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	02/14/2023

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on observation, record review, review of a facility investigation, review of a Materials Safety Data sheet and interviews with facility staff and Resident #10's daughter, the facility failed to ensure the environment on the memory care unit was free of accident hazards and failed to provide adequate supervision to prevent Resident #10, who was severely cognitively impaired and exhibited wandering behavior from obtaining and ingesting liquid from an unsecured bottle of all-purpose lemon scented cleaner with bleach. This resulted in Immediate Jeopardy on 12/22/22 at 12:30 A.M. when State tested Nursing Assistant (STNA) #214 placed a bottle of cleaner with bleach on the microwave oven in the dining room of the memory care unit. STNA #214 left the dining room to assist another resident, when STNA #214 returned, less than 20 minutes later, STNA #214 observed Resident #10 with the bottle to her lips and reported to Licensed Practical Nurse (LPN) #376 the resident may have consumed liquid from the bottle. Resident #10 was sent to the hospital for evaluation and treatment and returned the same day with no evidence of significant changes in her condition. The risk for serious harm, injury, death as a result of the consumption of cleaner with bleach occurred when staff left chemicals unsecured on the memory care unit resulting in Resident #10 accessing and potentially ingesting the cleaning solution which could have caused intraoral trauma, burning or swelling. This affected one resident (#10) and had the potential to affect 12 additional residents (#9, #11, #12, #14, #16, #43, #47, #54, #58, #66, #77 and #91) who resided on the memory care unit. The facility census was 89. On 02/07/23 at 9:00 A.M., the Administrator, Regional Operations Manager (ROM) #375, Assistant Director of Nursing (ADON) #347, and Minimum Data Set (MDS) Coordinator #331 were notified Immediate Jeopardy began on 12/22/22 at 12:30 A.M. when Resident #10, who had severely impaired cognition and was a known wanderer, obtained and ingested liquid from an unsecured bottle of all-purpose lemon scented cleaner with bleach. The cleaning solution had not been properly secured by staff and was left unattended in a common area of the unit. The facility failed to maintain a safe resident environment by not securing the cleaning supplies. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Although the facility implemented corrective actions on 12/22/22 including immediate care for Resident #10, staff education and audits to ensure chemicals were properly secured; on 02/07/23 at 8:22 A.M. chemicals were observed unsecured on the memory care unit. This included one bottle of cleaner with bleach, one bottle of multipurpose cleaner, and one bottle of toilet bowel cleaner were observed in an unsecured cabinet above a utility/handwashing sink in the center of the hallway of the memory care unit. The cabinet had a locking mechanism in place to accommodate a lock to be applied, however there was no lock in place to prevent residents from obtaining or ingesting the cleaning supplies. At the time of the observation, there were no residents observed in the immediate area and no evidence the chemicals had been accessed by residents. The Immediate Jeopardy was removed on 02/07/23 at 3:00 P.M. when the facility implemented the following corrective actions: On 02/07/23 at 1:30 P.M., ADON #320 removed the doors from the cabinet located above the utility/handwashing sink in the memory care unit. The facility implemented a new plan for all cleaning supplies to be stored in room [ROOM NUMBER] (that automatically locked upon closure and required a code entered on a keypad to open) on the memory care unit and in the housekeeping storage area in the main area of the facility by the activity room. On 02/07/23 at 1:36 P.M., all staff were educated via Carefeed communication, sent through the Administrator, on the process of all cleaning supplies to be kept in room [ROOM NUMBER]. On 02/07/23 at 3:00 P.M., agency staffing companies were contacted by the facility's scheduler regarding education to be provided to all employees utilized by the facility for chemical storage to be provided prior to the staff working in the facility. Beginning 02/07/23, a plan for the DON/or designee to validate five times weekly for eight weeks to ensure that audits and interventions were completed related to chemical storage. The Administrator and/or designee would monitor for compliance and results of the audits will be trended and results discussed with the Quality Assurance (QA) committee. Interviews on 02/09/23 from 9:10 A.M. to 11:09 A.M. with STNAs #327, #337, #339, #346, #369, LPN #354, Registered Nurse (RN) #348, RN #372, and Administrator verified education was received on 02/07/23 regarding all chemicals being stored in the locked area of room [ROOM NUMBER] on the memory care unit and not to be left unattended or unsecured. Although the Immediate Jeopardy was removed on 02/07/23 at 3:00 P.M., the deficiency remains at Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: 1. Review of Resident #10's closed medical record revealed the resident had an admitted [DATE] and discharge date of [DATE]. Diagnoses included multiple sclerosis, aphasia (loss of ability to understand or express speech), dementia, need for assistance with personal care, convulsions and seizures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #10's care plan, initiated 08/08/22 revealed the resident had behaviors including refusal of medications and being combative with hands on care. Interventions included to educate resident, family, and caregivers of the possible outcome(s) of not complying with treatment or care; and reassure resident, leave, and return five to ten minutes later and try again. Review of Resident #10's care plan, initiated 08/26/22 revealed the resident had poor safety awareness and a wheelchair for mobility. Interventions included to be up in wheelchair daily as tolerated and maintain call light within reach at all times. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/25/22 revealed Resident #10 had severely impaired cognition and was rarely or never understood. Resident #10 was assessed to require limited one staff assistance for transfers and staff supervision without setup for locomotion on and off the unit. Review of the Wandering/Elopement Risk Assessment, dated 11/04/22, revealed Resident #10 was a known wanderer. Review of a progress note, dated 12/21/22 revealed Resident #10 was re-evaluated by psychiatry services and assessed to be non-verbal, confused at times and unable to provide meaningful responses to questions. Resident #10 was reported by staff to have increased anxiety and restlessness particularly with hands on care and to be resistant to completing activities of daily living, notably showers, being more difficult to redirect. Review of progress note dated 12/22/22 at 12:38 A.M. revealed a nursing assistant from the memory care unit reported Resident #10 was found in the memory care unit common area drinking a bottle of all-purpose lemon scented cleaner with bleach while the nursing assistant was answering a call light and all other residents were in bed. The nurse practitioner (NP) and poison control were contacted. Resident #10 was transported to the hospital and left the facility without symptoms. Resident #10's daughter was notified of the incident. Review of a progress note, dated 12/22/22 at 3:39 A.M. revealed Resident #10 returned to the facility transported by Resident #10's daughter who reported the emergency room physician evaluated the resident's throat for burns and found no abnormalities, but provided intravenous (IV) fluids to the resident. The note indicated Resident #10 was stable without discomfort. Review of a progress note, dated 12/22/22 at 9:45 A.M. revealed Resident #10 ate two helpings of breakfast and consumed 420 milliliters of fluid including one container of milk and exhibited no signs or symptoms of pain or discomfort. Medications were consumed with four ounces of water. Review of a physician's order, dated 12/22/22 at 10:54 A.M. revealed an order for the medication, Protonix (pantoprozole) 40 milligram (mg) daily for acid reduction and prevention. Review of a physician's order, dated 12/22/22 at 10:55 A.M. revealed an order to monitor resident for nausea, vomiting and diarrhea. If any bleeding, send out to emergency department (ED) for evaluation of gastrointestinal system due to ingestion of chemicals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a progress note, dated 12/22/22 at 1:41 P.M. revealed the Administrator, SSW #373, and representative from MDS contacted Resident #10's daughter to follow-up regarding the incident, and there were no concerns or questions voiced from the daughter. Review of Consumption of Foreign or Hazard Substance form, dated 12/22/22 revealed an incident occurred around 12:30 A.M. and affected Resident #10 who was in the memory care unit common area and while the aide on the unit was answering a call light; poison control was notified at 12:38 A.M.; the physician and family were notified and Resident #10 was transferred to the hospital; all residents in the facility were interviewed and if not able to be interviewed received skin checks; education was provided for staff; and a Quality Assurance Performance Improvement meeting was held. Review of incident report entitled other revealed an unnamed nursing assistant working on the memory care unit reported on 12/22/22 at 12:30 A.M. Resident #10 could have ingested all-purpose surface cleaner and was observed attempting to drink the cleaning solution; Resident #10 was transported to the hospital, returned to the facility at 3:39 A.M. and was stable. On 12/22/22, cleaning supplies or solutions were removed from the unit and housekeeping initiated rounds three times daily including education to clean up messes and notify housekeeping of additional cleaning. A facility sweep was completed on 12/22/22 to ensure all cleaning solutions and or toxins were removed or stored in secured areas. Housekeeping audits were initiated on 12/22/22 and would remain ongoing. Skin sweeps and interviews with residents were completed on 12/22/22 with no negative findings. Review of written witness statement by the Administrator, dated 12/22/22 revealed around 12:30 A.M. a call was received by LPN #376 who reported a nursing assistant (unnamed) was cleaning on the memory care unit and went to answer a call light, then when coming out of a resident room saw Resident #10 with a bottle of spray cleaner up to the mouth. LPN #376 stated Resident #10's daughter, nurse practitioner and poison control were notified, and Resident #10 was sent to the emergency room . Review of a written witness statement by STNA #214 revealed the all-purpose spray cleaner with bleach was setting on the microwave when he arrived, and he used it to clean off the tables then put it back where it was before going to answer a call light. About five to ten minutes later, he returned and saw Resident #10 put her head back and start drinking it. STNA #214 immediately removed it from the resident's mouth and indicated there was hardly any in the bottle when it was used and still a decent amount in there after it was removed from Resident #10's mouth. STNA #214 stated going immediately to the LPN #376 to report the incident. Review of a written witness statement by LPN #376 revealed about 12:38 A.M. on 12/22/22 STNA #214 approached LPN #376 at the nurse's station on Elmwood carrying a bottle of all-purpose cleaner with added bleach and stated, I just found [Resident #10] drinking this in the dining room. When questioned why the cleaner was left unattended and within Resident #10's reach, STNA #214 responded he had just finished rounds and everyone was sleeping so he felt it was an okay time to clean and then a call bell went off, so he went to answer it and left the bottle on top of the microwave rather than bringing it to the room with him. LPN #376 contacted the NP and poison control and sent Resident #10 to the hospital. Resident #10 did not have any vomiting or distress. At approximately 3:30 A.M., Resident #10 returned with her daughter. The hospital evaluated for burns and no abnormalities were found. Intravenous fluids were provided. Resident #10's daughter stated Resident #10 was agitated and continuously attempted to pull out the IV. No clinical paper was given, just education paperwork regarding accidental adult poisoning. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Safety Data Sheet for Lemon Bright All Purpose Cleaner with Bleach, prepared on 11/13/18, revealed first aid measures were required for exposure to the eye, skin and with inhalation, and for ingestion to obtain medical attention. Review of the hospital documentation for the emergency services visit, dated 12/22/22 timed 1:08 A.M. revealed Resident #10 was sent to the ED for ingestion of bleach. Per report, Resident #10 ingested all-purpose cleaner with bleach. It was unclear how much was ingested but there was about one third of fluid left in the bottle. The amount in the bottle prior to the incident was unknown. Resident #10 was asymptomatic and was minimally verbal. There were no intraoral signs of trauma, burning or swelling. Poison control was contacted and recommended giving water orally but had no other recommendations if asymptomatic. Laboratory and imaging tests were reviewed with the family prior to discharge. Discharge planning with close outpatient follow-up was discussed and strict return precautions were given. Resident #10 was discharged back to the facility in stable condition. Review of Resident #10's care plan revealed it was updated on 12/22/22 to reflect the resident was sent to ED for potentially drinking a cleaning product. The care plan reflected discontinuation on 12/27/22 of 15-minute checks with no adverse effects and noted the resident had the potential for nausea, vomiting and gastrointestinal bleeding. Interventions included to call psychiatry hotline for emergency visit for any increased behaviors; monitor every 15 minutes and for any adverse reactions; administer medications and laboratory tests as ordered; encourage to drink water as tolerated; monitor for nausea, vomiting and diarrhea; and send to ED if any bleeding to evaluate gastrointestinal system due to ingestion of chemicals. Review of a progress note, dated 12/23/22 at 3:35 P.M. revealed Resident #10 had no signs or symptoms of distress, accepted medications without difficulty and consumed lunch and breakfast with a good appetite. Review of a fifteen- minute safety checks checklist revealed Resident #10 received safety checks every 15 minutes from 12/22/22 at 3:45 P.M. until 12/27/22 at 12:15 A.M. Review of a facility investigation, dated 12/22/22 revealed the Administrator and Housekeepers #318 and #319 searched resident rooms and areas to ensure cleaning supplies were secured, interviewed residents and conducted skin assessments on residents who were not interviewable with no adverse findings. On 01/10/23 Resident #10 was transferred to the emergency room due to a change in condition and treatment of seizures. The resident did not return to the facility following this date. Interview on 01/25/23 at 3:01 P.M. with the Administrator revealed (on 12/22/22) Resident #10 was observed drinking the cleaner. Resident #10 was sent to the hospital for an evaluation and returned to the facility a couple hours later. The Administrator revealed a plan of correction had been implemented following the incident, including to secure all cleaning supplies when not in use, educate staff and complete daily audits to monitor staff compliance. Interview on 01/25/23 at 3:52 P.M. with STNA #214 revealed on 12/22/22 he was exiting another resident's room and observed Resident #10 holding a bottle of cleaner to her lips. STNA #214 stated he was cleaning off tables earlier and had placed the bottle of cleaner on top of the microwave in the dining room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/07/23 at 11:44 A.M. with Resident #10's daughter revealed she was upset about the incident which occurred on 12/22/22. Resident #10's daughter stated about a week and a half after the incident Resident #10 stopped taking her medications and she believed it was because her throat was burned. A nurse had called to discuss the refusals with her, and she (the daughter) was going to come to the facility and encourage the resident to take her medications when she started having seizures (resident had a diagnosis of seizure disorder). Resident #10 went to the hospital and then was transferred to another hospital for additional care. Resident #10's daughter revealed it was then decided to choose Hospice care services and the resident did not return to the facility. Resident #10's daughter verified being at the hospital on 12/22/22, seeing the bottle of cleaner the facility sent which was a spray bottle and stated Resident #10 was very capable of twisting the sprayer top off and drinking it but indicated she would not be able to put the sprayer into the mouth and squeeze it repeatedly. Review of a progress note, dated 01/23/23 at 4:07 P.M. revealed an update on Resident #10's condition after the resident was transferred to the hospital for seizures. The daughter stated Resident #10 was in Hospice care now and would not be returning to the facility. Interview on 02/07/23 at 12:35 P.M. with the Regional DON and [NAME] President of Clinical Operations (VPCO) #377 revealed the DON was on-call on 12/22/22 when the incident occurred and stated STNA #214 observed Resident #10 put the squirt bottle to the mouth but did not know if any went into the mouth or not, and the bottle was intact as she was making a sucking motion as she tilted her head back. The physician stated if there was anything, there would be blistering, redness or changes, but none were noticed, and the daughter did not have any concerns. Resident #10 had an epileptic problem and was at a Hospice house. During a follow up interview on 02/07/23 at 2:54 P.M. with STNA #214, the STNA verified on 12/22/22, Resident #10 had the spray bottle container in her hand and upon returning from answering the call light he saw Resident #10 had removed the spraying apparatus from the top of the bottle and had set it on the counter-top and then tipped the container which had the chemical solution in it and her head backward to drink it. STNA #214 denied seeing solution dripping from the mouth but was uncertain if any had gone into the mouth. STNA #214 confirmed being gone at least up to ten minutes. The STNA revealed Resident #10 was in a wheelchair but could stand up which she was not supposed to do but made attempts which was how she reached the cleaner on top of the microwave which was located above the countertop in the common area on the memory care unit. STNA #214 indicated seeing Resident #10 again after returning from the hospital and stated she seemed alright, she was difficult to understand and was not talkative but would point out what she wanted. Resident #10 refused her snacks after the incident, but stated this was not something new. STNA #214 verified education was received after the incident to keep chemicals secured. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of mandatory in-service of Cleaning Supplies - Handling and Storage, dated 12/23/22 revealed all cleaning supplies should be properly stored in non-resident areas and out of reach from residents at all times and if a staff member had cleaning supplies for any reason in a resident area, they needed to have it in their possession at all times. All cleaning supplies or materials needed to be kept in housekeeping closets and locked at all times, and housekeeping could lock any cleaning supplies in the storage room of the memory care unit (room [ROOM NUMBER]) for use. Rounds would be conducted three times daily by staff on the memory care unit to ensure no cleaning supplies/hazardous material were in resident areas or within reach of residents. There were no instructions specific to the cabinet above the utility/handwashing sink in the memory care unit hallway. The in-service was received by all staff between 12/22/22 and 12/26/22. Review of memory care unit cleaning supply rounds checklist revealed rounds were completed daily at 8:00 A.M., 2:30 P.M. and 8:00 P.M. from 12/23/22 until 02/06/23. On 02/07/23 at 8:00 A.M. the rounds checklist was initialed as completed. 2. Medical record review revealed Resident #16 had a diagnosis of dementia. Review of the quarterly MDS 3.0 assessment, dated 01/03/23 revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of one indicating severe cognitive impairment. The assessment revealed the resident required staff supervision with locomotion. The assessment also noted the resident had no impairment with range of motion. Resident #16's balance was not steady when moving from a seated to a standing position, with walking, or when turning around and facing the opposite direction while walking but was able to stabilize without staff assistance. Medical record review revealed Resident #9 had a diagnosis of dementia. Review of Resident #9's care plan with a review start date of 12/21/22 revealed Resident #9 required secure unit placement due to cognitive impairment secondary to diagnosis of Alzheimer's disease. Resident #9 was a moderate elopement risk/wanderer as evidenced by impaired cognition, poor safety awareness, and wandered aimlessly at times. Review of the quarterly MDS assessment dated [DATE] revealed Resident #9 had impaired vision, a Brief Interview Mental Status (BIMS) score of 10 indicating moderate cognitive impairment, moved between locations in her room and adjacent corridor on same floor with no physical assist from staff, and had no functional limit in range of motion to upper or lower extremities. Medical record review revealed Resident #14 had a diagnosis of dementia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #14 had a BIMS score of three indicating severe cognitive impairment, walked in the corridor of the unit with no physical assist of staff and had no functional limitation in range of motion to upper or lower extremities. Resident #4 was independent with eating, toilet use, and her balance was steady at all times when walking and turning around. Observation on 02/07/23 at 8:22 A.M. during a tour of the memory care unit revealed one bottle of cleaner with bleach, one bottle of multipurpose cleaner, and one bottle of toilet bowel cleaner in an unsecured cabinet above a handwashing sink in the center of the hallway. The cabinet had a locking mechanism in place to accommodate a lock to be applied, however there was no lock in place to prevent residents from obtaining or ingesting the cleaning supplies. There were no residents observed in the immediate area at the time of the observation. Interview at the time of the observation with STNA #315 verified the cabinet contained the three bottles of cleaners and remained unlocked for use. STNA #315 stated no knowledge of a how the cabinet was to be locked despite a locking mechanism being in place to apply one. STNA #315 verified all three bottles of cleaners contained more than half of the cleaning solution. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 02/07/23 at 8:29 A.M. during a tour of the memory care unit revealed Resident #16 was opening and closing all unlocked drawers and cupboards in the common dining area of the memory care unit rummaging through each before going to the next. There were no chemicals observed in the area of Resident #16. Interview at the time of the observation with STNA #315 confirmed the observation and behavior of Resident #16. Observation on 02/07/23 at 8:29 A.M. near the entrance of the memory care unit adjacent to room [ROOM NUMBER] revealed an isolation storage cabinet with a four-ounce bottle of instant hand sanitizer sitting on top of the storage cabinet. Interview at the time of the observation with STNA #315 verified the instant hand sanitizer bottle was left sitting on top of the isolation storage cabinet and indicated hand sanitizers were not to be left out due to the type of residents on the memory care unit. STNA #315 proceeded to pick up the instant hand sanitizer bottle and stated it would be put away. Observation on 02/07/23 at 9:46 A.M. of the memory care unit revealed the cabinet above the utility/handwashing sink in the center of the hallway was locked with a padlock at this time. Interview on 02/07/23 at 9:50 A.M. with STNA #378 on the memory care unit verified the facility provided education about chemicals needing secured and residents were not permitted to have shampoos or other items that were hazardous including hand sanitizer which was to be locked away or in a staff member's pocket. STNA #378 confirmed the cabinet above the utility/handwashing sink in the memory care unit hallway had to be locked but stated the padlock was lost about two days ago. Interview on 02/07/23 at 9:53 A.M. with ADON #320 verified the chemicals in the cabinet over the utility/handwashing sink on the memory care unit in the hallway were used by the nursing assistants to clean off the tables in the common area which was completed mostly by the night shift staff or after meals. The nursing assistants were responsible to make sure the lock was in place but there was no checklist or procedure to ensure it was completed, they were just supposed to check it especially at shift change and during the shift. ADON #320 stated the lock was lost about two days prior because an agency nurse took the lock home in their pocket, another lock was purchased, and it was replaced yesterday but the ADON was not sure why it was not in place this morning. ADON #320 verified the all-purpose cleaner with bleach in the cabinet was the same cleaner involved in the incident on 12/22/22. Interview on 02/07/23 at 10:04 A.M. with STNA #315 verified the cabinet above the utility/handwashing sink in the hallway of the memory care unit was not locked yesterday while working on her shift and stated it was supposed to be locked since there were cleaners inside the cabinet. STNA #315 confirmed receiving education about keeping chemicals secured after the incident happened. Interview on 02/07/23 at 10:09 A.M. with Director of Housekeeping (DOH) #319 revealed housekeeping staff used chemicals off the housekeeping carts and did not get into any cabinets but had access to the locks. DOH #319 confirmed being aware of the missing lock yesterday morning and believed it was replaced but was aware it was not on this morning. DOH #319 stated the nursing assistants helped clean the tables and DOH #319 was told one of the aides had the lock in their pocket. DOH #319 stated housekeeping made rounds, checking the cabinets two to three times daily and checking to ensure no chemicals were left out then signed off on the check off list. This started after the incident on 12/22/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/07/23 at 10:17 A.M. with STNA #315 and STNA #378 denied the cabinet lock for the memory care unit cabinet above the handwashing sink in the hallway was left in their pockets and stated there was no lock available on this morning to put on the cabinet. Review of memory care unit cleaning supply rounds checklist revealed on 02/07/23 at 8:00 A.M. the rounds checklist was initialed as completed. Interview on 02/07/23 at 10:52 A.M. with DOH #319 verified the initials on the checklist were probably put in place because there were not chemicals seen out even though the cabinet was not locked at the time of the rounds. DOH #319 stated it was Housekeeper #318 who did the rounds check at the time. Interview on 02/07/23 at 11:08 A.M. with Housekeeper #318 revealed after the incident on 12/22/22 residents were not allowed to have anything like peri wash and shampoo, so all of it was moved to a storage area. Housekeeper #318 said they did rounds and checked to make sure no chemicals were out by going into resident rooms and the dining room area looking to ensure there were no chemicals. Housekeeper #318 stated not being aware the cabinet above the handwashing sink in the hallway as being part of the rounds but confirmed hand sanitizer was not to be setting out as a norm. Interview on 02/07/23 at 12:05 P.M. with Housekeeper #379 verified receiving education after the incident on 12/22/22 and conducting rounds as required to ensure all cleaning supplies were put away. Housekeeper #379 stated not being familiar with the cabinet over the handwashing sink in the memory care unit hallway but if the nursing staff used it then they would be responsible to ensure it was locked and housekeeping ensure no chemicals were left out/unsecured. Interview on 02/07/23 at 12:20 P.M. with ROM #375 revealed the facility policy on chemical storage was the education provided to staff on 12/22/22 with no revisions made to the policy. Interview on 02/07/23 at 12:35 P.M. with the Regional DON and [NAME] President of Clinical Operations (VPCO) #377 revealed all cleaning supplies were removed to secured areas and verified not providing education to the staff one way or the other regarding the cabinet above the utility/handwashing sink mid hallway on the memory care unit. VPCO #377 stated residents could not reach the cabinet, so it did not matter whether it was locked or unlocked, and rounds involved checking whether chemicals were left out and watching high risk areas. The DON stated residents on the memory care unit did not have the dexterity or height to reach the cabinet and there was open discussion and assessments completed regarding who could get into the cabinet. The DON verified there was no documentation regarding the referenced assessments. It was confirmed the nurses and housekeepers had a key to the lock on the cabinet above the utility/handwashing sink in the hallway of the memory care unit and there was no reference in the policy or education to staff regarding the cabinet or procedure for lock. VPCO #377 stated the items within the cabinet would be removed on this date and no longer used and new education provided to staff to only use room [ROOM NUMBER] for chemical storage. Observation on 02/07/23 at 1:22 P.M. revealed Resident #9 neatly dressed and groomed and ambulating about the hallway and dining/activity area of the memory care unit. Resident #9's gait was slow and steady as she stopped to talk to residents and staff in the memory care unit. Interview with Resident #9, at the time of the observation, revealed she was confused to person and time. Resident #9 was asked if she could reach the cupboard above the utility/handwashing sink in the hallway of the memory care unit and without hesitation Resident #9 reached up and pulled on the padlock repeatedly saying, it's locked, I can't open. This observation was observed and confirmed with STNA #215. (continued on next page)

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	365658	A. Building B. Wing	02/14/2023

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 02/07/23 at 1:27 P.M. revealed Resident #14 walking independently in the hallway of the memory care unit. Resident #14 stopped to talk with Resident #9 asking Resident #9 to come to her room and visit. Residents #9 and #14 were standing in front of the utility/handwashing sink at the time of observation. Continued observation revealed ADON #320 removing the doors to the cabinet above the utility/handwashing sink, removing the contents of the cupboard and placing the contents in a plastic bag. Interview with ADON #320, at the time of the observation, revealed the doors to the cupboard were removed because it was determined having any type of closed storage above the utility sink was not a good idea because staff could store things that did not belong such as chemicals. Cleaning products were to be stored in the housekeeping department near the kitchenette located near the center of the building. The cabinet without the doors would remain in place for storage of gloves, paper towels and odds and ends. Observation on 02/09/23 at 8:57 A.M. of memory care unit revealed no unsecured chemicals or hazards. The cabinet above the handwashing sink [TRUNCATED]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35768 Based on observations and interviews the facility failed to maintain a sanitary kitchen and store food appropriately. This had the potential to affect all residents except Resident #15 who did not receive nutrition by mouth. The census was 89. Findings include: Observations of the kitchen on 01/25/23 at 10:26 A.M. revealed food items in the refrigerator opened and not dated. The items included garlic in water, a bag of cabbage, ground sausage, a bag of shredded cheese, and a bowl of cooked white rice. Interview at time of observation with Culinary Director #212 confirmed the observations and indicated all items opened and in the refrigerator should be dated. Observations of tray line on 01/25/23 at 11:15 A.M. revealed a cool air vent located above the plating area was covered with dust, the dust was layered on the ceiling approximately six inches out from the vent. Interview at the time of the observation with Cook #1 verified the observation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19736 Based on observation and interview, the facility failed to ensure the memory care unit was clean, kept in good condition, and the furniture was in good repair. This affected 12 residents who resided in the memory care unit, Residents #11, #16, #9, #43, #47, #54, #58, #66, #12, #14, #77, and #91. Facility census was 89. Findings include: Observation of the memory care unit on 02/07/23 at 11:00 A.M. revealed one long hallway with resident rooms on the left and right. Further observation of the walls in the hallway revealed five screws sticking out of the walls, 10 holes, two nails with hooks (picture hangers) and six scuffed areas revealing dry wall. The base boards had a heavy build up of brown/black grime. A 12 inch x 1 inch area of laminate flooring was missing at the threshold of Resident #77's room. The utility sink on the right hand side of the hallway between rooms [ROOM NUMBERS] had 1/2 inch of standing brownish/rust colored water. There were five screws sticking out and three holes of various sizes in the wall to the left side of the utility sink and the three walls surrounding the utility sink were covered with dried liquid splashes, some of the splashes were hardened. The trim around the doors to each resident room had back scuff marks and areas of missing paint. The red electrical plate cover located in the hallway was not flush with the wall exposing the metal electrical box. The light cover over the ceiling light in front of the dining/activity area was cracked and had a hole the size of a fifty cent piece. At the end of the hallway was a dining/activity area. The walls in the dining/activity area were scuffed and had gouges exposing dry wall. A striped wing back chair in the dining/activity area near the refrigerator had a hole in the arm with stuffing exposed. The white colored two door refrigerator had many scratch marks which were rusted. A second striped wingback chair was covered with white stains, and the material was torn and frayed at the bottom front of the chair. Balled up used tissues were observed under the second striped wing back chair. One of the arms of a brown love seat recliner had a five inch area where the material was torn away exposing stuffing and the wood frame. The material on the right arm and seat of the large brown rocker recliner was severely worn to the point of the coloring being faded to an orange/red color. The dining/activity area had a laminate counter with cupboards above and below the counter. A bunched up used brown paper towel and vinyl glove were observed on the left hand corner of the counter top. The second cupboard door from the left underneath the counter was not level and sagging. Papers were sticking out of the closed cupboard doors above the counter. The floor in the dining/activity area had scuff marks and a heavy build up of brown/black grime along the baseboards. The flooring was covered with food crumbs and other unidentified debris. An empty cardboard box was observed in the corner by the heating unit. The box had paper debris inside. The window blinds in rooms [ROOM NUMBER] had broken slots. Observation and interview with State tested Nurse Aide (STNA) #315 on 02/07/23 at 12:15 P.M. confirmed all the above observations. STNA #315 demonstrated there was an electrical device that had to be activated to drain the utility sink, like a garbage disposal. STNA #315 said housekeeping was responsible for the cleanliness of the unit and maintenance was responsible for the blinds, cupboards, flooring and wall repairs. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility census sheet revealed Residents #11, #16, #9, #34, #43, #47, #54, #58, #66, #12, #14, #77, and #91 resided in the memory care unit. This deficiency represents non-compliance investigated under Complaint Number OH00139582. 41526