not ordered due to Resident #3's combative behavior as it was extremely difficult to even administer the insulin.
During an interview on [DATE] at 10:50 A.M. with MD #125 he stated he was the on-call physician and was contacted on [DATE] as Resident #3's long acting insulin wasn't available so an order was given to substitute with another long acting insulin.
MD #125 reported upon admission, Resident #3 should have had blood sugar monitoring ordered, and assumed the resident was already on routine blood sugar checks.
Interview on [DATE] at 12:14 P.M. with EMT Lieutenant #50 revealed services were requested on [DATE] for a resident who was unresponsive and having trouble breathing. Upon arrival to the facility, LPN #93 was at the far end of the room with the family, nobody was monitoring the resident, and Resident #3 was in [MEDICAL CONDITION] with a blood sugar of HI, over 600 mg/dL. EMT Lieutenant #50 reported attempts were made to revive Resident #3 for 30 minutes without success and the resident was pronounced dead at the scene.
Interview on [DATE] at 4:50 P.M. with RNC #76 revealed orders were transcribed by a nurse upon admission who does not necessarily review all accompanying hospital records.
Interview on [DATE] at 6:02 P.M. with RNC #75 revealed a physician was in the facility at least every two weeks. New admissions were seen within three days. Resident #3 had not been seen by a physician since admission to the facility but would have been seen within the next day or two. The protocol was for all new admission charts to be reviewed by clinical staff in morning meeting and this did not occur for Resident #3.

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 SUPPLIER **PREMIER ESTATES OF CINCINNATI-RIVERSIDE**		STREET ADDRESS, CITY, STATE, ZIP **315 LILIENTHAL STREET CINCINNATI, OH 45204**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Review of the Blood Glucose Monitoring System User's Guide revealed a test result of HI indicated blood glucose reading was above 600 mg/dL and a physician or healthcare professional should be contacted immediately. This deficiency substantiates Complaint Number OH 802.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, resident and staff interviews, review of employee timesheets, review of resident council meeting minutes, and review of Resident Census and Conditions of Residents the facility failed to ensure sufficient staffing levels to meet the care needs of the residents. This had the potential to affect all 59 residents at the facility. Findings include: Observation during an initial tour of the facility on 05/08/18 at 9:34 P.M. revealed one Licensed Practical Nurse (LPN) and one State tested Nursing Assistant (STNA) on the third floor with 30 skilled and long term care residents. During the tour Residents #48 and #50 stopped and informed the surveyor the facility needed more staff. Resident #59 reported he was still waiting to receive his night medications. Observation at 10:04 P.M. of the fourth floor unit with residents with memory and mild behavior disturbances revealed one LPN and two STNA's with a census of 29 residents. Residents received needed care and call lights were answered within 10 minutes. Observation during a facility tour on 05/12/18 at 6:14 A.M. revealed one LPN and two STNA's on the third floor and one LPN and two STNA's on the fourth floor. Residents were being provided morning care and there weren't any unanswered call lights. Interview on 05/12/18 at 6:41 A.M. with STNA #65 reported the ability to complete assigned job duties if appropriately staffed with two STNA's. Interview on 05/12/18 at 6:42 A.M. with STNA #67 reported only two out of 29 residents on the fourth floor were independent with activities of daily living (ADL's). STNA #67 reported residents functioning level varied daily and there could be anywhere from one to nine residents to feed at meals. STNA #67 reported on 05/06/18, there was only one STNA for the entire facility and reported it was impossible to meet the needs of all the residents when staffing fell below two STNA's on the floor. Interview on 05/12/18 at 10:39 A.M. with Resident #28 reported the facility did not have sufficient staff to provide needed care timely. Interview on 05/12/18 at 10:40 A.M. with Resident #31 reported he received medications late and one night there was only one STNA for the entire facility. Interview on 05/12/18 at 10:56 A.M. with Resident #14 reported there wasn't enough staff in the facility to provide timely needed care. Resident #14 reported at night, having to wait up to an hour for a bedpan and then an additional 30 minutes for staff to return and remove the bedpan. Resident #14 reported staffing was more a problem at night when there was only one STNA on the floor. Interview on 05/12/18 at 1:25 P.M. with Resident #10 reported the facility didn't always have enough staff at night to provide needed care. Resident #10 reported needing help with transfers from the chair to bed and if there wasn't enough help, he remained where he was and just did without. Interview on 05/16/18 at 6:42 P.M. with LPN #97 reported many nights there wasn't a STNA assigned to the floor including on 05/05/18 and 05/06/18 at which time LPN #97 provided care as much as possible under the circumstances. When asked how care was provided to the residents whom required two person assistance, LPN #97 responded, I do the best I can. Interview on 05/17/18 at 12:12 P.M. with STNA #69 reported inability to complete assigned job duties and meet the needs of the residents due to poor staffing levels. Interview on 05/17/18 at 12:48 P.M. with STNA #62 reported sometimes residents didn't receive showers as scheduled dependent upon staffing levels. Interview on 05/17/18 at 12:58 P.M. with LPN #94 reported dependent upon staffing levels, resident showers may be moved to another day or shift. Review of daily staffing sheets for 05/02/18 to 05/08/18 and review of the third set of timesheets provided by the facility for 05/05/18 and 05/06/18 due to inaccuracies discovered by the surveyor revealed insufficient staffing of one LPN (#97) and one STNA (#55) from 7:45 P.M. to 10:50 P.M. on 05/05/18 with a census of 59 residents and two LPN's (#97, #94) until 11:00 P.M., and (#132) at 10:30 P.M. and one STNA (#65) for night shift on 05/06/18 with a census of 59 residents. The facility did not have any registered nurse (RN) hours on 05/06/18. Review of the daily staffing sheet for 05/08/18 was inaccurate and did not reflect the staff working in the building during the initial tour. Interview on 05/17/18 at 12:25 P.M. with the Director of Nursing (DON) reported she did not work at the facility on 05/06/18. The DON reviewed the timesheets, daily staffing sheets, and confirmed there wasn't an RN who worked at the facility on 05/06/18. The DON reported the Administrator managed staffing responsibilities up until a few days ago. Review of resident council meeting minutes dated 01/30/18 to 04/24/18 revealed documented complaints about slow call light response times on 01/30/18, 02/27/18, and 04/24/18. Review of CMS Resident Census and Conditions of Residents completed by the facility on 05/12/18 revealed nine residents required the assistance of one or two staff and six residents were dependent upon staff for eating, forty residents required the assistance of on or two staff with toileting, 25 residents required the assistance of one or two staff and six residents were dependent upon staff for transferring, 42 residents required the assistance of one or two staff and two residents were dependent upon staff for dressing, and 57 residents required the assistance of one or two staff and two resident were dependent upon staff for bathing. This deficiency substantiates Complaint Numbers OH 670 and OH 802.
F 0727 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on observation, resident and staff interviews, review of employee timesheets, review of resident council meeting minutes, and review of Resident Census and Conditions of Residents the facility failed to ensure a Registered Nurse worked eight hours daily at the facility to meet the care needs of the residents. This had the potential to affect all 59 residents at the facility. Findings include: Observation during an initial tour of the facility on 05/08/18 at 9:34 P.M. revealed one Licensed Practical Nurse (LPN) and one State tested Nursing Assistant (STNA) on the third floor with 30 skilled and long term care residents. During the tour Residents #48 and #50 stopped and informed the surveyor the facility needed more staff. Resident #59 reported he was still waiting to receive his night medications. Observation at 10:04 P.M. of the fourth floor unit with residents with memory and mild behavior disturbances revealed one LPN and two STNA's with a census of 29 residents. Residents received needed care and call lights were answered timely, within 10 minutes. Observation during a facility tour on 05/12/18 at 6:14 A.M. revealed one LPN and two STNA's on the third floor and one LPN and two STNA's on the fourth floor. Residents were being provided morning care and there weren't any unanswered call lights. Interview on 05/12/18 at 6:41 A.M. with STNA #65 reported the ability to complete assigned job duties if appropriately staffed with two STNA's. Interview on 05/12/18 at 6:42 A.M. with STNA #67 reported only two out of 29 residents on the fourth floor were independent with activities of daily living (ADL's). STNA #67 reported residents functioning level varied daily and there could be anywhere from one to nine residents to feed at meals. STNA #67 reported on 05/06/18, there was only one STNA for the entire facility and reported it was impossible to meet the needs of all the residents when staffing fell below two STNA's on the

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 SUPPLIER **PREMIER ESTATES OF CINCINNATI-RIVERSIDE**		STREET ADDRESS, CITY, STATE, ZIP **315 LILIENTHAL STREET CINCINNATI, OH 45204**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0727 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) floor. Interview on 05/12/18 at 10:39 A.M. with Resident #28 reported the facility did not have sufficient staff to provide needed care timely. Interview on 05/12/18 at 10:40 A.M. with Resident #31 reported he received medications late and one night there was only one STNA for the entire facility. Interview on 05/12/18 at 10:56 A.M. with Resident #14 reported there wasn't enough staff in the facility to provide timely needed care. Resident #14 reported at night, having to wait up to an hour for a bedpan and then an additional 30 minutes for staff to return and remove the bedpan. Resident #14 reported staffing was more a problem at night when there was only one STNA on the floor. Interview on 05/12/18 at 1:25 P.M. with Resident #10 reported the facility didn't always have enough staff at night to provide needed care. Resident #10 reported needing help with transfers from the chair to bed and if there wasn't enough help, he remained where he was and just did without. Interview on 05/16/18 at 6:42 P.M. with LPN #97 reported many nights there wasn't an STNA assigned to the floor including on 05/05/18 and 05/06/18 at which time LPN #97 provided care as much as possible under the circumstances. When asked how care was provided to the residents whom required two person assistance, LPN #97 responded, I do the best I can. Interview on 05/17/18 at 12:12 P.M. with STNA #69 reported inability to complete assigned job duties and meet the needs of the residents due to poor staffing levels. Interview on 05/17/18 at 12:48 P.M. with STNA #62 reported sometimes residents didn't receive showers as scheduled dependent upon staffing levels. Interview on 05/17/18 at 12:58 P.M. with LPN #94 reported dependent upon staffing levels, resident showers may be moved to another day or shift. Review of daily staffing sheets for 05/02/18 to 05/08/18 and review of the third set of timesheets provided by the facility for 05/05/18 and 05/06/18 due to inaccuracies discovered by the surveyor revealed insufficient staffing of one LPN (#97) and one STNA (#55) from 7:45 P.M. to 10:50 P.M. on 05/05/18 with a census of 59 residents and two LPN's (#97, #94) until 11:00 P.M., and (#132) at 10:30 P.M.) and one STNA (#65) for night shift on 05/06/18 with a census of 59 residents. The facility did not have any registered nurse (RN) hours on 05/06/18. Review of the daily staffing sheet for 05/08/18 was inaccurate and did not reflect the staff working in the building during the initial tour. Interview on 05/17/18 at 12:25 P.M. with the Director of Nursing (DON) reported she did not work at the facility on 05/06/18. The DON reviewed the timesheets, daily staffing sheets, and confirmed there wasn't an RN who worked at the facility on 05/06/18. The DON reported the Administrator managed staffing responsibilities up until a few days ago. Review of resident council meeting minutes dated 01/30/18 to 04/24/18 revealed documented complaints about slow call light response times on 01/30/18, 02/27/18, and 04/24/18. Review of CMS Resident Census and Conditions of Residents completed by the facility on 05/12/18 revealed nine residents required the assistance of one or two staff and six residents were dependent upon staff for eating, forty residents required the assistance of on or two staff with toileting, 25 residents required the assistance of one or two staff and six residents were dependent upon staff for transferring, 42 residents required the assistance of one or two staff and two residents were dependent upon staff for dressing, and 57 residents required the assistance of one or two staff and two resident were dependent upon staff for bathing. This deficiency substantiates Complaint Numbers OH 670 and OH 802.
F 0729 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of daily staffing sheet, timesheet, and Nurse Aide Registry the facility failed to ensure employees were qualified with required credentials to perform job duties. This affected one (#63) of 16 State tested Nursing Assistants reviewed and had the potential to affect all 59 Residents at the facility. Findings include: Observation during an initial tour of the facility on [DATE] at 9:34 P.M. revealed STNA #63 was working as an STNA and providing care to residents on the fourth floor. Review of the daily staffing sheet dated [DATE], after requesting a correct copy to reflect whom was observed on tour as the original copy provided did not include STNA #63, revealed STNA #63 worked from 2:00 P.M. to 7:00 P.M. on the third floor and from 7:00 P.M. to 11:00 P.M. on the third floor. Review of timesheet for [DATE] revealed STNA #63 worked nine hours on [DATE]. Interview on [DATE] at 5:00 P.M. with human resources/payroll (HRP) #88 reported STNA #63 had been employed at the facility and worked both floors since [DATE]. An audit was conducted on all employees credentials on [DATE] and it was discovered his STNA registry was never reviewed upon hire and was expired. STNA #63 was terminated on [DATE] due to being unqualified to work as an STNA. Review of Nurse Aide Registry revealed STNA #63's registry status was expired on [DATE] as no work verification had been received in the past 24 months, and therefore was not eligible for employment in a long term care facility. This deficiency substantiates Complaint Numbers OH 670 and OH 993.
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** Based on closed medical review, staff and pharmacy interviews, and review of pharmacy shipment detail the facility failed to ensure prescribed medications were available for administration. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365925	A. BUILDING ______ B. WING _____	**05/23/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF CINCINNATI-RIVERSIDE	**315 LILIENTHAL STREET CINCINNATI, OH 45204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) 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. Interview on [DATE] at 2:51 P.M. with pharmacist #710 reported delivery records revealed [MEDICATION NAME] and oral medications were delivered to the facility for Resident #3 on [DATE] and intravenous medications were delivered on [DATE]. Upon informing Pharmacist #710 that the [MEDICATION NAME] was not included in the shipment and pharmacy was notified about this error, Pharmacist #710 reported she did not have access to that information, would email pharmacy to investigate the issue, and inform the surveyor about the results of the investigation. No further information was provided by the Pharmacist as of [DATE]. This is an incidental deficiency and was discovered during the course of the investigation of Complaint Number OH 802.

F 0760 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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.

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 SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF CINCINNATI-RIVERSIDE	**315 LILIENTHAL STREET CINCINNATI, OH 45204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) Interview on [DATE] at 2:51 P.M. with pharmacist #710 reported delivery records revealed [MEDICATION NAME] and oral medications were delivered to the facility for Resident #3 on [DATE] and intravenous medications were delivered on [DATE]. Upon informing Pharmacist #710 that the [MEDICATION NAME] was not included in the shipment and pharmacy was notified about this error, Pharmacist #710 reported she did not have access to that information, would email pharmacy to investigate the issue, and inform the surveyor about the results of the investigation. No further information was provided by the Pharmacist as of [DATE]. Review of the Blood Glucose Monitoring System User's Guide revealed a test result of HI indicated blood glucose reading was above 600 mg/dL and a physician or healthcare professional should be contacted immediately. This is an incidental deficiency and was discovered during the course of the investigation of Complaint Number OH 802.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review and staff interviews the facility failed to ensure medical records contained accurate information. This affected one (#3) of nine residents reviewed during the survey. 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 hospital discharge instructions revealed Resident #3 was admitted to the hospital from [DATE] to [DATE] and diagnosed with [REDACTED]. Resident #3 had a history of [REDACTED]. Resident #3 was an insulin dependent brittle diabetic and was prescribed [MEDICATION NAME] eight units twice daily for diabetes. Blood sugar results in the past 24 hours while hospitalized , prior to admission to the facility, included: 400 mg/dL on [DATE] at 9:25 A.M.; 453 mg/dL on [DATE] at 11:06 A.M.; 245 mg/dL on [DATE] at 12:49 P.M.; 32 mg/dL on [DATE] at 4:27 P.M.; 29 mg/dL on [DATE] at 4:31 P.M.; 77 mg/dL on [DATE] at 4:48 P.M.; 123 mg/dL on [DATE] at 5:05 P.M.; 194 mg/dL on [DATE] at 7:48 P.M.; and 188 mg/dL on [DATE] at 6:47 A.M. Review of the admission physician orders [REDACTED].#3 was prescribed nothing by mouth, 240 milliliters (ml) of Glucerna 1.2 tube feeding five times a day until [MEDICATION NAME] HN arrived, and [MEDICATION NAME]eight units twice daily at 6:00 A.M. and 9:00 P.M. There weren't any orders for blood glucose monitoring. Review of the medication administration record (MAR) revealed [MEDICATION NAME]was not administered at the facility on [DATE] at 9:00 P.M. and on [DATE] at 6:00 A.M. an 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. Review of an additional MAR revealed fingerstick blood sugar checks dated [DATE] completed three times daily at 9:00 A.M., 12:00 P.M., and 9:00 P.M. (This was the only thing on documented on the MAR). Results were recorded without any nurses initials or signatures. The results recorded on this fingerstick blood sugar MAR for [DATE] at 9:00 P.M. were 301. On [DATE] at 9:00 A.M. results were 245, on [DATE] at 12:00 P.M. results were 413, on [DATE] at 9:00 A.M. results were 316, on [DATE] at 12:00 P.M. results were 281, on [DATE] at 9:00 P.M. results were 426, on [DATE] at 9:00 A.M. results were 358, and on [DATE] results were 436. 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. There wasn't any further monitoring of blood sugars to ensure effectiveness of insulin. 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. Fingerstick blood sugar was rechecked at 6:15 P.M. and remained HI. A message was left for the physician, awaiting a return call. Review of the nursing progress note dated [DATE] at 9:15 P.M. revealed at 7:00 P.M. Resident #3 was assessed and had a respiration rate of 12 breaths per minute, skin was pale and cool, eyes were open, head moved slightly to verbal prompts, and radial pulse rate was 62 beats per minute. Continued to wait for call back from physician. At 7:10 P.M., the family once again requested the nurse assess the Resident. Assessment revealed oxygen saturation was 72 % and respiration were eight to 10 per minute. Oxygen was applied at five liters per minute. The family requested Resident #3 be transported to the hospital. 911 was notified, EMT's arrived at the facility, began cardiopulmonary resuscitation (CPR), and pronounced the Resident expired at 7:35 P.M. Review of paramedic incident report dated [DATE] revealed the unit was dispatched at 7:20 P.M. for an unconscious, unresponsive, not breathing resident. Upon arrival at 7:25 P.M., Resident #3 was unresponsive, without any spontaneous respirations, in [MEDICAL CONDITION], with a blood sugar which registered HI. CPR was initiated without success and Resident #3 was pronounced dead at 7:53 P.M. Interview on [DATE] at 1:08 P.M. with Licensed Practical Nurse (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. The fingerstick blood sugar was rechecked around 6:00 P.M. and remained HI. A message was left for the physician to call the facility. Interview on [DATE] at 9:11 P.M. with LPN #93 reported Resident #3 was not on routine blood sugar monitoring. LPN #93 had obtained a fingerstick blood sugar on the resident only once, based upon nursing judgement, due to the residents [MEDICATION NAME]being unavailable. LPN #93 reported she assumed routine blood sugar monitoring was not ordered due to Resident #3's combative behavior as it was extremely difficult to even administer the insulin. Interview on [DATE] at 4:13 P.M. with Regional Nurse Consultant (RNC) #75 reported the facility did not have any policies related to diabetic management, just notify the physician of any HI or LO blood sugar results. Interview on [DATE] at 10:50 A.M. with MD #125 reported being contacted on [DATE] as Resident #3's long acting insulin wasn't available so an order was given to substitute with another long acting insulin. MD #125 reported upon admission, Resident #3 should have had blood sugar monitoring ordered, and MD #125 assumed the resident was already on routine blood sugar checks. Interview on [DATE] at 12:14 P.M. with Emergency Medical Technician (EMT) Lieutenant #50 reported services were requested for a resident who was unresponsive and having trouble breathing. Upon arrival to the facility, LPN #93 was at the far end of the room with the family, nobody was monitoring the resident, and Resident #3 was in [MEDICAL CONDITION] with a blood sugar of HI, over 600 mg/dL. EMT Lieutenant #50 reported attempts were made to revive Resident #3 for 30 minutes without success and the resident was pronounced dead at the scene. Interview on [DATE] at 2:09 P.M. with RNC #75 was unable to explain how Resident #3 had a MAR with recorded three times daily fingerstick blood sugar results when routine blood sugars were not ordered, the nurses providing care for the resident denied obtaining routine fingerstick blood sugars, and the recorded result for 9:00 P.M. on [DATE] did not coincide with the result documented in the progress notes and on another MAR. RNC #75 reported she did not know where the fingerstick blood sugar MAR came from, she just provided the surveyor with the medical record, and the Administrator was terminated and not able to be questioned.

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 SUPPLIER **PREMIER ESTATES OF CINCINNATI-RIVERSIDE**	STREET ADDRESS, CITY, STATE, ZIP **315 LILIENTHAL STREET** **CINCINNATI, OH 45204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) This is an incidental deficiency and was discovered during the course of the investigation of Complaint Number OH 802.
F 0868 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on record review and staff interview, the facility failed to ensure a quality assessment and assurance committee meeting was conducted quarterly. This had the potential to affect all 59 residents at the facility. Findings include: Facility record review revealed no record of a quality assessment and assurance committee meeting being held during (YEAR). Interview on 05/17/18 at 9:50 A.M. with Clinical Regional Manger #75 reported inability to locate any evidence of a quality assessment and assurance committee meeting being conducted in (YEAR). This is an incidental deficiency discovered during the course of investigation of Master Complaint Number OH 993 and Complaint Numbers OH 670, OH 802 and OH 969.