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	08/01/2019

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15503 Based on observation, record review, and interview, the facility failed to ensure residents who were served breakfast in the dining room were treated in a dignified manner that promoted their quality of life at the facility. This affected one (Resident #82) resident. The facility census was 79 residents. Findings include: Review of Resident #82's record revealed she was admitted to the facility on [DATE], with pertinent diagnoses of Alzheimer's disease, dementia with behavioral symptoms, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the cognitively impaired resident required supervision of staff with eating tasks. The resident was on a pureed diet. A care plan dated 07/13/19 revealed the resident was at nutritional risk related to diagnoses of dementia requiring a mechanically altered diet. Pertinent interventions included monitoring for any signs of dysphagia, pocketing, choking, coughing, or holding food in mouth, providing supplements as ordered, providing supervision, cueing, encouragement, and feeding assistance at meals, and providing a pureed diet as ordered. The lunch meal was observed on 07/29/19 at 12:20 P.M., in the lounge across the hall from the 200 hall nurse's station. Residents #14 and #82 were seated at the dining table in the lounge awaiting their lunch trays. Resident #14's tray as delivered at 12:20 P.M., and placed in front of him. He was served four fish sticks, rice, carrots, and piece of cake. Resident #82 was not given a tray and watched Resident #14 as he ate a fish stick, a few bites of rice, carrots, and his cake. At 12:30 P.M., Resident #14 finished eating. Resident #82, who still had not received a tray, stated she was starved. Resident #14 then picked a fish stick off of Resident #14's tray and began eating. She also used her fingers and scooped some rice and carrots to eat. No staff were monitoring the dining room, nor did they deliver a tray for Resident #82. At 12:35 P.M., a State tested Nurse Aide (STNA) was questioned if Resident #82 should be eating off of the other resident's tray. She stated she was working through an agency and would get the nurse. At 12:37 P.M., Licensed Practical Nurse (LPN) #7 entered the dining room and stated the Resident #82 was on a pureed diet and should not be eating off Resident #14's tray due to potential of choking. She stated both residents' trays should have been delivered together, so they could eat at the same time. LPN #7 then removed Resident #14's tray from the room. At 12:45 P.M., 25 minutes later, Resident #82's tray was brought to the dining room and given to the resident. The resident's food was pureed and on a three compartment plate.

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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** 39967 Based on observation, record review and interview, the facility failed to ensure a resident's physician and resident representative were notified of an accident that resulted in a bruise to a resident's forehead. This affected one (Resident #9) of three residents reviewed for accidents. The facility census was 79. Findings include: Record review revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including frontotemporal dementia. Review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired and required supervision with bed mobility, transfers and eating and required extensive assistance with dressing, toileting and personal hygiene. Review of Resident #39's progress notes and shower sheets from 06/01/19 to 07/31/19 revealed no documentation regarding bruising on Resident #39's forehead. Observation of Resident #39 on 07/29/19 at 11:50 A.M. revealed a light yellow colored bruise approximately one inch by one half inch on the right side of her forehead. Interview with the Director of Nursing (DON) on 08/01/19 at 10:39 A.M. verified resident to have a light yellow colored bruise on the right side of her forehead. Interview with Licensed Practical Nurse (LPN) #23 on 08/01/19 at 12:06 P.M. revealed Resident #39 walks with her head facing towards the ground. LPN #23 stated on 07/28/19 around 7:00 P.M. she witnessed Resident #39 hit her head on a wooden door while walking down the hall. LPN #23 reported she informed the charge nurse of the incident on 07/28/19. Interview with the DON on 08/01/19 at 12:06 P.M. revealed she was not made aware that resident had hit her head on a wooden door on 07/28/19. The DON verified the resident's physician or resident representative was not notified of the incident.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, interview and record review, the facility failed to ensure four residents (Residents #9, #15, #79 and #31) were free from resident to resident abuse. This resulted in Actual Harm for one resident (Resident #9) when Resident #39 pushed Resident #9, causing her to fall and sustain a laceration to her head that required five staples The facility census was 79. This affected four of seven residents reviewed. Findings include: 1. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, other pneumonia, Alzheimer's disease with early onset, difficulty in walking, need for assistance with personal care, dysphagia, muscle weakness, other secondary parkinsonism, anxiety disorder, unspecified psychosis not due to substance or known physiological condition, type two Diabetes Mellitus with diabetic neuropathy and recurrent depressive disorders. Review of Resident #9's quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed the resident was cognitively impaired and required extensive assistance with bed mobility, transfers, dressing, eating, toileting and personal hygiene. Record review revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including frontotemporal dementia, deficiency of B group vitamins, vitamin D deficiency, other long term drug therapy, major depressive disorder, age related osteoporosis without current pathological fracture, gastro esophageal reflux disease without esophagitis and low back pain. Review of Resident #39's quarterly MDS assessment dated [DATE] revealed the resident was cognitively impaired and required supervision with bed mobility, transfers and eating and required extensive assistance with dressing, toileting and personal hygiene. Resident #39 was also reported to exhibit physical behaviors, verbal behaviors, rejection of care, wandering and other behaviors. Review of Resident #39's progress notes revealed on 07/16/19 Resident #39 was observed pacing the unit, hitting and pushing on staff, throwing ice water on staff and residents, charging staff members attempting to knock them over and being intrusive towards staff and other residents personal spaces. On 07/19/19 at 10:38 A.M., Resident #39 was aggressive towards residents and staff and was witnessed slapping another resident with no injury. At 1:00 P.M., Resident #39 threw milk onto a staff member while she was walking down the hallway. At 1:31 P.M., Resident #39 was extremely agitated. She came running out of her room, ran up to Resident #9 and pushed her, causing her to hit her head on the floor. Resident #39 was placed on one on one on 07/19/19. Review of Resident #9's progress notes revealed Resident #9 was pushed by another aggressive resident on 07/19/19, sustaining a laceration to the back of her head. Resident #9 was transported to the hospital for evaluation. The resident returned to the facility from the hospital on 07/19/19 with five staples to the top of her head and a diagnosis of a head injury with a laceration to her scalp. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's self reported incident (SRI), dated 07/19/19, revealed a staff member reported to Director of Nursing (DON) that there was a resident to resident altercation on the secured unit. Staff members interviewed reported that Resident #9 was standing in hallway with a staff member when Resident #39 ran out of bedroom and pushed Resident #9 onto the floor. Staff members immediately separated the two residents. Resident #9 acquired a small laceration to her head and was sent out to the hospital. Resident #39 was placed on one on one care until she was sent out to the hospital for a psychiatric evaluation. Review of the facility's investigation regarding the resident to resident abuse between Resident #39 and Resident #9 revealed Licensed Practical Nurse (LPN) #41 wrote a statement dated 07/19/19 that stated Resident #39 came out of the room agitated and aggressively pushed another resident, causing her to hit her head on the door frame and fall back onto the floor. Resident #39 was assisted to her room and placed on one on one. Review of LPN #23's statement dated 07/19/19 revealed Resident #39 was being aggressive with residents and staff. Redirection was given and was ineffective. Resident #39 ran out of the room and pushed another resident causing her to fall. Review of State tested Nurse Aide (STNA) #79's statement dated 07/19/19 revealed Resident #39 was combative and aggressive towards staff and other residents. Resident #39 charged out of the room and pushed another resident causing her to hit her head on the door frame and then fall onto the floor. Interview with the DON and the Administrator on 07/31/19 at 11:26 A.M. revealed Resident #39 charged at Resident #9 and caused her to fall. Staff immediately separated both residents and Resident #9 was sent out to the hospital. Resident #39 was placed on one on one and sent out to psychiatric services that day. The DON reported Resident #39 was placed back on one on one after she returned from the hospital. The DON stated Resident #9 had a laceration to her head with five staples as a result of the incident on 07/19/19. 2. Record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including acute kidney failure, weakness, encephalopathy, chronic diastolic heart failure, dementia with behavioral disturbance, type two diabetes mellitus, osteoarthritis, acute duodenal ulcer without hemorrhage or perforation, essential hypertension, altered mental status and cognitive communication deficit. Review of Resident #15's quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and required supervision with eating, was independent with bed mobility, transfers and she required limited assistance with toileting, dressing and personal hygiene. Record review revealed Resident #79 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, essential hypertension, hyperlipidemia, dry eye syndrome, gastro esophageal reflux disease, type two diabetes, mood disorder, muscle weakness, lower back pain and shortness of breath. Review of Resident #79's quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and require limited assistance with bed mobility and transfers, and required extensive assistance with dressing, eating, toileting and personal hygiene. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review revealed Resident #236 was admitted to the facility on [DATE] with diagnoses including vascular dementia with behavioral disturbance, history of thyroid, schizoaffective disorder, hyperlipidemia, hypertension, bipolar disorder and chronic kidney disorder. Review of Resident #236's discharge MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired and require limited assistance with toileting, personal hygiene and dressing and required supervision with transfers, bed mobility and eating. Review of Resident #236's progress notes revealed the resident had increased behaviors including cursing and hitting staff and other residents on 04/19/19. Review of Resident #15 and Resident #79's progress notes revealed both residents were ambulating in the corridor on 04/21/19 when Resident #236 physically assaulted both residents, hitting them both on the right side of their faces, resulting in bruising and swelling. Review of the facility's self reported incident (SRI) dated 04/21/19 revealed Resident #236 was sitting in the hallway while Resident #15 and Resident #79 were walking by her. Resident #236 hit both Resident #15 and Resident #79 in the face. Review of the facility's investigation regarding the incident revealed LPN #23's statement, dated 04/21/19, that Resident #236 walked up to Resident #79 and Resident #15 and slapped them both in the face. Review of STNA #800's statement revealed she observed Resident #236 punch Resident #15 in the face. Review of STNA #88's statement revealed Resident #236 punched Resident #15 in the right side of her face with her fists. Review of Laundry #21's statement dated 04/21/19 revealed Resident #79 and Resident #15 were walking down the hallway when Resident #236 came out of her room and walked by Resident #79 and punched her in the right side of her face. Resident #236 then walked up to Resident #15 and punched her in the right side of her face. Resident was #236 verbally abusive with staff and another resident threatening to strike the other resident on 04/22/19. Resident #236 had scissors and nail clippers stating she was going to kill them. Resident #236 was discharged to the psychiatric hospital on 04/22/19. Interview with the Director of Nursing (DON) and the Administrator on 07/31/19 at 11:26 A.M. revealed Resident #236 hit Resident #15 and Resident #79 in the face on 04/21/19. Residents were separated and Resident #236 was sent out to the psychiatric hospital. 3. Record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including unspecified dementia without behavioral disturbance, muscle weakness, essential hypertension, hyperlipidemia, transient cerebral ischemic attach, primary osteoarthritis, and type two diabetes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #31's quarterly MDS assessment, dated 06/06/19, revealed the resident was severely cognitively impaired and required supervision with bed mobility and eating, and required limited assistance with transfers and extensive assistance with dressing, toileting and personal hygiene. Record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, mixed hyperlipidemia, essential hypertension, anemia, cognitive communication deficit, need for assistance with personal care, muscle weakness, Alzheimer disease, major depressive disorder and insomnia. Review of Resident #16's quarterly MDS assessment, dated 05/14/19, revealed the resident was severely cognitively impaired and required limited assistance with transfers, toileting and personal hygiene and was independent with bed mobility and required extensive assistance with dressing, supervision with eating. Review of the facility's SRI, dated 07/15/19, revealed Resident #16 struck Resident #15 in the mouth. Staff immediately separated residents and Resident #16 appeared calm. Resident #16 then pushed Resident #31 in the hallway. Review of the facility's investigation revealed STNA #88's statement reported she heard loud voices in the hallway on 07/15/19 and came out of a resident's room and saw one resident shaking another resident. STNA #88 stepped in the middle of the two and redirected one of the residents. Review of LPN #720's statement dated 07/14/19 revealed she was in another resident's room administering medications and did not see Resident #16 touch another resident. LPN #720's statement also reported that during the evening Resident #16 was verbally aggressive towards staff and other residents. All interventions were ineffective. Review of LPN #750's statement dated 07/14/19 revealed Resident #16 had a verbal and physical altercation with Resident #15 and Resident #31. Resident #16 struck Resident #15 near her mouth. Resident #15 and Resident #16 were immediately separated and Resident #16 appeared calm. Resident #31 was in the hallway and Resident #16 pushed Resident #31. Interview with the Director of Nursing (DON) and the Administrator on 07/31/19 at 11:26 A.M. revealed Resident #16 hit Resident #15 in the hallway. The DON stated Resident #16 was separated from Resident #15 and appeared calm. Resident #16 then hit Resident #31. Review of the progress notes for Resident #15, Resident #16 and Resident #31 's progress notes revealed no information regarding an incident of resident to resident abuse that occurred on 07/14/19. Review of the facility policy titled Abuse Investigation and Reporting, dated August 2018, revealed residents have the right to be free from abuse, neglect and misappropriation. This includes the right to remain free from physical abuse.

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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** 15503 Based on observation, record review and interview, the facility failed to ensure residents received timely incontinence care. This affected two (Residents #56 and #61) of 19 sampled residents The facility census was 79 residents. Findings include: 1. Record review revealed Resident #56 was admitted to the facility on [DATE] with diagnoses including diabetes, vascular dementia, arthropathy, osteoporosis, dysarthria, cerebral vascular accident with hemiplegia, dysphagia, hypertensive retinopathy, glaucoma, major depressive disorder, seizures, aphasia, hypertension, and cerebral infarction. A care plan was developed on 07/23/17 that stated the resident was at risk of developing complications secondary to having functional bladder incontinence related to dementia and impaired mobility. Interventions included coordinating care with hospice team, checking for incontinence during rounds, washing, rinsing, and drying his perineum after incontinence episodes, and monitor for symptoms of urinary tract infections. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed the cognitively impaired resident was dependent on staff to provided bed mobility, transferring, dressing, and toilet use task and was always incontinent of bowel and bladder. On 07/29/19 at 10:30 A.M., the resident was observed in bed, feeding himself breakfast. He started to get visibly anxious and picked up an incontinence brief on his bed side table and handed it to this surveyor. When asked if he needed changed, he stated yes. His speech was garbled somewhat. State tested Nurse Aide (STNA) #89 was informed of the resident's request to be changed. She entered the room with STNA #16 to change the resident. When STNA #16 removed his incontinence brief, it was heavily soaked with urine and loose stool. When asked when the resident was last changed, STNA #89, stated it was around 7:30 A.M., three hours earlier. When asked when how often residents should be changed, STNA #16 stated every two hours. During the care, the resident had a reddened scrotum with two small excoriated areas. STNA #16 stated she would inform the nurse, so the nurse could apply some ointment. On 07/31/19 at 11:00 A.M., Resident #56 was observed again receiving care from STNA's #16 and #46. When asked if anyone had changed him since 7:00 A.M., (four hours prior) he answered no. When STNA #16 removed his brief, it was saturated with urine. The resident's scrotum was observed with a white, zinc based barrier cream in place. Both STNA's confirmed the resident's saturated brief. They stated they were not assigned to care for the resident, so were not aware when he was last changed. On 07/31/19 at 11:15 A. M., the resident's assigned STNA #256 was interviewed. She stated she worked for an agency and was assigned to care for the resident. She stated she had not changed the resident as of yet this shift which started at 7:00 A.M. 2. Record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses including vascular dementia, tachycardia, hypertension, benign prostatic hyperplasia with lower urinary tract symptoms, repeated falls, and dysphagia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan initiated on 01/28/19, revealed the resident was at risk for urinary incontinence, impaired skin integrity, urinary tract infections, and impaired dignity related to functional incontinence, mobility deficit, decreased bladder capacity, and cognitive deficit. Interventions included assessing the resident for a urinary tract infection, placing the call light within reach and answering promptly, checking and changing the resident as needed, encouraging fluid intake, monitoring bowel and bladder assessment and patterns, and providing peri-care when incontinent including the use of incontinence briefs, assisting with hygiene and clothing as needed, and keeping the resident clean and dry. The quarterly MDS assessment, dated 07/04/19, revealed the cognitively impaired resident required extensive assistance of staff with bed mobility, transferring, dressing, toilet use, and personal hygiene tasks and was totally incontinent of bowel and bladder. On 07/29/19 at 2:40 P.M., the resident's wife stopped the surveyor in the hallway and stated her husband had not been changed all day and asked this surveyor if she would make sure he was changed. The Administrator was informed of the wife's concern and sent STNA #16 to the room to change the resident. STNA #16 informed the surveyor she was not the resident's assigned STNA. When the resident was asked when he was last changed, he answered, last night. Once STNA #16 removed his disposable brief, it was observed to be so drenched with dark yellow urine that it began to clump. The resident's sheets under him were also soaked with urine, with large, wet, yellow stains observed. His dark blue mattress had a large wet spot of urine. The nurse aide confirmed how soaked the resident was. After changing the resident, she then placed him into his wheelchair and stated she was going to get the housekeeper to clean and sanitize his mattress. This deficiency substantiates complaint OH00105539.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, interview and review of the activity calendar, the facility failed to provide an ongoing program of activities for each resident that met their individual needs and preferences. This affected four (Resident #10, Resident #15, Resident #24 and Resident #39) residents and had the potential to affect all 20 residents of the secured unit for residents with dementia related diagnoses. The facility census was 79. Findings include: 1. Record review revealed Resident #15 was admitted to the facility on [DATE]. Review of Resident #15's activity interview for daily and activity preferences dated 02/13/19 revealed listening to music, being around animals, going outside and getting fresh air were somewhat important to Resident #15. Review of Resident #15's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired. Review of Resident #15's activities care plan revealed staff should assist resident in developing a program of activities that are meaningful and of interest. Observation of the secured unit on 07/30/19 at 9:46 A.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 10:05 A.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation of the main dining room on 07/30/19 at 10:05 A.M. revealed residents were drinking coffee. The scheduled flex and stretch activity was not provided. There were no residents that resided on the secured unit present for coffee in the main dining room. Observation of the secured unit on 07/30/19 at 12:33 P.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 1:24 P.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 1:59 P.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation on 07/30/19 at 3:08 P.M. revealed Resident #15 to be wandering the secured unit. No activities were provided on the secured unit. There was a musical event with ice cream in the main dining room at the time of the observation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the secured unit on 07/31/19 at 9:26 A.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 9:56 A.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 10:39 A.M. revealed a painting activity was occurring on the unit. Resident #15 was observed wandering the unit at the time of the activity. Observation of the secured unit on 07/31/19 at 2:20 P.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 3:10 P.M. revealed Resident #15 was wandering around the secured unit. No activities were provided. Interview with State tested Nurse Aide (STNA) #37 on 07/31/19 at 4:36 P.M. verified there was only one activity on the secured unit on 07/31/19. STNA #37 also reported music was played on 07/30/19 but no other activities were held on the unit on that date. STNA #37 stated Resident #15 is not taken to the main dining room for activities due to her becoming combative and not wanting to return to the unit. 2. Record review revealed Resident #24 was admitted to the facility on [DATE] with the following diagnoses; non traumatic intracerebral hemorrhage, weakness, restlessness, unspecified dementia with behavioral disturbance, pain in unspecified hip, hypertension, cognitive communication deficit and major depressive disorder. Review of Resident #24's activity interview for daily and activity preferences dated 02/28/19 revealed listening to music, going outside and getting fresh air were very important to Resident #24. Review of Resident #24's quarterly MDS assessment, dated 05/22/19, revealed the resident was severely cognitively impaired. Review of Resident #24's activities care plan revealed staff will invite and encourage resident to attend activities of interest and will escort her to activities of interest. The care plan also stated resident will be assisted in developing a program of activities that is meaningful and of interest. Observation of the secured unit on 07/30/19 at 9:46 A.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 10:01 A.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 10:05 A.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. (continued on next page)

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	366175	A. Building B. Wing	08/01/2019

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the main dining room on 07/30/19 at 10:05 A.M. revealed residents were drinking coffee. The scheduled flex and stretch activity was not provided. There were no residents that resided on the secured unit present for coffee in the main dining room. Observation of the secured unit on 07/30/19 at 12:33 P.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 1:24 P.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 1:59 P.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 9:26 A.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 9:56 A.M. revealed Resident #24 was in the day room on the secured unit. A bucket was brought onto the unit and placed on the floor. No activities were provided. Observation of the secured unit on 07/31/19 at 10:39 A.M. revealed a painting activity was occurring on the unit. Resident #24 was observed laying in her geri chair and was not participating in the activity. Observation of the secured unit on 07/31/19 at 2:20 P.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 3:10 P.M. revealed Resident #24 was in the day room on the secured unit. No activities were provided. 3. Record review revealed Resident #39 was admitted to the facility on [DATE] with the following diagnoses; other frontotemporal dementia, deficiency of other specified B group vitamins, vitamin D deficiency, other long term drug therapy, major depressive disorder, age related osteoporosis without current pathological fracture, gastro esophageal reflux disease without esophagitis and low back pain. Review of Resident #39's quarterly MDS assessment dated [DATE] revealed the resident was cognitively impaired. Review of Resident #39's activity interview for daily and activity preferences dated 12/04/18 revealed listening to music, being around animals, going outside and getting fresh air were very important to Resident #39. Review of Resident #39's activities care plan revealed staff should ensure that resident is attending activities that are compatible with her physical and mental capabilities, compatible with her interests and adapted to her needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the secured unit on 07/30/19 at 9:46 A.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 10:05 A.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation of the main dining room on 07/30/19 at 10:05 A.M. revealed residents were drinking coffee. The scheduled flex and stretch activity was not provided. There were no residents that resided on the secured unit present for coffee in the main dining room. Observation of the secured unit on 07/30/19 at 12:33 P.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 1:24 P.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/30/19 at 1:59 P.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation on 07/30/19 at 3:08 P.M. revealed Resident #39 to be wandering the secured unit. No activities were provided on the secured unit. There was a musical event with ice cream in the main dining room at the time of the observation. Observation of the secured unit on 07/31/19 at 9:26 A.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 9:56 A.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 10:39 A.M. revealed a painting activity was occurring on the unit. Resident #39 was observed wandering the unit at the time of the activity. Observation of the secured unit on 07/31/19 at 2:20 P.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Observation of the secured unit on 07/31/19 at 3:10 P.M. revealed Resident #39 was wandering around the secured unit. No activities were provided. Interview with Licensed Practical Nurse (LPN) #600 on 07/31/19 at 4:34 P.M. revealed there was only one activity provided on the secured unit on 07/31/19. Interview with STNA #37 on 07/31/19 at 4:36 P.M. verified there was only one activity on the secured unit on 07/31/19. STNA #37 also reported music was played on 07/30/19 but no other activities were held on the unit on that date. 15503 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of resident #10's admission record, revealed he was admitted to the facility on [DATE]. with diagnoses including acute respiratory failure with hypoxemia, chronic anoxic encephalopathy, late effect stroke, functional quadriplegia, gastrostomy, seizures, anemia, hypertension, dysphagia, diabetes, peripheral vascular disease, chronic viral hepatitis, glaucoma. Review of the care plan developed on 05/23/17, revealed the resident had little or no activity involvement related to physical limitations and immobility. There were two interventions for this care plan, provide the resident with one on one bedside, in room visits and activities if unable to attend out of room events and provide resident with assistance/escort to activity functions. Review of the annual MDS dated [DATE], revealed the resident had short and long term memory losses and was dependent on staff to provide all transferring. The resident had no speech or ability to verbalize and rarely/never understands and rarely/never is understood. Observation of the resident on 07/29/19 at 10:00 A.M. and 2:00 P.M., on 07/30/19 at 09:23 A.M. and 11:00 A. M., 07/31/19 at 10:00 A.M. and 11:35 A.M., revealed the resident was in bed, with no evidence of activities including the television on or a radio on. No type of stimulation was observed. Review of the record of One on One Activities form for July 2019, revealed the resident was bedfast and was to have one on one activities three times a week. Further review of the form, revealed the resident was only engaged in a single one on one activity on 07/30/19, when the resident received a hand massage. During interview with the Activity Director #54 on 07/31/19 at 1:57 P.M., she stated the resident should have his television or a radio on each day. AD #54 also stated the resident received one on one activities in his room three times a week. The resident receives a hand massage or has music played. AD #54 confirmed there was only a single one on one activity activity recorded for the resident for the entire month of July 2019. Review of the activity schedule for the secured until on 07/30/19 revealed there was to be a balloon toss at 10:00 A.M., flex and stretch at 10:00 A.M., paint club at 11:00 A.M., flex your brains at 11:00 A.M., karaoke at 2:00 P.M., ice cream soda social at 3:00 P.M. and walking club at 6:00 P.M. The secured activities schedule for 07/31/19 revealed the unit was to have a news and coffee social at 9:30 A.M., an outing to the park at 10:00 A.M., sitting outdoors at 11:00 A.M., live entertainment at 3:00 P.M. and walking club at 6:00 P. M. Review of the facility policy titled Activities Programs, dated December 2018, revealed activities offered are based on the comprehensive resident centered assessment and preferences of each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 39967 Based on observation, record review and interview, the facility failed to ensure a resident who sustained a bruise to her forehead received appropriate assessment, treatment and monitoring. This affected one (Resident #39) of three residents reviewed for accidents. The facility census was 79. Findings include: Record review revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including dementia. Review of Resident #39's quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively impaired and required supervision with bed mobility and transfers and required extensive assistance with dressing, toileting and personal hygiene. Review of Resident #39's progress notes and shower sheets from 06/01/19 to 07/31/19 revealed no documentation regarding bruising on Resident #39's forehead. Observation of Resident #39 on 07/29/19 at 11:50 A.M. revealed resident to have a light yellow colored bruise approximately one inch by one half inch on the right side of her forehead. Interview with the Director of Nursing (DON) on 08/01/19 at 10:39 A.M. verified resident to have a light yellow colored bruise on the right side of her forehead. Interview with Licensed Practical Nurse (LPN) #23 on 08/01/19 at 12:06 P.M. revealed Resident #39 walks with her head facing towards the ground. LPN #23 stated on 07/28/19 around 7:00 P.M. she witnessed Resident #39 hit her head on a wooden door while walking down the hall. LPN #23 reported she informed the charge nurse of the incident on 07/28/19. Interview with the DON on 08/01/19 at 12:06 P.M. revealed she was not made aware that resident had hit her head on a wooden door on 07/28/19. The DON verified the resident's physician or resident representative was not notified of the incident. The DON also confirmed there was no documented incident report or assessment of the resident after the incident on 07/28/19. The DON reported no monitoring of Resident #39 had occurred.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15503 Based on record review and staff interview, the facility failed to ensure residents received their treatments consistently to promote healing. This affected two (#65 and #81) of four residents reviewed for pressure sores. The facility identified three residents with pressure sores. The facility census was 79 residents. Findings include: 1. Review of Resident #65's record revealed she was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, anxiety state, depression, kidney disease, chronic obstructive pulmonary disease and urinary incontinence. Review of a care plan, developed on 04/07/17, revealed the resident had the potential for impairment of skin integrity related to diabetes mellitus, immobility and incontinence. Pertinent interventions included assistance with repositioning, assisting with hygiene and general skin care including the application of barrier cream to the buttocks and skin prep to the heels and the use of a low air loss mattress. Review of the annual Minimum Data Set (MDS) assessment, dated 07/01/19, revealed the resident had short and long term memory losses and was dependent on staff to provide bed mobility and transferring. The resident was always incontinent of bowel and bladder and had moisture associated skin damage (MASD). On 07/15/19, the resident developed a stage two pressure sore (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough) on her sacrum that measured 3.5 centimeters (cm.) by 3.8 cm, with undetermined depth. The physician was notified and gave orders to cleanse the wound to the sacrum with normal saline, pat dry, and cover with border foam dressing daily and as needed. Review of the Treatment Administration Record (TAR) from 07/16/19 through 07/31/19, revealed the nurse did not document the treatments were completed as ordered on 07/17/19, 07/19/19, 07/23/19, 07/24/19, and 07/31/19 (five out of 15 treatments). Interview with the Director of Nursing on 08/01/19 at 1:00 P.M., she confirmed the treatments were not signed off as completed. She stated agency nurses cared for the resident on those dates. 2. Review of the record for Resident #81, revealed he was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus with diabetic peripheral angiopathy with gangrene, peripheral vascular disease, osteomyelitis of the right foot and ankle and chronic pain. The resident was admitted to the facility after incision and drainage of the right heel wound due to osteomyelitis and a partial left foot and toes amputation. The resident was under the care of the wound physician since his admission to the facility. The resident was documented as currently having a stage four pressure sore (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed) on his right heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the significant change MDS assessment, dated 07/04/19, revealed the cognitively intact resident was dependent on staff to provide bed mobility and transferring tasks. The MDS revealed the resident had a stage IV pressure sore. Review of the resident's pressure sore care plan, last updated 07/20/19, stating he had a stage IV pressure sore to his right heel and trauma to his right and left foot. Pertinent interventions included the application of skin prep to the bilateral heels every shift, keeping the skin clean and dry and applying protective cream to the buttocks after each incontinent episode, turning and repositioning per protocol, consulting with wound clinic as ordered, elevating the heels off of the bed surface when in bed, encourage resident not to pick at affected areas, ensure adequate hydration, apply foam boots when in bed, the use of an air loss mattress, the provision of hospice care, medicate for pain as needed, provide treatments as ordered and provide nutritional supplements as ordered. Review of the physician orders, dated 07/2019, revealed the resident was to have a foam, border dressing applied to his right heel twice daily, on the day shift and night shift and was also to have skin prep applied to his bilateral heels twice daily, on the day shift and night shift. Review of the wound physician note, dated 07/30/19, revealed the stage four pressure sore on the right heel measured 0.8 cm. by 1.4 cm. with a depth of 0.1 cm. The wound physician surgically excised 0.11 cm. of devitalized tissue including slough at a depth of 0.2 cm. with healthy, bleeding tissue observed. Review of the Treatment Administration Record (TAR) from 07/01/19 through 07/31/19, was revealed the nurses did not document the treatments of the application of skin prep to the bilateral heels and the application of a foam, border dressing to the right heel twice daily as being completed as ordered on 07/05/19, 07/19/19, 07/20/19, 07/23/19, 07/24/19, and 07/31/19 on the day shift, and on 07/20/19, 07/21/19, and 07/31/19 on the night shift. During interview with the Director of Nursing on 08/01/19 at 1:00 P.M., she confirmed the treatments were not signed off as completed. She stated agency nurses cared for the resident on those dates.

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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** 15503 Based on record review and staff interview, the facility failed to ensure a resident received sliding scale insulin in accordance to physician orders. This affected one (#18) of five residents reviewed for unnecessary medications. The facility identified 17 residents on insulin. The facility census was 79 residents. Findings include: Review of the record Resident #18 revealed the resident was admitted to the facility on [DATE] with diagnoses including diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/15/19, revealed the resident was cognitively intact. Review of the physician orders, dated 11/10/18, revealed the resident received Novolog Insulin 10 units subcutaneously before meals for diabetes mellitus. He also was to receive Novolog Insulin in accordance to the sliding scale results before meals which stated if blood sugar test results were 150 - 200 administer five units Novolog Insulin; 201 - 250 administer 10 units Novolog Insulin; 251 - 300 administer 15 units Novolog Insulin; 301 - 350 administer 20 units Novolog Insulin; 351 - 400 administer 25 units Novolog Insulin. For results above 400, call the medical doctor. Review of the 06/2019 and 07/2019 Medication Administration records revealed on 06/28/19 at 11:00 A.M., the sliding scale result was 459. On 07/02/19 at 6:00 A.M., the result was 530, on 07/05/19 at 11:00 A.M., the result was 409, on 07/22/19 at 6:00 A.M., the result was 484, on 07/23/19 at 4:00 P.M., the result was 458, and on 07/31/19, the result was 478. There was no evidence the physician was not notified of the high blood sugar results in accordance to the orders. Interview with the Director of Nursing on 07/31/19 at 3:50 P.M. verified the physician was not notified per physician orders on 06/28/19, 07/02/19, 07/05/19, 07/22/19, 07/23/19 and 07/31/19 .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review and staff interview, the facility failed to ensure pharmacy recommendations were addressed timely by the physician. This affected two (Resident #5 and #24) of five residents reviewed for unnecessary medications. The facility census was 79. Findings include: 1. Record review for Resident #5 revealed the resident was admitted to the facility on [DATE] with the following diagnoses dementia with behavioral disturbance, major depressive disorder, psychosis and insomnia. Review of Resident #5's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be severely cognitively impaired and received antipsychotics and antidepressants. Review of Resident #5's physicians orders revealed resident was prescribed Seroquel 50 milligrams (mg.) by mouth at bedtime for dementia on 06/08/18 and Seroquel 50 mg. by mouth in the afternoon for dementia on 06/08/18. Review of Resident #5's pharmacy recommendation, dated 04/11/19, revealed a trialed decrease of Seroquel was recommended. Further review of the pharmacy recommendation revealed the pharmacy recommendation was not responded to by the Certified Nurse Practitioner (CNP) until 07/22/19. Interview with the Director of Nursing (DON) on 07/30/19 at 3:55 P.M. verified Resident #5's pharmacy recommendation dated 04/11/19 was not responded to by the CNP until 07/22/19. 2. Record review revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, cognitive communication deficit and major depressive disorder. Review of Resident #24's quarterly MDS assessment, dated 05/22/19, revealed the resident to be severely cognitively impaired and received antipsychotics and antidepressants. Review of Resident #24's physicians orders revealed resident was prescribed Trazodone 25 mg. by mouth at bedtime for insomnia on 05/13/19. Review of Resident #24's pharmacy recommendation, dated 02/18/19, revealed a recommendation was made for resident's Trazodone be discontinued. Further review of the pharmacy recommendation revealed the pharmacy recommendation was not responded to by the physician until 04/26/19. Interview with the Director of Nursing (DON) on 07/30/19 at 5:13 P.M. verified Resident #24's pharmacy recommendation dated 02/18/19 was not responded to by the physician until 04/26/19.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15503 Based on record review and staff interview, the facility failed to ensure a resident received adequate monitoring for the use of an anticoagulant. This affected one (Resident #34) of five residents reviewed for unnecessary medications. The facility identified 13 residents on anticoagulants. The facility census was 79 residents. Findings include: Review of Resident's #34's admission record, revealed he was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (CVA) and cerebral infarction. Review of the annual Minimum Data Set (MDS) assessment, dated 06/07/19, revealed the resident had intact cognition. Review of the care plan, dated 04/17/17, revealed the resident needed monitoring for the use of Coumadin, an anticoagulant, with the potential for uncontrolled bleeding. Pertinent interventions included administering the Coumadin as ordered, monitoring his labs as ordered and adjusting the Coumadin dosage per physician orders, and monitoring for any bruising, blood in urine, and stool or coffee ground emesis. Review of the physician orders for 07/2019, revealed the resident was on Coumadin 5.0 milligrams (mg.) daily for cerebral infarction. The physician orders also stated the resident was to have a prothrombin time test (PT) and international normalized ration (INR) test once weekly on Monday. These tests measure how quickly the resident's blood clots. Review of the resident's lab reports, from 06/10/19 through 07/30/19, revealed there were no PT/INR tests conducted as ordered by the physician. After surveyor intervention on 07/30/19, the tests were obtained. On 07/31/19 at 3:50 P.M., the Director of Nursing (DON) verified the monitoring of the resident's PT/INR levels had not been completed as ordered by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, review of facility policy and staff interviews, the facility failed to provide a gradual dose reduction for two residents who were receiving psychotropic medications and failed to provide rationale for extended use of an as needed psychotropic drug for one resident. This affected three residents (#5, #18 and #24) of five resident reviewed for unnecessary medications. The resident census was 79. Findings include: 1. Record review revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included dementia with behavioral disturbance, major depressive disorder and psychosis. Review of Resident #5's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be severely cognitively impaired and received antipsychotics and antidepressants during the seven-day look back period of the assessment date. Review of the physician orders, dated 06/08/18, revealed the resident was prescribed Seroquel 50 milligrams (mg.) by mouth at bedtime for dementia, Seroquel 50 mg. by mouth in the afternoon for dementia, Trazodone 50 mg by mouth at bedtime for insomnia and Depakote delayed release 135 mg. by mouth every morning and at bedtime for dementia with behavioral disturbance. Review of Resident #5's chart revealed there were no gradual dose reductions or documentation contraindicating a gradual dose reduction on Resident #5's Trazodone 50 mg. by mouth at bedtime for insomnia prescribed on 06/08/18 and Depakote delayed release 135 mg. by mouth every morning and at bedtime for dementia with behavioral disturbance prescribed on 06/08/18. Interview with the Director of Nursing (DON) on 07/30/19 at 3:55 P.M. verified Resident #5's Trazodone 50 mg. by mouth at bedtime for insomnia prescribed on 06/08/18 and Depakote delayed release 135 mg. by mouth every morning and at bedtime for dementia with behavioral disturbance prescribed on 06/08/18 did not have a gradual dose reduction or any documentation contraindicating a gradual dose reduction. The DON also confirmed Resident #5's Seroquel 50 mg. by mouth at bedtime for dementia prescribed on 06/08/18 and Resident #5's Seroquel 50 mg. by mouth in the afternoon for dementia prescribed on 06/08/18 did not have an appropriate diagnosis or indication of use. 2. Record review revealed Resident #24 was admitted to the facility on [DATE]. Diagnoses included dementia with behavioral disturbance and major depressive disorder. Review of the quarterly MDS assessment, dated 05/22/19, revealed the resident to be severely cognitively impaired and received antipsychotics and antidepressants during the seven-day look back period of the assessment date. (continued on next page)

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	366175	A. Building B. Wing	08/01/2019

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders revealed resident was prescribed Buspirone 10 mg. one tablet by mouth two times a day for anxiety on 07/16/19 and Buspirone 10 mg. by mouth every eight hours as need for anxiety on 05/13/19. Review of Resident #24's chart revealed no documentation regarding a stop date or rationale for continuing Resident #24's Buspirone 10 mg. by mouth every eight hours as need for anxiety prescribed on 05/13/19. Interview with the Director of Nursing (DON) on 07/30/19 at 5:13 P.M. verified Resident #24's Buspirone 10 mg by mouth every 8 hours as need for anxiety prescribed on 05/13/19 did not have a stop date or rationale from the physician. 15503 3. Review of the record for Resident #18 revealed the resident was admitted to the facility on [DATE], with diagnoses including anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/15/19, revealed the resident was cognitively intact. Review of the physician order sheet, dated 11/08/18, revealed the resident was placed on a hypnotic, Ambien 10 milligrams (mg.) daily for insomnia. Review of the care plan, dated 02/19/19, revealed the resident received psychotropic medication related to altered thought processes, anxiety, insomnia, and behavior management. Pertinent interventions included administering the medication as ordered, monitor for side affects, and monitor and re-evaluate the need for the medication on a quarterly basis and initiate medication reduction if appropriate. Review of the resident's record, revealed the facility had not attempted a gradual dose reduction (GDR) in two separate quarters (with at least one month between the attempts), even though the resident had been on Ambien for three full quarters. Interview on 07/31/19 at 3:50 P.M. with the Director of Nursing (DON) verified the resident had been on Ambien for nine months with the required GDR's not yet attempted. Review of the facility's policy titled Antipsychotic Medication Use, dated December 2018, revealed diagnoses alone do not warrant the use of antipsychotic medications. Further review of the policy revealed antipsychotic medication will not be used if the only symptoms are impaired memory. The policy stated the need to continue as needed orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for extending the order.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15503 Based on observation, record review and resident and staff interview, the facility failed to ensure one (#34) of five residents reviewed for dental services, received his dentures timely. The facility census was 79 residents. Findings include: Review of Resident #34's record, revealed he was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (CVA), degenerative joint disease, anxiety, and depression. Review of the annual Minimum Data Set (MDS) assessment, dated 06/07/19, revealed the cognitively aware resident, required extensive assistance with personal hygiene tasks. The MDS also revealed the resident had no natural teeth and was edentulous. Review of the care plan, dated 04/17/17, revealed the resident had a potential for or altered dental status related to the need for assistance with dental hygiene. Interventions included assisting with oral care as needed, notifying the nurse of any chewing problems or complaints of discomfort, assist with referrals as needed, consult with dentist if needed or requested by resident/family/physician, and monitor for any signs of oral/dental problems. On 02/27/19, the resident received dental care from the facility's contracted dental company. The dentist documented the resident was edentulous and dental prosthetics/dentures were in process. Mandibular ridge was minimal. At that time, impressions were made for the resident's dentures. Review of the physician orders, dated 05/06/19, revealed the resident was placed on a mechanical soft texture diet, with thin consistency liquids. On 07/29/19 at 4:11 P.M., the resident was interviewed and stated he saw the facility dentist about a year ago. The dentist took impressions and the resident was supposed to have new dentures made. The resident stated he has never heard about his dentures again. He stated he has trouble gumming his food. He showed the surveyor a cut on his upper right gum due to eating a crisp cookie. He asked this surveyor to find out when his new dentures would be coming in. During interview with the Social Services Director (SSD) #24 on 07/31/19 at 10:30 A.M., she stated the facility hired a new dental company when this facility was taken over by a new management company. When she contacted the old dental company who took the resident's impressions and were making the dentures, they stated since the facility did not renew their contract, they would not be following up with the resident's dentures. The resident would have to start the process to obtain dentures over again with the facility's current dental company. The SSD confirmed no one had followed up regarding the resident's dentures until surveyor intervention. She confirmed the resident had been without dentures since at least 02/19/19, with no follow up.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39967 Based on observation, staff interview and record review, the facility failed to ensure the portion sizes reflected in the menu spreadsheet were followed to ensure residents received adequate nutrition. This affected nine (Resident #9, #23, #24, #56, #62, #72, #74, #81 and #83) of 79 residents residing in the facility that received pureed diets. The facility census was 79. Findings include: Review of the dietary menu spreadsheet revealed residents on pureed diets were to get four oz. of pancake. Observation of Dietary Director #35 on tray line on 07/31/19 at 7:34 A.M. revealed Dietary Director #35 gave Resident #72 and Resident #9 an ivory scoop or 3.2 ounces (oz.) of pureed pancake. Interview with Dietary Director #35 on 07/31/19 at 7:34 A.M. verified he was using an ivory scoop to serve the pureed pancakes. Interview with Dietician #500 on 07/31/19 at 2:45 P.M. verified the ivory scoop used to serve the pureed pancakes on 07/31/19 was a 3.2 oz scoop. Dietician #500 also confirmed the dietary menu spreadsheet reported pureed diets were to get four oz of pureed pancakes on 07/31/19. Review of the undated list of scoop sizes provided by the facility revealed the ivory scoop was 3.2 oz. Review of a list of residents on pureed diets provided by the facility revealed Residents #9, #23, #24, #56, #62, #72, #74, #81 and #83 received pureed diets.

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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. 39967 Based on observation, staff interview and review of facility policy, the facility failed to ensure food items in the kitchen, nourishment refrigerators and the facility food thermometer were maintained in a manner to prevent and protect food against contamination and spoilage. This affected all residents residing in the facility except for two residents (Resident #10 and #65) who received nothing by mouth (NPO). The facility census was 79. Findings include: 1. Observation of the kitchen on 07/29/19 at 9:35 A.M. revealed a bag of open undated strawberries and a bag of open undated blueberries to be in the ice cream freezer. There was also a plastic tub of cooked chicken breasts, dated 07/29/19, with no lid on them and a plastic tub of stir fry, dated 07/27/19, with no lid on it in the refrigerator. Interview with Dietary Director #35 on 07/29/19 at 9:35 A.M. verified there to be a bag of open undated strawberries and a bag of open undated blueberries to be in the ice cream freezer. Dietary Director #35 also confirmed there was a plastic tub of cooked chicken breasts dated 07/29/19 with no lid on them and a plastic tub of stir fry dated 07/27/19 with no lid on it in the walk in refrigerator. 2. Observation of Dietary Director #35 taking food temperatures on 07/31/19 at 7:34 A.M. revealed Dietary Director #35 took the temperature of the pureed eggs which was 130 degrees Fahrenheit (F) and then wiped off the thermometer probe with a towel. Dietary Director #35 was then observed putting the thermometer probe into the pancakes without sanitizing the thermometer probe. Dietary Director #35 placed the thermometer probe directly into the pureed pancakes after taking the temperature of the regular pancakes without sanitizing the thermometer probe. Interview with the Dietary Director #35 on 07/31/19 at 7:34 A.M. verified he did not sanitize the thermometer probe between the pureed eggs, pancakes and pureed pancakes. 3. Observation of the B wing nurses station nourishment refrigerator on 08/01/19 at 10:39 A.M. revealed there to be an open boost breeze supplement (a nutritional supplement) that was uncovered, unlabeled and undated, an open TwoCal supplement (a nutritional supplement) that was uncovered, unlabeled and undated, an open slim fast (a nutritional supplement) that was undated and unlabeled and an unknown sandwich that was undated and unlabeled in the refrigerator. Interview with the Director of Nursing (DON) on 08/01/19 at 10:29 A.M. verified there to be an open boost breeze supplement that was uncovered, unlabeled and undated, an open TwoCal supplement that was uncovered, unlabeled and undated, an open slim fast that was undated and unlabeled and an unknown sandwich that was undated and unlabeled in the nourishment refrigerator on the B wing. Review of the facility's list of residents that received no food by mouth (NPO) revealed Resident #10 and #65 were NPO. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled Food Receiving and Storage, dated October 2018, revealed all foods stored in the refrigerator or freezer must be covered, labeled and dated. Review of the facility's food handling policy, dated December 2018, revealed all food service equipment and utensils will be sanitized according to current guidelines.

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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 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** 39967 Based on observation, record review and staff interview, the facility failed to ensure a resident's code status was accurately documented in the care plan and hard chart. The facility also failed to ensure an incident that caused a bruise to a resident's forehead was documented in the chart. This affected two (Resident #9 and #39) of 24 residents reviewed for complete and accurate medical records. The facility census was 79. Findings include: 1. Record review revealed Resident #9 was admitted to the facility on [DATE] with the diagnoses including dementia in other diseases classified elsewhere with behavioral disturbance, Alzheimer's disease with early onset, type two diabetes mellitus with diabetic neuropathy and recurrent depressive disorders. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/30/19, revealed the resident to be cognitively impaired. Review of Resident #9's chart revealed Resident #9 to have a full resuscitation paper signed by Resident #9's representative on 09/06/19. Resident #9's chart also contained a signed Do Not Resuscitate Comfort Care (DNRCC) signed by the physician on 06/05/19. Review of Resident #9's care plan revealed resident to be a full code. Interview with the Director of Nursing (DON) on 07/31/19 at 9:45 A.M. verified Resident #9's code status form in the hard chart indicating resident was a full code should have been removed. The DON also confirmed Resident #9's code status in the care plan was inaccurate. 2. Record review revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including other frontotemporal dementia, major depressive disorder, age related osteoporosis without current pathological fracture and gastroesophageal reflux disease without esophagitis. Review of the quarterly MDS assessment, dated 06/14/19 ,revealed the resident to be cognitively impaired. Review of Resident #39's progress notes from 06/01/19 to 07/31/19 revealed no information regarding bruising on Resident #39's forehead. Review of Resident #39's shower sheets from 06/01/19 to 07/31/19 revealed no information regarding bruising on Resident #39's forehead. Observation of Resident #39 on 07/29/19 at 11:50 A.M. and on 08/01/19 at 10:39 A.M. revealed resident to have a light yellow colored bruise approximately one inch by 0.5 inch on the right side of her forehead. Interview with the Director of Nursing (DON) on 08/01/19 at 10:39 A.M. verified the resident to have a light yellow colored bruise on the right side of her forehead. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #23 on 08/01/19 at 12:06 P.M. revealed Resident #39 walks with her head facing towards the ground. LPN #23 stated on 07/28/19 around 7:00 P.M. she witnessed Resident #39 hit her head on a wooden door while walking down the hall. LPN #23 reported she informed the charge nurse of the incident on 07/28/19. Interview with the DON on 08/01/19 at 12:06 P.M. revealed she was not made aware that resident had hit her head on a wooden door on 07/28/19. The DON confirmed there was no documented incident report or assessment of the resident after the incident on 07/28/19.