STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365658	A. Building B. Wing	12/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cardinal Woods Skilled Nursing & Rehab Ctr	6831 Chapel Road Madison, OH 44057

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	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37095 Based on observation, interview, and record review, the facility failed to give medications according to physician orders. Harm occurred when Resident #38 did not receive methadone for which was ordered to treat long-term pain. This resulted in the resident experiencing and increased level of pain along with withdrawal, including trembling, feeling sick and sweaty, and being unable to sleep at all night. This affected one (Resident #38) of four residents reviewed for medication administration. The facility census was 89 residents. Findings include: Interview with Resident #38 on 12/09/21 at 8:45 A.M. revealed he said he was having withdrawal symptoms due to not getting his methadone (an opioid analgesic used to treat long-term pain and opioid dependence) for over a day. He said he was up all night and felt hot and sick to his stomach and had trembling. He said he had gone through withdrawal before and these were familiar symptoms for him. He said this had happened before in November and he had to wait multiple days to get his methadone due to it not being reordered timely. He took methadone for pain for his spine injury and it had increased due to him being off the medication to a 8 out of 10 pain level. Observation of Resident #38 at the time of the above interview revealed him to appear sweaty and with a fan blowing on him in bed, and with an upset or worried facial expression. Interview with Licensed Practical Nurse (LPN) #568 on 12/09/21 at 8:55 A.M. revealed she was Resident #38's nurse and was waiting for the doctor to sign his methadone script. She could not receive it from pharmacy or pull from the starter box until this was done. She was told Resident #38 didn't get his methadone last night. Interview with LPN #568 on 12/09/21 at 12:58 P.M. revealed Resident #38's primary doctor said they could not prescribe methadone, so she was trying to get in touch with the medical director. He still had not received his methadone dose as of yet. Interview with LPN #568 on 12/09/21 at 2:30 P.M. revealed she received an authorization to pull methadone from the starter box from the medical director, and a three-day supply was being sent from pharmacy. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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	Record review of Resident #38 (on 12/09/21) revealed he was admitted [DATE] and had diagnoses including major depressive disorder, schizophrenia, spinal stenosis, morbid obesity, and uncomplicated opioid abuse. He had an order dated 07/17/21 for three tablets of methadone 10 milligrams to be given twice daily for pain. These were documented as not given from the 11/25/21 evening dose to the 11/27/21 morning dose, and from the 12/07/21 evening dose to the current time (12/09/21). Nursing progress notes at these times revealed the medication was unavailable at these times. Record review of Resident #38 on 12/13/21 revealed he received his morning dose of methadone on 12/09/21 at 1:50 P.M. He then received the medication as ordered until 12/12/21, where there was no documentation for his morning dose and a progress note in the evening noting the facility was awaiting delivery of the medication from pharmacy. Interview with the Director of Nursing (DON) on 12/13/21 at 9:11 A.M. confirmed the above findings, including that Resident #38 was again not receiving his ordered methadone. She said the facility was changing psych services and neither would agree to prescribe it, so they were trying to get in touch with a methadone clinic. These findings substantiate Complaint Numbers OH00114903, OH00114464, OH00113829, and OH00110419.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39969 Based on observation and interview, the facility failed to ensure residents meals were palatable and served at appropriate temperatures. This had the potential to affect all 89 facility residents. Findings include: During interview on 12/07/21 from 10:37 A.M. to 1:43 P.M., Residents #6, #16, and #74 stated the food was often served cold and that the food was either terrible or horrible. Interviews on 12/08/21 from 11:04 A.M. to 3:07 P.M. with Residents #5, #24, #65, and #87, they all complained that the food was often served cold and did not taste good due to lack of seasoning. Review of a sample test tray on 12/08/21 at 1:01 P.M., after all room trays were served, revealed the food was visually appealing. The coleslaw tempted at 53.6 F and tasted warm and very vinegary. The turkey tempted at 121.6 and tasted lukewarm but was tender and seasoned. The turkey had a good taste. The steak fries tempted at 124.2 and tasted slightly buttery, no salt but was also lukewarm. The milk tempted at 40.3 F. During interview at this time with RFM #581, who did not taste the food, RFM #581 stated based on the temperature readings verified the cold food tasted warm and the hot food tasted lukewarm. RFM #581 stated she had not heard a cold food complaints but had heard complaints about the taste of the food and had recently hired a new dietary manager and cook in the last two months. Interview on 12/13/21 at 12:42 P.M. with Registered Dietitian (RD) #583 revealed he was at the facility once a week on Wednesdays for eight to nine hours and would do a test tray. RD #583 stated the food while on the tray line tempted within normal ranges but would be out of compliance when on the units. RD #583 stated he has heard the residents complain about the food but had not had any concerns related to running out of food. This deficiency substantiates Complaint Numbers OH00127994 and OH00115870.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 39969 Based on observation, record review, and interview, the facility failed to honor Resident #70's food preferences. This affected one (Resident #70) of three residents reviewed for food concerns. The facility census was 89 residents. Findings include: Interview on 12/09/21 at 8:55 A.M. revealed with Resident #70 revealed he hadn't received his breakfast yet but stated 90 percent of time he was not getting what was on the menu. Resident #70 stated might as well not have a menu. Resident #70 stated yesterday he didn't eat the lunch due to it was cold. Resident #70 stated he tried the turkey, and it was alright but could use more seasoning, the coleslaw was good, and the sweet potato fries were soggy and wet. Resident #70 stated condiments were never on the tray and that he had to ask for it but ended up buying his own. Observation at this time of salt and pepper shakers on the resident's tray table. On 12/09/21 at 9:00 A.M., STNA #544 was observed bring in Resident #70's tray which contained orange juice, two four-ounce containers of milk, two slices of toast, and a large portion of scrambled eggs with ham. Review of the resident's tray ticket revealed fried eggs over easy and milk 2% were on the tray ticket. Interview on 12/09/21 at 9:03 A.M. with STNA #544 verified Resident #70's tray ticket did not match what the resident received. STNA #544 stated she was told by the kitchen it was a special order and special orders were not in the budget. STNA #544 stated this had been happening recently in the last couple of weeks and stated yesterday they gave Resident #70 two containers of cold cereal but no eggs. STNA #544 stated Resident #70 had complained and that other residents had similar complaints. Observation on 9:15 A.M. with RFM #581 in Resident #70's room of his breakfast and tray ticket. RFM #581verified that the resident tray ticket said fried eggs and the res received a large portion of scramble eggs with ham. RFM #581 stated she wasn't in the kitchen when breakfast was served and obtained the resident's food preferences. Resident #70 then informed RFM #581 of the complaints of cold food. This deficiency substantiates Complaint Numbers OH00127994 and OH00115870.