STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365892	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BURLINGTON HOUSE REHAB & ALZHEIMER'S CARE CENTER	2222 SPRINGDALE ROAD CINCINNATI, OH 45231

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F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review, the facility failed to provide or arrange for residents to have access to prescribed pain medication upon discharge from the facility. This affected one (#106) of three residents reviewed for discharge planning. The census was 101. Findings include: Review of the medical record for Resident #106 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #106 dated 03/18/20 revealed resident was cognitively intact and required extensive assistance of staff with activities of daily living. Review of the MDS for Resident #106 dated 04/02/20 revealed Resident #106 was discharged with a return not anticipated. Review of the March 2020 monthly physician orders for Resident #106 revealed an order for [REDACTED].#106 dated 03/12/20 revealed resident had pain related [MEDICAL CONDITION] with metastasis to the bone. Interventions included: administer [MEDICATION NAME] as per orders, and monitor/record pain characteristics when pain is voiced and as needed. Review of the discharge care plan for Resident #106 dated 03/13/20 revealed resident was a new admission to the facility with discharge potential with a stay in the facility projected to be of short duration. Interventions included to provide resident with needed education and teaching for a safe discharge to the community. Review of the April 2020 Medication Administration Record [REDACTED].M. for pain rated as 10 out of 10 (on a scale of 1 to 10 with 10 being the worst pain) and a routine dose of [MEDICATION NAME] on 04/02/20 at 8:00 A.M. for pain which was rated as 10 out of 10 Review of nurse progress notes for Resident #106 dated 04/02/20 revealed the resident was discharged to home with a three-day supply of medication excluding prescribed narcotic medication ([MEDICATION NAME] and [MEDICATION NAME]). Review of discharge summary for Resident #106 dated 04/02/20 revealed resident had a follow up appointment scheduled with her primary care physician on 04/06/20 and had medication orders which included routine [MEDICATION NAME] and as needed [MEDICATION NAME] pain. Interview with the Director of Nursing (DON) on 09/14/20 at 1:47 P.M. confirmed it was the facility's practice to send a three-day supply of medication with the resident upon discharge from the facility to the community. Interview with the DON on 09/15/20 at 3:17 P.M. confirmed the facility did not send a three-day supply of Resident #106's [MEDICATION NAME] or [MEDICATION NAME] with resident upon her discharge from the facility on 04/02/20 nor did the facility arrange for resident to receive her medications upon discharge. Review of the facility policy titled Transfer and discharge date d 05/28/19 revealed the facility would develop a discharge plan for each resident which identified the discharge needs of the resident and addressed the resident's goals of care and treatment preferences. This deficiency substantiates Complaint Number OH 290 and Complaint Number OH 470.
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** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to use clean bandage scissors during a dressing change for a pressure ulcer. This affected one (#13) of three residents reviewed for pressure ulcers. The census was 101. Findings include: Review of the medical record for Resident #13 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #13 dated 07/01/20 revealed resident was cognitively impaired, required extensive assistance of two staff with activities of daily living and was coded positively for the presence of an unstageable pressure ulcer. Review of the monthly physician's orders [REDACTED]. Observation on 09/08/20 at 10:01 A.M. of the dressing change to Resident #13's left heel performed by Registered Nurse (RN) #275 revealed the nurse used bandage scissors which were taken directly from a pocket on the nurse's uniform to remove the soiled dressing from resident's left heel. RN #275 did not sanitize the scissors after removing them from the uniform pocket. Interview on 09/08/20 at 10:15 A.M. with RN #275 confirmed the employee removed the bandage scissors from their uniform pocket without sanitizing them and used the scissors to assist in removing the dressing from Resident #13's left heel. Review of the facility competency checklist undated titled Uncomplicated Dressing Changes revealed if scissors were used during a dressing change, they should be cleaned with a disinfectant wipe. This deficiency substantiates Complaint Number OH 290.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure medication carts were locked to prevent resident access to medications. This had the potential to affect one (#3) of 10 residents observed for medication administration. The census was 101. Findings include: Review of the medical record for Resident #3 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #3 dated 08/05/20 revealed resident was cognitively impaired, was coded as positive for the presence of behavioral symptoms and used a wheelchair for mobility. Observation of medication administration on 09/09/20 with Registered Nurse (RN) #625 from 6:57 A.M. to 7:47 A.M. revealed Resident #3 was observed propelling herself up and down the hall in her wheelchair. Resident #3 was making repetitive requests for medication, and RN #625 redirected resident away from the cart multiple times and told resident she was not due yet for medication. Observation on 09/09/20 at 7:15 A.M. revealed RN #625 went into Resident #19's room and left the medication cart unlocked. The nurse was inside Resident #19's room and did not have visual control of the cart. On 09/09/20 at approximately 7:19 A.M. Resident #3 was observed pulling on the drawers of the unlocked medication cart attempting without success to open them. Interview on 09/09/20 at 7:20 A.M. with RN #625 confirmed she had left the cart unlocked and unattended for approximately five minutes. Review of facility policy titled Medication Administration dated 05/29/17 revealed the medication cart should never be left unlocked.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy the facility failed to properly document the administration of oxygen. This affected one (#106) of three residents reviewed for oxygen administration. The census was 101. Findings include: Review of the medical record for Resident #106 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #106 dated 03/18/20 revealed resident was cognitively intact and required extensive assistance of staff with activities of daily living. Review of the MDS for Resident #106 dated 04/02/20 revealed Resident #106 was discharged with a return not anticipated. Review of the Medication Administration Record (MAR) for March 2020 MAR for Resident #106 revealed it did not include documentation of oxygen administration. Further review of the Treatment Administration Record (TAR) for March 2020 for Resident #106 revealed it did not include documentation of oxygen administration. Review of physician orders for Resident #106 for March 2020 revealed they did not include an order for [REDACTED].#106 revealed the resident received oxygen at three liters per

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

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

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) minute per nasal cannula. Review of the care plan for Resident #106 dated 03/27/20 revealed resident received continuous oxygen therapy related to [MEDICAL CONDITION], ineffective gas exchange, and [MEDICAL CONDITION]. Interventions included to administer oxygen continuously at three liters per nasal cannula. Interview on 09/15/20 at 3:30 P.M. with the Director of Nursing (DON) confirmed Resident #106 received oxygen routinely at three liters per minute during her stay at the facility. The DON further confirmed Resident #106's March 2020 physician orders did not include an order for [REDACTED]. Review of the facility policy titled Oxygen Therapy Safety Standards dated 12/21/18 revealed oxygen use is considered a medication and follows the same medication regulations including obtaining a physician order for [REDACTED]. Further review of the policy revealed the nurse would document the use of oxygen in the medical record. This deficiency substantiates Complaint Number OH 470.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on record review, staff interview, and review of facility policy, the facility failed to document the shift to shift controlled substance count for the South Unit Music Hall medication carts. This had the potential to affect residents five (#3, #34, #53, #58 and #61) residents with controlled substance medications stored in the carts. The census was 101. Findings include: Review of the South Unit Music Hall medication cart shift to shift controlled substance count sheets revealed the sheets did not include the signature of the nurse going off duty and the nurse coming on duty on 09/08/20 at 7:00 P.M. nor did they include the total number of controlled substance sheets associated with each cart. Interviews on 09/09/20 at 6:57 A.M. with Registered Nurse (RN) #625 and Licensed Practical Nurse (LPN) #400 confirmed they had counted the controlled substances in the South Unit Music Hall medication cart together on 09/08/20 at 7:00 P.M. RN #625 and LPN #400 confirmed neither nurse had signed the count sheet nor had either nurse documented the total number of controlled substance sheets associated with each cart. The facility confirmed there are five (#3, #34, #53, #58 and #61) residents with controlled substances in the South Unit Music Hall medication cart. Review of facility policy titled Chain of Custody for Controlled Substances dated 05/29/20 revealed nursing staff would count controlled medications at the end of each shift or at any time the narcotic keys are given to another nurse for any reason. Further review of the policy revealed the nurse coming on duty and the nurse going off duty must make the count together and both nurses should sign the designated controlled substance forms.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of facility policy, and review of online resources from the United States Food and Drug Administration (FDA), the facility failed to serve food in a sanitary manner. This affected seven (#7, #20, #30, #48, #67, #88, #91) of seven residents observed for dining. The census was 101. Findings include: 1. Review of the medical record for Resident #88 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #88 dated 08/27/20 revealed the resident was severely cognitively impaired and required supervision with eating. Observation on 09/08/20 at 12:48 P.M. revealed Registered Dietitian (RD) #600 was holding a sandwich in her bare hands and was feeding it to Resident #88 who was standing in the doorway of her room taking bites of the sandwich. Interview on 09/08/20 at 12:48 P.M. with RD #600 confirmed she was holding a sandwich with her bare hands and was feeding it to Resident #88. Review of the FDA Food Code dated 2013 on pages 415-416 revealed employees having bare-hand contact with ready-to-eat food was prohibited and placed individuals in highly susceptible populations such as persons who are immunocompromised or elderly at increased risk for infection and food borne illness. 2. Observation of the luncheon meal service on 09/08/20 revealed State tested Nursing Assistant (STNA) #575 arrived in the North Hall at approximately 12:28 P.M. and delivered and set up meal trays in the North Hall dining area for Resident #20 at 12:30 P.M., for Resident #30 at 12:30 P.M., for Resident #7 at 12:33 P.M., and for Resident #48 at 12:35 P.M. STNA #575 delivered a room tray to Resident #91 at 12:37 P.M. At 12:45 P.M. STNA #575 delivered a room tray to Resident #67 and assisted with setting up the resident's meal. At 12:46 P.M. STNA #575 returned to the North Hall dining room, poured a glass of milk and a glass of juice and carried them uncovered down the hallway turned at the nurses station and went to the end of another hallway and delivered the beverages to Resident #67's room. The observations revealed STNA #575 did not sanitize her hands during the meal service. Interview on 09/08/20 at 12:49 P.M. with STNA #575 confirmed she had not sanitized her hands prior to assisting with the meal service or during the meal service. STNA #575 further confirmed she had transported Resident #67's beverage uncovered from the North Hall dining area to the resident's room and food and beverages should be covered during transport through the facility. Review of the facility policy titled Standard Precautions dated 10/31/18 revealed staff should perform hand hygiene before feeding or assisting in the dining room and tray pass. Review of the facility policy titled Infection Prevention Program dated 01/25/20 revealed the facility would provide a safe environment for residents which reduces the risk of acquiring infections.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on observation, staff and vendor interview, review of facility documents, review of facility policy, and review of online resources from the Centers for Disease Control (CDC) and the Ohio Department of Health (ODH), the facility failed to implement and maintain appropriate infection control measures, including ensuring staff/vendors wore masks, wore masks appropriately and/or maintained social distancing in resident/staff areas of the facility; ensuring staff and vendors were screened prior to entering the resident care area; ensuring staff practiced appropriate hand hygiene during medication administration, to potentially prevent the spread of Coronavirus Disease 2019 (COVID-19). This had the potential to affect all 101 residents residing in the facility. The census was 101. Findings include: 1. Observation on 09/08/20 at 8:40 A.M. of Hospitality Aide (HA) #150 revealed employee was seated behind the front desk and was functioning as the screener for essential visitors to the facility. Further observation of HA #150 revealed employee was wearing a facemask positioned below her nose. Interview on 09/08/20 at 8:45 A.M. with HA #150 confirmed her facemask was positioned below her nose and it should cover her nose and mouth. Observation on 09/08/20 A.M. of Occupational Therapist (OT) #200 on 09/08/20 at 9:35 A.M. revealed employee was seated in the therapy gym wearing a facemask positioned below his nose. Further observation revealed OT Student #175, Speech Therapist (ST) #225, and Resident #12 were in the therapy gym at 9:35 A.M. and Certified Occupational Therapy Assistant (COTA) #250 entered the gym at 9:41 A.M. Interview on 09/08/20 at 9:42 A.M. with OT #200 confirmed he was wearing a facemask positioned below his nose and it should cover the nose and mouth. Observation on 09/08/20 at 9:59 A.M. of Maintenance Director (MD) #350 in the resident hallway revealed employee was wearing a mask positioned below his nose. Interview on 09/08/20 at 10:00 A.M. with MD #350 confirmed he was wearing a facemask positioned below his nose and it should cover the nose and mouth. Observation on 09/08/20 at 10:34 A.M. of State tested Nursing Assistant (STNA) #475 on the resident hallway revealed employee was wearing a facemask positioned below her nose. Interview on 09/08/20 at 10:35 A.M. with STNA #475 confirmed she wearing a facemask positioned below her nose and it should cover the nose and mouth. Interview on 09/16/20 at 10:00 A.M. with Registered Nurse (RN) #275 the facility's Infection Preventionist confirmed staff should wear facemask's at all times in work areas to prevent the spread of COVID-19 and masks should cover the mouth, nose and chin. Review of the facility policy titled PPE Masks dated 10/31/18 revealed facemask's should be placed over the nose, mouth, and chin and the flexible nose piece at the top of the mask should be pinched slightly to secure it in place. 2. Observation on 09/08/20 at 9:39 A.M. of Speech Therapist (ST) #225 revealed employee was seated at a desk in the therapy gym and was not wearing a mask. Further observation revealed OT #200, OT Student #175, and Resident #12 were in the therapy gym at 9:39 A.M. and COTA #250 entered the gym at 9:41 A.M. Interview on 09/08/20 at 9:40 A.M. with ST #225 confirmed she had started work at 9:00 A.M. on 09/08/20 and had not donned a mask since arriving at the facility. ST #225 confirmed she had not taken her temperature or completed the COVID 19 signs and symptom screening since arrival at work at 9:00 A.M. on 09/08/20. Observation on 09/08/20 at 9:41 A.M. of Certified Occupational Therapy Assistant (COTA) #250 revealed employee entered the therapy gym with residents and staff present and was not wearing a mask. Interview on 09/08/20 at 9:42 A.M. with COTA #250 confirmed employee had entered the building through a side entrance and had not

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) completed the COVID-19 signs and symptom screening form prior to entering the therapy gym and was not wearing a mask. Interview on 09/08/20 at 10:35 A.M. with STNA #475 confirmed she had arrived at work on 09/08/20 at 7:00 A.M. but had not checked her body temperature or completed a COVID-19 sign and symptom screening prior to starting work. Observation on 09/09/20 at 9:13 A.M. revealed Housekeeper #675 was mopping the floor in a staff hallway just outside the kitchen and the laundry room and adjacent to the elevator. Housekeeper was not wearing a mask. Interview on 09/09/20 at 9:15 A.M. with Housekeeper #675 confirmed she had removed her mask while she was outside on break and did not don the mask when she returned to work. Housekeeper #675 further confirmed she had a mask provided by the facility and she forgot to put it back on. 3. Observation on 09/09/20 at 9:20 A.M. revealed STNA #700, Nursing Assistant (NA) Trainee #725, and NA Trainee #750 were sitting next to one another (closer than six feet to one another) in the admissions office watching a video. Further observation revealed STNA #700 and NA Trainee #725 and #750 were wearing their masks below their nose. Interview on 09/09/20 at 9:20 A.M. with the Administrator confirmed STNA #700 and NA Trainee #725 and #750 were sitting next to one another closer than six feet apart in the admissions office and were wearing their masks positioned below their noses. Interview on 09/09/20 at 9:21 A.M. with Human Resources Director #775 confirmed STNA #700 and NA Trainee #725 and #750 were in orientation and had been assigned to watch a video in the admissions office as part of their training. Interview on 09/16/20 at 10:00 A.M. RN #275 confirmed staff should complete a COVID-19 signs and symptom screening form immediately upon arriving at work, should wear masks while in the facility, and should maintain social distancing (a distance of at least six feet between other individuals) as much as possible. Review of online resource from the CDC (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html) revealed the following guidance regarding facemask's: ensure all healthcare care personnel (HCP) wear a facemask for source control while in the facility. Review of ODH Director's Order dated 07/08/20 revealed(NAME)County, the county in which the facility was situated, was experiencing a very high exposure and spread of COVID 19 and facial coverings were required at all times while in(NAME)County in any indoor space that was not a private residence. 4. Observation on 09/08/20 at 10:31 A.M. revealed Vendor #425 was working on the ice machine on the West unit in area where residents and staff were present. Interview on 09/08/20 at 10:32 A.M. with Vendor #425 confirmed he had not been asked to have his temperature taken or to complete a COVID-19 sign and symptom screening prior to being admitted to the resident care area of the facility. Observation on 09/08/20 at 10:38 A.M. revealed Vendor #525 was in Resident #28's room while resident was in bed. Further observation revealed Vendor #525 was wearing a cloth face covering and was setting up a bed in the resident's room. Resident #28 was not wearing a mask or face covering. Interview on 09/08/20 at 10:39 A.M. with Vendor #525 confirmed he was delivering a bed to Resident #28's room and he had brought the cloth mask from home. Vendor #525 further confirmed the facility had not offered him a facemask and confirmed he had not been asked to have his temperature taken or to complete a COVID-19 sign and symptom screening prior to being admitted to the resident care area of the facility. Interview on 09/16/20 with RN #275 confirmed all vendors should be screened for signs and symptoms of COVID-19 and have their temperature checked and this information should be recorded on the visitor screening log prior to vendor entering the resident care area. Further interview confirmed any individual entering the resident care area should wear a medical grade facemask provided by the facility. Review of the facility visitor screening log dated 09/08/20 revealed it did not include an entry for screening of Vendor #425 or #525 body temperature upon entry to the facility or a screening of COVID-19 signs and symptoms. At the top of the log a statement indicated any visitor entering the facility including vendors must have their temperature recorded before entering resident areas. The log had spaces to record the visitors name, date and time in and out of the facility, area of the facility visiting, acceptable body temperature, presence or absence of COVID-19 signs and symptoms, screening for international travel, screening for presence in other facilities with COVID-19 and initials of staff person conducting the screening. 5. Observation on 09/09/20 at 6:57 A.M. revealed RN #625 donned gloves and administered medication to Resident #78. RN #625 then removed and discarded the gloves and did not sanitize her hands. RN #625 donned a new pair of gloves and prepared medication for Resident #19 and administered medications to resident in her room at 7:15 A.M. At 7:20 A.M. RN #625 returned to the medication cart and removed her gloves. Interview on 09/09/20 at 7:20 A.M. with RN #625 confirmed she was wearing gloves for medication administration because she didn't have hand sanitizer on her cart. Review of facility policy titled Medication Administration dated 05/29/19 revealed the nurse should perform hand hygiene before and after each resident's medication is administered. This deficiency substantiates Complaint Number OH 066 and Complaint Number OH 548.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that a working call system is available in each resident's bathroom and bathing area.** Based on observation, staff interview, and review of facility policy, the facility failed to ensure the staff had pager devices on their person to receive resident calls for assistance via the facility's wireless call light system. This had the potential to affect all 101 residents residing in the facility. The census was 101. Findings include: Observation on 09/10/20 at 11:40 A.M. on the North Hall revealed Licensed Practical Nurse (LPN) #800 had a functioning portable pager on her person which emitted an audible and visual signal when a resident call light was pressed. Further observation of the North Hall revealed the resident hallways had LED (light emitting diode) display devices which showed the correct time and also displayed the room number when a resident's call light was activated. Interview on 09/10/20 at 11:40 A.M. with LPN #800 confirmed each resident hallway had an LED display hanging from the ceiling in the hallway which showed the room number when a call light was activated. LPN #800 further confirmed the only audible signal to the staff when a call light was activated was via the portable pager which she had with her. Observation on 09/10/20 at 11:45 A.M. on the West Hall revealed the LED display portion of the call light system was functioning and lit up with the room number when the call light was activated. Interviews on 09/10/20 with State tested Nursing Assistant (STNA) #850 and #875 at 11:47 A.M. and with LPN #500 at 11:48 A.M. confirmed they did not have pagers connected with the call light system in their possession and had not had them during the entire shift. Observation on 09/10/20 at 11:49 A.M. of the South Hall revealed the LED display portion of the call light system was functioning and lit up with the room number when the call light was activated. Interview on 09/10/20 with STNA #325 at 11:50 A.M. confirmed usually carried a pager with her but had left it at the nurses' station. Interview on 09/10/20 with STNA #900 at 11:51 A.M. confirmed she had a pager with her from the start of her shift at 7:00 A.M. but it had stopped functioning about an hour ago. Interview on 09/10/20 at 11:52 A.M. with LPN #925 and at 11:53 A.M. with LPN #950 confirmed nurses did not have pagers and they thought only STNA's carried the pagers. Interview on 09/10/20 at 11:57 A.M. with STNA #975 confirmed she did not have a pager in her possession, and she hadn't had one for several weeks while at work. Interview on 09/10/20 at 11:58 A.M. with STNA #575 confirmed she did not have a pager because she was still in orientation. Interview on 09/10/20 at 12:10 P.M. with RN #275 confirmed LPN #800 was the only staff person in the facility who had a pager connected with the call light system in her possession during the tour of the facility. RN #800 confirmed all staff were supposed to carry pagers with them so they would get a direct communication/signal when a call light was pressed. Interview on 09/15/20 at 3:30 P.M. with the Director of Nursing (DON) confirmed all nurses and STNA's working on the floor should be carrying a functioning pager connected to the call light system throughout their shift. The facility confirmed all residents have the ability to use the call light system. Review of the facility policy titled Call Lights dated 09/10/20 revealed the facility would provide residents with a device to signal staff when needed. This deficiency substantiates Complaint Number OH 470.