STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366175	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at the Meadows	11760 Pellston Court Cincinnati, OH 45240

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39703 Based on medical record review, observation, resident and staff interview and policy review, the facility failed to provide personal hygiene including providing fingernail care and hair washing to dependent residents. This affected one (#8) of 14 facility-identified residents dependent on staff with bathing. The census was 63. Findings include: Review of record for Resident #8 revealed an admitted [DATE] with a diagnosis of multiple sclerosis (MS). Review of Minimum Data Set (MDS) assessment for Resident #8 dated 11/09/21 revealed resident was cognitively impaired and was totally dependent on the assistance of one staff with bathing. Review of care plan for Resident #8 dated 09/06/19 revealed resident had an activities of daily living self-care performance deficit related to activity intolerance, confusion, fatigue, impaired balance, limited mobility, shortness of breath, disease process. Review of nurse progress notes for Resident #8 dated 11/01/21 through 12/01/21 revealed notes contained no documentation regarding refusal of care. Observation on 12/01/21 at 11:10 A.M. revealed Resident #8 had visible debris under her fingernails and the residents nails were long and did not appear to have been trimmed recently, with some nails extending approximately one-half inch beyond resident's fingertips. Further observation revealed resident's hair was greasy and appeared unwashed and resident had untrimmed facial hair to her chin and upper lip. Interview on 12/01/21 at 11:20 A.M. with Resident #8 confirmed she received bed baths twice weekly, but she had not had her nails trimmed, hair washed, or facial hair trimmed for weeks and it was her preference to have these things done. Interview on 12/01/21 at 11:21 A.M. with Licensed Practical Nurse (LPN) #530 confirmed Resident #8 had debris under her nails and they needed to be trimmed, resident's hair was dirty, and she had untrimmed facial hair growing from her chin and upper lip. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/01/21 at 11:25 A.M. with State tested Nursing Assistant (STNA) #550 confirmed Resident #8 had debris under her nails and they needed to be trimmed, resident's hair was dirty, and she had untrimmed facial hair growing from her chin and upper lip. STNA #550 confirmed these tasks should be completed on bath day. Review of the policy titled Quality of Life-Dignity dated February 2020 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem and residents should be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). This deficiency substantiates Complaint Number OH00127494.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	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** 39703 Based on medical record review, review of hospital records, staff interview, and review of facility policy, the facility failed to ensure residents received adequate supervision and/or assistance when being provided with hot beverages. This resulted in Actual Harm when staff gave Resident #70 very hot water to mix with instant coffee powder and the hot coffee spilled on the resident resulting in a burn to the left hip which required an emergency room visit for evaluation/treatment. This affected one (#70) out of three residents reviewed for accidents. The facility census was 63. Findings include: Review of the medical record for Resident #70 revealed an admitted [DATE]. Resident #70 discharged home on 11/19/21. The resident had diagnoses which included quadriplegia. Review of the Minimum Data Set (MDS) assessment for Resident #70 dated 10/18/21 revealed the resident was cognitively intact and required extensive assistance of two staff with bed mobility, total dependence on two staff for transfer and toilet use and required extensive assistance of one staff with eating. Review of the care plan for Resident #70 dated 10/19/21 revealed the resident was dependent on staff for activities, cognitive stimulation, and social interaction related to immobility/bedbound status. Review of nurse progress note for Resident #70 dated 11/14/21 timed at 5:42 P.M. per Licensed Practical Nurse (LPN) #265 revealed the nurse was providing care and discovered a burn to the resident's left hip which the resident said had occurred earlier when she spilled coffee on herself. Further review of the note revealed Resident #70 said she did not feel hot and cold on her skin due to her diagnosis. LPN #265 notified the attending physician and Resident #70 was sent to the emergency room via nine-one-one (911) to be evaluated. Review of the hospital note dated 11/14/21 timed at 6:15 P.M. revealed Resident #70 was treated for a burn to her left hip which she sustained due to report of a coffee spill which occurred in the morning of 11/14/21. Review of a nurse progress note for Resident #70 dated 11/15/21 timed at 1:00 A.M. revealed the resident returned from the hospital and a burn was noted to her left hip. Review of a nurse progress note for Resident #70 dated 11/15/21 per the Director of Nursing (DON) revealed the DON met with the resident to discuss the incident resulting in a burn to resident's left hip. Resident #70 explained she preferred her own coffee instead of the facilities and while drinking it she dropped it causing a burn on her left hip. The DON said going forward Resident #70 needed to use a sippy cup that the facility would provide. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan for Resident #70 dated 11/15/21 revealed the resident had impaired skin integrity related to the resident prefers to drink own coffee versus the facility coffee and the resident refuses adaptive equipment for meals and drops items. Interventions included the following: educated on risks of instant coffee at bedside, educated on importance of using adaptive equipment. Review of wound physician progress note for Resident #70 dated 11/17/21 revealed the resident had a partial and full thickness burn to her left hip sustained on 11/14/21 measuring 22.2 centimeters in length by 10.0 cm. in width by 0.2 cm. in depth. The composition of the wound bed was 35 percent (%) epithelial/64% granulation tissue/5.0% slough. Treatment order given to cleanse wound with normal saline, apply wound gel to wound bed, and cover with dry dressing once daily. Interview on 12/01/21 at 6:53 A.M. with the DON confirmed she met with Resident #70 on 11/15/21 regarding the situation that caused the burn to the residents left hip. The DON confirmed Resident #70 preferred to drink flavored instant coffee which she brought from home. The DON confirmed Resident #70 said a female State tested Nursing Assistant (STNA) brought her hot water in the morning of 11/14/21. The DON said Resident #70 was unsure which STNA brought her the hot water and also wasn't sure if it came from the facility kitchen or not. The DON confirmed Resident #70 said no one checked her for injury until LPN #265 came in to do wound care for a wound she was admitted with. The DON confirmed she spoke to Resident #70 about using a sippy cup for safety. Interview on 12/01/21 at 6:58 A.M. with the Administrator confirmed the staff were educated on 11/19/21 to make sure resident requests for hot water and food heated up all go through the kitchen. The Administrator further confirmed the facility did not know who brought the resident hot water on 11/14/21. Interview on 12/01/21 at 11:57 A.M. with LPN #265 confirmed on 11/14/21 at approximately 5:40 P.M. she went to do a treatment to Resident #70's right side and when she rolled the resident over, she saw a large burn on her left hip. LPN #265 said Resident #70's burn was red and blistered and the resident said she could not feel hot or cold on her skin due to her condition, so she was unaware she had a burn. LPN #265 further confirmed Resident #70 told the nurse one of the night shift aides that she didn't know had brought her hot water so she could mix it with instant coffee powder for her coffee. LPN #265 confirmed Resident #70 said she spilled the coffee on herself and an aide changed her bed linens, but no one had checked her skin for injury until LPN #265 came into her room at 5:40 P.M. Review of the facility policy titled Assistance with Meals dated July 2017 revealed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. This deficiency substantiates Complaint Number OH00127494.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39703 Based on observation, staff interview, review of educational in-service documents, and review of facility policy, the facility failed to ensure staff practiced proper hand hygiene during medication administration and during dressing changes. This affected three (#25, 26, #28) of three residents reviewed for medication administration and one (#8) of four facility identified residents with pressure ulcers. The facility also failed to ensure nurses created a clean field/work area for performing wound care which had the potential to affect one (#8) of four facility-identified residents with pressure ulcers. The census was 63. Findings include: Observation on 12/01/21 at 8:25 A.M. of preparation for medication administration to Resident #26 per Licensed Practical Nurse (LPN) #530 revealed the nurse was wearing gloves and was touching the resident's medications with her hands. LPN #530 popped pills out of cards into her gloved hand and dropped them into medicine cup and took pills from bottles and emptied them into her gloved hand first before putting them in the cup for administration. The observations revealed LPN #530's gloved hands were contaminated as she handled/touched multiple surfaces such as handling keys, unlocking medication cart, touching the drawers on the medication cart, etc. Further observation revealed LPN #530 administered the medication to Resident #26 at 8:30 A.M. Interview on 12/01/21 at 8:25 A.M. with LPN #530 confirmed she wore gloves because she didn't know if residents had potentially infectious conditions. LPN #530 confirmed she touched Resident #26's medication with her gloved hands after handling the keys, unlocking the med cart, touching the drawers on the medication cart, etc. Observation on 12/01/21 at 8:39 A.M. revealed LPN #530 removed her gloves after medication administration to Resident #26 and discarded gloves in the medication cart and said she probably should wash her hands but did not wash or sanitize hands. LPN #530 then donned a new pair of gloves and prepared and administered medication to Resident #25 at 8:40 A.M. After medication administration to Resident #25, LPN #530 removed her gloves, discarded them, and donned another pair of gloves and prepared and administered medication to Resident #28 at 8:49 A.M. Interview on 12/01/21 at 8:39 A.M. with LPN #530 confirmed she did not have hand sanitizer on her cart, and she had not washed or sanitize her hands between medication administration to Resident #26, #25 and #28, despite discussion with the surveyor throughout the observation. LPN #530 insisted she did not need to perform hand hygiene between residents because she was wearing gloves. Interview on 12/01/21 at 9:00 A.M. with the Director of Nursing (DON) confirmed nurses should perform hand hygiene after removing gloves and prior to donning a clean pair of gloves and also should wash or sanitize hands during a medication pass between residents. DON further confirmed the facility would provide education to LPN #530 regarding hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of dressing change for Resident #8 on 12/01/21 at 11:10 A.M. with LPN #530 revealed nurse entered resident's room and placed dressing change supplies on resident's overbed table. There was a wet washcloth on the table with a brown identified substance on it. LPN #530 did not dispose of the washcloth and set the dressing supplies on the overbed table with wiping down the table first. LPN #530 then donned gloves without performing hand hygiene first. LPN #530 removed soiled dressing from Resident #8's feet, cleaned wounds with normal saline and applied clean dressings and wrapped resident's feet with gauze without performing hand hygiene. There was a moderate amount of exudate on the soiled dressing which LPN #530 removed from Resident #8's left foot. Interview on 12/01/21 at 11:10 A.M. with LPN #530 confirmed did she perform hand hygiene when she entered the room and donned gloves. LPN #530 confirmed she had washed her hands after using the restroom about five to ten minutes before entering the room. An additional interview on 12/01/21 at 11:21 A.M. with LPN #530 further confirmed she did not clean the overbed table before using it as a clean field for the dressing change despite prompting from the surveyor nor did she perform hand hygiene and don clean gloves after cleaning resident's wounds. Interview on 12/01/21 at 11:30 A.M. with the DON confirmed nurses should set up a clean area for dressing supplies prior to performing a dressing change. DON confirmed nurse should wash hands and don clean gloves prior to a dressing change. DON confirmed nurse should remove gloves and perform hand hygiene after removing a soiled dressing and cleaning the wound. Interview on 12/01/21 at 1:20 P.M. per the Administrator confirmed she educated LPN #530 regarding hand hygiene. Review of facility policy titled Administering Medications dated April 2019 revealed staff should follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of facility policy titled Hand Hygiene dated revealed the use of gloves did not replace hand washing/hand hygiene, and hand hygiene should be performed as follows: before and after direct contact with residents, before preparing or handling medications, before handling clean or soiled dressings, gauze pads, etc., after handling used dressings, contaminated equipment, etc., after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, after removing gloves. This deficiency substantiates Complaint Number OH00111658.

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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. 39703 Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for the residents. This had the potential to affect 20 residents (#30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48 and #49) residing on the women's secured behavioral unit. The census was 63. Findings include: Observation on 11/30/21 at 10:25 A.M. revealed there was a ceiling tile which had been broken in half with a jagged unfinished edge and several nails sticking out of it hanging from the ceiling in the women's secured behavioral unit adjacent to Resident #46's room. There was a cable running through the center of the damaged ceiling tile holding it suspended in the air at a height of approximately six feet from the ground. Further observation revealed the ceiling tile was hanging low that an individual of below average height (60 inches tall) could reach it. Interview on 11/30/21 at 10:26 A.M. with Licensed Practical Nurse (LPN) #300 confirmed the ceiling tile by Resident #46's room had been broken and pulled down sometime on 11/29/21 but she was not aware why or how it happened. Interview on 11/30/21 at 10:55 P.M. with the Administrator confirmed the ceiling tile by Resident #46's room was broken and had nails sticking out of it and a jagged edge and was suspended by a cable running through it. Administrator further confirmed she heard Resident #46 had damaged the ceiling tile on 11/29/21 and she would have Maintenance Director (MD) #80 fix it right away. Observation on 12/01/21 at 6:45 A.M. revealed the damaged ceiling tile hanging from the ceiling adjacent to Resident #46's room was unchanged from the observation made on 11/30/21. Interview on 12/01/21 at 6:45 A.M. with the Administrator confirmed the damaged ceiling tile was unchanged from the day before and MD #80 was not at the facility, but he told her he had fixed the tile. Administrator further confirmed staff called her on 11/29/21 in the afternoon at approximately 4:00 P.M. to report the damaged ceiling tile and the potential hazard. Administrator confirmed no one witnessed Resident #46 damaging the ceiling tile but staff suspected it due to resident's history. The facility confirmed there are 20 residents (#30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48 and #49) residing on the women's secured behavioral unit who would have access to this area. Observation on 12/01/21 at 10:10 A.M. revealed the ceiling tile had been removed and was replaced by two pieces of intact ceiling tile. Interview on 12/01/21 at 10:11 A.M. with MD #545 confirmed he had found the ceiling tile damaged with a jagged edge and a few nails sticking out suspended by a cable. MD #545 confirmed he worked at one of the facility's sister facilities and was asked in the morning of 12/01/21 to come over and repair the tile. MD #545 confirmed he couldn't replace the tile until he found one that was the proper size so in the meantime, he pieced two ceiling tiles together for safety. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency substantiates Complaint Number OH00127494.