STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366470	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESLEY WOODS AT NEW ALBANY	4588 WESLEY WOODS BLVD NEW ALBANY, OH 43054

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review the facility failed to ensure a signed advanced directive for a resident was available. This affected one (Resident #113) of nine residents reviewed for advanced directives. The facility census was 9. Findings include: Review of Resident #113's electronic medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of physician orders [REDACTED]. Review of Resident #113's admission medicare five day Minimum Data Set (MDS) 3.0 dated 03/06/20 revealed a Brief Interview for Mental Status (BIMS) score of 09 indicating mild to moderate cognitive impairment. Resident #113 required extensive assistance from two staff members for bed mobility, transfers, toilet use and personal hygiene, and was independent with set up help only for eating. Resident #113 had no impairment to her upper extremities and impairment to one of her lower extremities. Resident #113 was frequently incontinent of bowel and bladder. Interview on 03/09/20 at 11:10 A.M. with Registered Nurse (RN) #68 revealed when a resident was admitted , their code status and advanced directive was placed in the facility's code book. In the event of a code, staff could easily access the code book to check and see what the resident's code status was. Every resident in the facility should have a signed advanced directive in the code book. Observation on 03/09/20 at 11:20 A.M. of the facility's code status book revealed no evidence of a signed advanced directive for Resident #113. Interview on 03/10/20 at 4:21 P.M. with the Director of Nursing (DON) confirmed Resident #113 did not have a signed directive in the code status book. The DON confirmed Resident #113 wished to be a DNRCC and the advanced directive was not signed by the physician until 03/09/20.
F 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the resident assessment indicator (RAI) 3.0 manual the facility failed to complete a significant change assessment after Resident #9 was admitted to end of life (Hospice) services. This affected one Resident (#9) of three reviewed for Hospice services. The facility census was nine. Findings include: Record review revealed Resident #9 was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Review of physician orders [REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessments revealed there was no significant change assessment completed within 14 days after Resident #9 was admitted to Hospice services. Interview on 03/10/19 at 1:48 P.M. with the Director of Nursing (DON) revealed Resident #9 did not have significant change assessment completed. The DON verified according to the MDS 3.0 manual the significant change assessment should have been completed within 14 days of the resident's admission to Hospice services. Review of the RAI 3.0 manual revealed a significant change assessment must be completed within 14 days of an admission to Hospice services.
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 observation, interview, and medical record review the facility failed to ensure fall interventions were in place for Resident #113. This affected one (Resident #113) of four residents reviewed for accidents. The facility census was nine. Findings include: Review of Resident #113's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #113's baseline care plan dated 02/29/20 revealed Resident #113 was at risk for falls due to a history of falls in the community. Interventions to prevent falls included, a low bed, fall mats, and non-slip socks. Review of Resident #113's Fall Risk Assessment completed for 03/02/20 revealed Resident #113 was at a high risk for falls due to a history of falls in the community which resulted in a fracture of her right femur. Review of Resident #113's admission medicare 5 day Minimum Data Set (MDS) 3.0 dated 03/06/20 revealed a Brief Interview for Mental Status (BIMS) score of 09. Resident #113 required two staff assistance for bed mobility, transfers, dressing, and toilet use. Multiple observations from 03/09/20 through 03/11/20 between 10:00 A.M. and 4:30 P.M. revealed Resident #113's bed was not in the lowest position at any time, there were no floor mats beside resident's bed or in her room and the resident did not have non-slip socks on at any time during these observations. On 03/11/20 at 12:00 P.M. the Director of Nursing (DON) confirmed Resident #113's fall interventions were not in place at anytime during the above noted observations.
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, observation, staff interview and review of facility policy the facility failed to ensure Oxygen administration tubing was properly labeled to indicate the date. This affected two (Residents #9 and #161) of two residents reviewed for respiratory care services. The facility identified five residents receiving oxygen. The facility census was nine. Findings include: 1. Review of Resident #9's medical record revealed an admission date of [DATE] and re-admission on 03/06/20 with [DIAGNOSES REDACTED]. Review of Resident #9's care plan dated 02/14/20 revealed the resident was at risk ineffective breathing patterns secondary to acute [MEDICAL CONDITION], with interventions including to administer oxygen as prescribed. Review of Resident #9's Minimum Data Set ((MDS) dated [DATE] revealed the resident was severely cognitively impaired and required total assistance of two persons for transfers and toilet use; extensive assistance of two-persons for bed mobility and dressing; and extensive assistance of one-person for eating. Review of Resident #9's physician's order dated 03/09/20 revealed an order for [REDACTED].#9 on 03/09/20 at 11:54 A.M. revealed the resident had a nasal cannula and oxygen concentrator in her room. The oxygen tubing was not labeled or dated. Observation and interview on 03/09/20 at 11:57 A.M. with Assistant Director of Nursing (ADON) #1 revealed per facility policy oxygen tubing should be labeled with the date it was initiated and changed every seven days to reduce the risk of contamination. ADON #1 verified Resident #9's oxygen tubing was not labeled or dated. 2. Review of Resident #161's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #161's care plan dated 0[DATE] revealed the resident was at risk for ineffective airway exchange secondary to [MEDICAL CONDITION] with interventions including oxygen to be administered as ordered. Review of Resident #161's MDS dated [DATE] revealed the resident was severely cognitively impaired. The resident was totally dependent on the assistance of two-persons for bed mobility, dressing, toileting, personal hygiene, transfers and bathing; and totally dependent on one-person for eating. Review of Resident #161's physician's order dated 03/03/20 revealed an order for [REDACTED].#161 on 03/09/20 at 11:27 A.M. revealed the resident had a nasal cannula and oxygen concentrator in his room. The oxygen tubing was not labeled or dated. Observation and interview

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) on 03/09/20 at 11:57 A.M. with Assistant Director of Nursing (ADON) #1 revealed per facility policy oxygen tubing should be labeled with the date it was initiated and changed every seven days to reduce the risk of contamination. ADON #1 verified Resident #9's oxygen tubing was not labeled or dated. Review of the facility policy, Department (Respiratory Therapy)-Prevention of Infection dated 10/17 revealed under Steps in Procedure, step number seven stated to change the oxygen cannula and tubing every seven days or as needed.
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** Based on interview, and medical record review the facility failed to ensure appropriate indication was in place for residents who received antipsychotic medication. This affected one (Resident #3) of four residents reviewed for unnecessary medications. The facility census was nine. Findings include: Review of the medical record for Resident #3 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's plan of care dated 12/19/19 revealed the resident may experience impaired cognition related to the [DIAGNOSES REDACTED]. Resident #3 also had a care plan for the use of drugs having an altering effect on the mind characterized by hallucinations, delusions, involuntary movements, and tremors. Review of Resident #3's admission Medicare five day Minimum Data Set (MDS) 3.0 dated 12/24/19 revealed a Brief Interview for Mental Status (BIMS) score of 06 indicating severe cognitive impairment. Resident #3 was noted to reject care and wander at times. Resident #3 was totally dependent on two staff members for all activities of daily living. Review of Resident #3's physician orders [REDACTED]. Resident #3 was ordered to take half a tablet, 12.5 mg, two times a day for agitation. Review of Resident #3's behavior monitoring for December 2019, January 2020, February 2020, and March 2020, revealed one to two occurrences of the resident rejecting care per month. Interview on 03/11/20 at 12:00 P.M. with the Director of Nursing (DON) confirmed Resident #3 was receiving the antipsychotic medication [MEDICATION NAME] for agitation and not for one of the indicated [DIAGNOSES REDACTED].