STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366432	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANCTUARY POINTE NURSING & REHABILITATION CENTER	11501 HAMILTON AVENUE CINCINNATI, OH 45231

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to notify the physician when a resident had to wait for transportation to the hospital emergency room . This affected one (#6) out of 31 residents sampled during the annual survey. Facility census was 103. Findings include: Review of the medical record for Resident #6 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6's cognition was severely impaired. Review of Resident #6's nursing notes dated 01/07/20 revealed a note which revealed the facility nurse practitioner had seen and examined Resident #6, ordered an antibiotic for the resident, intravenous fluids, orders for labs to be drawn on the morning of 01/08/20 and an order for [REDACTED].#6's nursing notes dated 01/08/20 at 2:14 P.M. revealed the resident's responsible party was notified of a new order to send Resident #6 out to the local hospital for a computerized topography (CT) due to altered mental status. Continued review of Resident #6's nursing notes dated 01/08/20 at 2:16 P.M. revealed the nurse practitioner was notified of abnormal lab values and at 3:10 P.M. contacted a local ambulance company for transport and was notified their first available pick up time for Resident #6 was 7:30 P.M. The nursing staff called report to the local hospital and the resident's responsible party was notified. Further review of Resident #6's nursing notes dated 01/08/20 at 3:41 P.M. revealed an order was given for a chest x-ray with two views and vitals signs every eight hours was given and the resident's responsible party was notified. Further review of Resident #6's nursing notes dated 01/08/20 at 10:40 P.M. revealed the facility had called the local ambulance company at 10:00 P.M. inquiring about the status of the pick up for Resident #6 to the local emergency room and was informed the previous dispatcher failed to schedule the pick up and the next available time 01/09/20 at 1:30 A.M. The facility contacted Resident #6's responsible party who informed the facility they couldn't get to the hospital at that hour in the morning and requested the facility move the CT to 7:00 A.M. on the morning of 01/09/20. The facility called the local ambulance company and moved the CT scan for Resident #6. Review of Resident #6's nursing note on 01/08/20 at 10:58 P.M. revealed the resident was noted with congestion and bright yellow drainage from her nose. Her blood pressure was noted as 190/82, pulse was 58 beats per minute, respirations were 16 and her oxygen saturation was noted as 98% on two liters of oxygen via nasal cannula. Resident #6's nursing notes revealed on 01/08/20 at 11:50 P.M. the physician was notified of abnormal lab results and gave another order to send the resident to the local emergency room for a CT scan. On 01/08/20 at 11:55 P.M. the results of Resident #6's chest x-ray came back which revealed frontal and lateral views of the chest compared with 03/04/19. Now seen mild central [MEDICAL CONDITION] venous fullness. No facial consolidation or effusion. No pneumothorax. Stable enlargement of the cardiac silhouette size. Aortic calcifications. [MEDICATION NAME] spondylosis. Impressions: 1. Central [MEDICAL CONDITION] venous congestion without overt [MEDICAL CONDITIONS]. 2. No focal pneumonia evident. Review of Resident #6's transfer discharge letter revealed the resident was sent out of the facility due to the resident's physician determined she required medical evaluation at the local hospital. Resident #6's documented blood pressure was documented as 196/81. Review of the local hospital admission paperwork dated 01/08/20 revealed Resident #6's admitting [DIAGNOSES REDACTED]. Interview on 03/10/20 at 10:44 with Licensed Practical Nurse (LPN) #200 revealed depending on the situation for a change in condition of a resident if the facility had called the local ambulance company and the company stated they were going to be two or three hours late she would notify the Director of Nursing (DON) and notify the physician to get an order to send the resident out via nine-one-one (911). LPN #200 stated it was expected to document the notification of the physician and family in progress notes. Interview on 03/11/20 at 11:44 A.M. with the DON revealed she expected her staff to assess the resident, notify the physician, get an order to send the resident out, obtain transport if it was a 911 or true emergency. The DON further explained the staff could call a local transport company if the physician was ok with that and they could schedule that as well. The DON stated that depended on the resident's condition and what was going on. The DON further explained the staff were to notify the family and call report to the hospital and it was the facility expectation to document everything in a progress note. Interview on 03/11/20 at 11:55 A.M. with the DON verified it was her expectation that the staff should have called the physician and notified him that there was a delay in Resident #6's transportation and the nursing staff should have asked to send the resident out. The DON verified the nursing staff failed to do that. Review of the facility policy titled Change of Resident Condition, Family and Physician Notification, undated revealed, if a residents physical, mental or psychosocial condition has significantly changed, call attending physician, and report changes and nursing observations as soon as is feasibly possible depending upon circumstances.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and review of the Resident Assessment Instrument (RAI) 3.0 manual, the facility failed to code a resident's minimum data set (MDS) assessment accurately to reflect the resident's prognosis. This affected one (#62) of one resident's reviewed for hospice services. The total facility census was 103. Findings include: Review of Resident #62's medical record revealed resident was admitted on [DATE]. [DIAGNOSES REDACTED]. Review of the resident physician orders [REDACTED]. Review of Resident #62's quarterly minimum data set ((MDS) dated [DATE] revealed the resident was coded under section J1400 as no, and section O0100-Special Treatment, Procedures and Programs; K-Hospice- as yes for receiving hospice services. Further review of question J1400 revealed the question was regarding the resident's prognosis and asks Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician documentation). Review of Resident #62's historic MDS's revealed section J1400 was coded no on MDS' dated 11/01/19, and 08/01/19 when the resident was receiving hospice services. During an interview with MDS Nurse #558 on 03/11/20 at 9:10 A.M. verified Resident #62 was receiving hospice services since July of 2019 and the nurse stated the facility codes J 1400 yes if the physician documents in the medical record the resident has a life expectancy of less than six months life expectancy. MDS Nurse #558 confirmed all Resident #62's MDS assessments since hospice services were ordered on [DATE] were coded no for J1400. Review of the RAI 3.0 Manual revealed to coding instructions for J1400: Code 0 or No: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services; Code 1 or Yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services.
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**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366432	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANCTUARY POINTE NURSING & REHABILITATION CENTER	11501 HAMILTON AVENUE CINCINNATI, OH 45231

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on medical record review and staff interview, the facility failed to follow physician's orders regarding monitoring resident's weights and/or implementing as needed medications as physician ordered related to a residents weight. This affected two (#54 and #55) out of 31 residents reviewed during the annual survey. Facility census was 103. Findings include: 1. Review of the medical record for Resident #54 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54's cognitive was moderately impaired. Review of Resident #54's current physician orders revealed an order for [REDACTED]. Review of Resident #54's February and March Medication Administration Records (MAR) and Resident #54's weight records revealed Resident #54 was missing weight entries on the following dates: 02/01/20, 02/09/20, 02/10/20, 02/15/20 through 02/21/20, 0[DATE], 02/27/20, 02/29/20, 03/05/20 and 03/06/20. Interview on 03/12/20 at 10:35 A.M. with the Director of Nursing (DON) verified Resident #54's February and March 2020 MAR and medical record contained gaps regarding monitoring his weights and the staff were not weighing Resident #54 according to the physician orders. 2. Review of the medical record for the Resident #55, revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS 3.0 assessment, dated 01/18/20, revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident was a one-person physical assist, required extensive or limited assistance for activities for daily living (ADL's), was occasionally incontinent to urine and always incontinent to bowel. Review of a plan of care dated 10/12/19 indicated Resident #55 was at risk for altered cardiovascular status related to [MEDICAL CONDITION], arrhythmia, hypertension, history of [MEDICAL CONDITION] infarction, and on diuretic therapy. Interventions included administer medications as ordered, daily weights and monitor for pedal [MEDICAL CONDITION]. Physician orders for Resident #55 dated 01/30/20 revealed resident was to be weighed daily before breakfast. Physician orders for Resident #55 dated 02/18/20 indicated if resident had weight increase of three pounds or more in one day or five pound in one week, resident was to receive as needed (PRN) [MEDICATION NAME] (water pill) 10 milligram (mg) one time a day for weight gain. Review of daily weights for Resident #55 from 02/01/20 to present revealed no evidence resident was weighed on 02/01/20, 02/02/20, 02/10/20, 02/12/20, 02/13/20, 02/21/20, 02/26/20, 02/27/20, 03/04/20, 03/10/20 and 03/11/20. Review of advanced provider noted notes dated 02/18/20 revealed resident was assessed for a weight gain and PRN [MEDICATION NAME] 10 mg was ordered for weight gain. Review of March 2019 MAR for Resident #55 revealed there was no documentation or any indication the resident received PRN [MEDICATION NAME] on 03/03/20 when a five-pound weight gain was discovered and on 03/07/20 when a three-pound weight gain was discovered. Review of nurse's progress notes for Resident #55 revealed there was no documentation or any indication the resident was weighed on 02/01/20, 02/02/20, 02/10/20, 02/12/20, 02/13/20, 02/21/20, 02/26/20, 02/27/20, 03/04/20, 03/10/20 and 03/11/20. Nurses progress notes contained no documentation regarding any indication resident received PRN [MEDICATION NAME] 10 mg on 03/03/20 and 03/07/20. Interview with Director of Nursing on 03/12/20 at 12:00 P.M. verified there was no evidence Resident #55 was weighed on 02/01/20, 02/02/20, 02/10/20, 02/12/20, 02/13/20, 02/21/20, 02/26/20, 02/27/20, 03/04/20, 03/10/20 and 03/11/20. DON also verified there was no evidence Resident #55 received PRN [MEDICATION NAME] 10 mg on 03/03/20 and 03/07/20 when a weight gain was discovered.
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff and resident interviews, the facility failed to provide timely care and services regarding audiology recommendations. This affected one (#75) of one residents reviewed for communication-sensory services. Facility census was 103. Findings include: Review of Resident #75 medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #75 medical record contained a signed consent for treatment for [REDACTED]. The resident required extensive assist for toileting, dressing, transfers, bed mobility, limited for hygiene, and supervision for eating. The resident is coded as being occasionally incontinent of urine and frequently incontinent of bowel. The resident received seven days of antipsychotic and antidepressant medications. Review of progress notes revealed on 02/12/20 at 11:53 A.M. the social services noted resident was seen by the ear nurse practitioner on 02/11/20. Record review revealed no audiology progress notes. Review of the medical record revealed there was no audiology consult note in the medical record. During an interview with Licensed Practical Nurse LPN #555 on 03/10/20 confirmed there was no audiology progress note in the resident medical record. During an interview with Resident #75 on 03/09/20 at 11:26 A.M. revealed the resident was seen by audiology when he/she came into the facility and had one ear cleaned out and the other could not be cleaned. Resident #75 further stated he/she was to have drops put in the ear but that has not happened yet and the resident stated by the time he/she gets the drops he/she will probably be deaf. During an interview with Social Services Director (SSD) #557 on 03/09/20 at approximately 3:00 P.M. revealed the audiologist nurse practitioner was at the facility on 02/11/20, the audiologist last visited the facility on 02/25/20. SSD #557 verified the progress notes from the audiologist visits should be in the resident hard medical record kept on the hall. During an interview with the Director of Nursing on 03/11/20 at 7:43 A.M. confirmed the audiologist progress note was not in Resident #75's medical record and the nursing staff was unaware of the recommendation made on 02/11/20. The DON provided the audiology note at this time and the note was reviewed with the DON revealed Resident #75 was seen by the audiologist on 02/11/20 and the note revealed the resident had ear fullness and the symptoms are reported as severe. The note documented Resident #75 wants wax removed at the visit. The wax removal was noted to be successful for the left ear, but the procedure was documented as incomplete in the right ear. The plan included: right ear unable to clear ear obstruction at this visit, if no contraindication (no history of tympanic membrane rupture, ear surgeries, or trauma and with primary care physician approval,) would recommend [MEDICATION NAME] five drops (gtts) twice daily for three days in the right eat then a gentle warm water rinse on the fourth day or defer to the primary care physician for treatment of [REDACTED]. Attempt re-treat in one to three months. The DON stated the progress note was provided to him/her from the SSD #557 on 03/10/20. The DON verified Resident #75 had not received the recommended [MEDICATION NAME] treatment as nursing was not aware of the recommendation until 03/10/20, and at that time the resident received an order from the physician to have the [MEDICATION NAME] drops initiated. During an interview with SSD #557 on 03/11/20 at 9:21 A.M. revealed the SSD scans the audiology notes into their computer and then gives them to the unit manager. SSD #557 states he/she did not know if the notes were on the resident chart or not prior to 03/10/20.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview, and policy review, the facility failed to ensure residents head of bed (HOB) was at or greater than 30 degrees during a bolus gastrostomy tube ([DEVICE]) feeding administration and facility failed to ensure resident had a gauze covering her stoma for a [DEVICE]. This affected one (#4) of the 15 residents reviewed during the survey. Facility census was 103. Findings include: Review of the medical record for the Resident #4, revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set (MDS) 3.0 assessment, dated 02/26/29, revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander. Resident was a two-person physical assist, dependent for eating, and dependent or required extensive assistance for activities of daily living (ADL's). Review of plan of care for Resident #4 dated 11/27/17 revealed resident required tube feeding (TF) related to dysphagia, swallowing problems and resident had a [DEVICE]. Interventions included elevated head of bed (HOB) 30 to 45 degrees during and thirty minutes after TF; provide local care to [DEVICE] site as ordered and monitor for signs and symptoms of infection. Review of physician orders [REDACTED]. Physicians orders dated 01/16/20 revealed resident was to receive bolus feed of Diabetisource 250 milliliters (ml) twice daily at 11:00 A.M. and 4:00 P.M. and a 40 ml water flush before and after bolus. Physician orders [REDACTED]. Physician orders [REDACTED]. Observation of Resident #4 being transferred from a wheelchair by State tested Nurses Aide (STNA) #33 and RN #280 on 03/11/20 at 11:08 A.M. and placed resident in her bed with the HOB in a flat position. Observation of bolus feeding via [DEVICE] for Resident #4 on 03/11/20 at 11:15 A.M. by Registered Nurse (RN) #280 revealed resident was lying in bed with HOB in the flat position. Observation revealed RN #280 flushed the [DEVICE] with 40 ml of water and administered approximately half of the 250 ml carton of Diabetisource when resident complained of being uncomfortable in the bed. RN #280 used the hand control for bed to elevate the HOB slightly but still well below 30 degrees, completed the bolus feed and administered a 40 ml water flush with HOB below 30 degrees. Observation of bolus feeding also revealed no evidence of a dressing covering resident's [DEVICE] stoma site. Interview with RN #280 on 03/11/20 at 11:25 A.M. verified Residents #4's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366432	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANCTUARY POINTE NURSING & REHABILITATION CENTER	11501 HAMILTON AVENUE CINCINNATI, OH 45231

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 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) HOB was below 30 degrees when she administered the bolus feeding of Diabetisource and water flush before and after. RN #280 stated the HOB should have been at 30 degrees or more during enteral bolus feeding. RN #280 also verified there was no dressing was in place over resident's stoma. RN #280 stated she recently assumed care for resident due to a nurse going home sick. Review of undated policy titled Enteral Feeding reveled enteral feedings will be provided according to physician's orders [REDACTED]. Policy also revealed the residents HOB was to be placed at 30 degrees or higher.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to timely remove and dispose of discontinued controlled narcotics being stored in the medication carts. This affected two (#60 and #355) residents out of four medication storage areas observed during the survey. Facility census was 103. Findings include: 1. Observation of the 300-B hall medication storage cart with Licensed Practical Nurse (LPN) #230 on 03/11/20 at 8:56 A.M. revealed two discontinued [MEDICATION NAME] (Scheduled II controlled narcotic pain patches) 50 micrograms (mcg)/hour (hr) for Resident #60 in the locked narcotic bin. Interview with LPN #230 on 03/11/20 at 8:57 A.M. verified the two discontinued controlled [MEDICATION NAME]es for Resident #60 were discontinued on 01/15/20. LPN #230 stated Registered Nurse (RN) #250 and the Director of Nursing (DON) were supposed to remove the discontinued controlled medications on a weekly basis. 2. Observation of 100-B hall medication storage cart with LPN #100 on 03/11/20 at 9:15 A.M. revealed two discontinued [MEDICATION NAME] (Scheduled II controlled pain medication) five milligram (mg) cards for Resident #355 in the locked narcotic bin. Observation revealed 59 tablets of [MEDICATION NAME] five mg remained in the storage bin for Resident #355 and the last recorded administration was noted on 01/19/20. Interview with LPN #100 on 03/11/20 at 9:16 A.M. verified the discontinued [MEDICATION NAME] five mg for Resident #355 being stored in the medication cart. LPN #100 stated Resident #355 was discharged on [DATE] and family was supposed to come back and get it on 02/21/20. LPN #100 stated [MEDICATION NAME] five mg card should have been removed by RN #250 and DON. Interview with RN #250 on 03/11/20 at 9:41 A.M. verified the discontinued controlled medications for Residents (#60 and #355) were being stored in the medication carts. RN #250 stated discontinued controlled medications should be removed from the medication carts within one week.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to discard discontinued controlled narcotics and discard an opened influenza (flu) vaccine after it expired. This affected one out of four medication storage areas observed during the survey and had the potential to affect four (#1, #17, #22 and #104) residents on 100 hallway who could potentially receive the expired flu vaccine. Facility census was 103. Findings include: Observation of 100 hall medication storage room refrigerator on [DATE] at 9:12 A.M. with RN #50 revealed one multi vial flu vaccine dated [DATE]. Interview with RN #50 on [DATE] at 9:13 A.M. verified the multi vial flu vaccine was opened and dated [DATE] being stored inside the refrigerator. RN #50 stated the multi vial flu vaccine should have discarded 28 days after it was opened. RN #50 confirmed this had the potential to affect four (#1, #17, #22 and #104) residents on 100 hallway who could potentially receive the expired flu vaccine.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews with a local health department Epidemiologist and facility staff, review of the Ohio Department of Health Infection Disease Control Manual and review of the Ohio Administrative Code (OAC), the facility failed to report an outbreak of suspected scabies to local and state health departments. This affected five (#6, #25, #40, #54, and #306) of five residents reviewed and had the potential to affect all 103 residents residing in the facility. The facility in-house census was 103. Findings include: 1. Review of the medical record for the Resident #25, revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set (MDS) 3.0 assessment, dated 12/31/19, revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident was a one-person physical assist and required supervision for activities of daily living (ADL's). Review of physician orders [REDACTED]. Physician orders [REDACTED]. Physician orders [REDACTED]. Review of advanced provider notes for Resident #25 dated 02/27/20 revealed resident was assessed to have an acute scabies outbreak. Physician orders [REDACTED]. were discussed with nursing staff. Review of nurse's progress notes from 02/27/20 through 03/10/20 revealed resident was in contact isolation for scabies. Further review of the February and March 2020 Medication Administration Record [REDACTED]. Interview with Director of Nursing (DON) on 03/12/20 at 12:10 P.M. verified Resident #25 was in contact isolation for scabies from 02/27/20 through 03/10/20 and verified resident was treated for [REDACTED]. 2. Review of the medical record for the Resident #40, revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set (MDS) 3.0 assessment, dated 01/08/20, revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident required supervision for ADL's. Review of nurse's progress notes for Resident #40 dated 03/05/20 revealed resident was ordered [MEDICATION NAME] cream and resident was to be in contact isolation for skin rash. Review of physician orders [REDACTED]. Physician orders [REDACTED]. Review of MAR for Resident #40 revealed resident was treated with [MEDICATION NAME] Cream five percent as ordered on [DATE]. Interview with DON on 03/12/20 at 12:12 P.M. verified Resident #40 was in contact isolation for scabies and was treated for [REDACTED]. 3. Review of the medical record for Resident #6 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/09/20, revealed the resident had severe cognitive impairment. Further review of the MAR for Resident #6 revealed the resident was treated with [MEDICATION NAME] Cream five percent on 03/07/20 apply to entire body topically one time only for suspected scabies for one day leave in place for eight hours, then shower off. Repeat in seven days. Review of the nurse's progress notes for Resident #6 dated 03/06/20 revealed the resident was ordered [MEDICATION NAME] cream and the resident was in contact isolation and treated for [REDACTED]. Review of the medical record for Resident #54 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/18/20, revealed the resident had moderate cognitive impairment. Further review of the MAR for Resident #54 revealed the resident was treated with [MEDICATION NAME] Cream five percent on 03/06/20 apply to entire body topically one time only for suspected scabies for one day leave in place for eight hours, then shower off. Repeat in seven days. Review of the nurse's progress notes for Resident #54 dated 03/05/20 revealed the resident was ordered [MEDICATION NAME] cream and the resident was in contact isolation and treated for [REDACTED]. Review of the medical record for Resident #306 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the five-day admission MDS assessment, dated 02/28/20, revealed the resident had severe cognitive impairment. Further review of the MAR for Resident #306 revealed the resident was treated with [MEDICATION NAME] Cream five percent on 03/06/20 apply to entire body topically one time only for suspected scabies for one day leave in place for eight hours, then shower off. Repeat in seven days. Review of the nurse's progress notes for Resident #306 dated 03/05/20 revealed the resident was ordered [MEDICATION NAME] cream and the resident was in contact isolation and treated for [REDACTED].M. the local county health department Epidemiologist #1000 stated health facilities are expected to reported two or more cases of suspected scabies skin infections. Epidemiologist #1000 confirmed the facility had not reported any reportable diseases in the last 30 to 60 days. Interview on 03/11/20 at 1:25 P.M. with Registered Nurse (RN) #650 who stated the facility collectively discussed the situation related to the treatment of [REDACTED].#40, #6, #54 and #306) residents for suspected scabies but not did call to report. The facility confirmed the failure to report the outbreak to the local health department had the potential to affect all 103 residents residing in the facility. Review of the ODH's Infection Disease Control Manual dated May 2015 and the OAC Chapter 3701-3 revealed that scabies is considered a Class C reportable infectious disease. Outbreaks, unusual incidents, or epidemics should be reported by the end of the next business day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366432	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANCTUARY POINTE NURSING & REHABILITATION CENTER	**11501 HAMILTON AVENUE CINCINNATI, OH 45231**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3)