| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365504 | A. Building<br>B. Wing | 04/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wesley Glen Health Services Corp | 5155 North High Street<br>Columbus, OH 43214 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure the resident's had care plans in place for pain management, enhanced barrier precautions, and an acute infection. This affected two (Residents #10 and #31) of 18 residents reviewed for care plans. The facility census was 51.<br><br>Findings include:<br><br>1. Record review revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included wedge compression fracture of second lumbar vertebra. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had a significant cognitive impairment.<br><br>Review of Resident #10 current physician orders revealed the following medications order for low back pain: diclofenac sodium external gel one percent and Tylenol extra strength 500 milligrams (mg).<br><br>Review of Resident #10's care plan revealed there was no care plan in place for pain management/treatment.<br><br>Interview with Director of Nursing (DON) on 04/24/25 at 3:31 P.M. confirmed Resident #10 did not have a pain care plan. The DON confirmed there should be a pain care plan in place for Resident #10.<br><br>2. Record review revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included pneumonia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had a mild cognitive impairment.<br><br>Review of the physician orders dated 03/29/25 revealed Resident #31 was placed on enhanced barrier precautions (EBP) on 03/29/25. There was also an order for Levaquin (antibiotic) 750 milligrams (mg) for seven days related to pneumonia, which started on 04/12/25.<br><br>Review of Resident #31's care plans revealed there were no antibiotic and EBP care plans developed/initiated.<br><br>Interview with the Director of Nursing (DON) on 04/23/25 at 3:11 P.M. confirmed Resident #31 did not have a care plan in place for antibiotic use and EBP. The DON confirmed Resident #31 should have been care plans for antibiotic use and EBP. |

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.

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure fall interventions were in place for a resident who was at a high risk for falls. This affected one (Resident #40) of two residents reviewed for falls. The facility census was 51.<br><br>Findings include:<br><br>Review of Resident #40's medical record revealed she was admitted on [DATE]. Diagnoses included diabetes mellitus, myocardial infarction, depression, frequent falls, and acute ischemic cerebrovascular accident.<br><br>Review of the comprehensive care plan dated 11/03/24 revealed Resident #40 was at risk for falls. An intervention was added on 11/07/24 to apply a perimeter mattress to the resident's bed.<br><br>Review of the fall risk assessments, dated 11/07/24 and 03/03/25 revealed Resident #40 was at a high risk for falls.<br><br>Review of Certified Nursing Aide (CNA) [NAME], dated 04/23/25 revealed a perimeter mattress to bed was listed under the safety section.<br><br>Observation on 04/23/25 at 7:30 A.M. revealed Resident #40 was sleeping in a low bed with no perimeter mattress in place.<br><br>Observation on 04/23/25 at 4:57 P.M. revealed Resident #40's bed with no perimeter mattress in place.<br><br>Interview with Director of Nursing (DON) on 04/23/25 at 4:45 P.M. revealed CNA's should use the resident's [NAME] for activities of daily living levels and to view current fall interventions that should be in place.<br><br>Interview with Licensed Practical Nurse (LPN) #233 on 04/23/25 at 5:05 P.M. confirmed Resident #40 did not have a perimeter mattress on her bed. LPN #233 stated Resident #40 had a room change in January 2025 and Resident #40 did have a perimeter mattress in her previous room. LPN #233 stated maybe hospice did not bring it down. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, resident and staff interview, and policy review, the facility failed to ensure food was served at a palliative and safe food temperature. This had the potential to affect all 51 residents in the facility who the facility identified to receive food from the kitchen.<br><br>Findings include:<br><br>Interview on 04/21/25 at 1:35 P.M. with Resident #37 stated the food was not hot enough when it comes to his room.<br><br>Interview on 04/23/25 at 2:19 P.M. with Registered Nurse (RN) #321 stated Resident #37 has complained about the temperature of his food.<br><br>Interview on 04/23/25 at 2:41 P.M. with Certified Nursing Assistant (CNA) #227 stated she receives complaints from residents about the temperature of food. CNA #227 stated she always warms up Resident #37's food.<br><br>Interview on 04/23/25 at 4:37 P.M. with Dining Services Director (DSD) #276 stated hot food should be served to residents at a minimum of 135 degrees Fahrenheit (F) and cold food should be served to residents at 41 degrees F or below.<br><br>Observation of the second floor tray line was made on 04/23/25 at 5:02 P.M. with Universal Dining Server #331 who was taking temperatures of the food. The dinner menu consisted of shrimp alfredo, Italian wedding soup, and Normandy vegetables. A test tray was requested, and DSD #276 took temperatures of the food being placed on the test tray on 04/23/25 at 6:12 P.M. DSD #276 confirmed the normandy vegetables were 145 degrees F, shrimp alfredo 140 degrees F, and Italian wedding soup was 137 degrees F. The tray was then placed immediately on the meal cart. The meal cart left the kitchen on 04/23/25 at 6:15 P.M. The meal cart arrived on the hallway on 04/23/25 at 6:17 P.M.<br><br>Observation of the test tray revealed it was served on 04/23/25 at 6:27 P.M. after all other hall trays were served. DSD #276 took temperatures and confirmed the normandy vegetables were 120 degrees F, shrimp alfredo was 123 degrees F, and the Italian wedding soup was 130 degrees F. The food was tasted and the normandy vegetables and shrimp alfredo were cold and the Italian wedding soup was lukewarm. DSD #276 confirmed the food temperatures of the test tray.<br><br>Interview on 04/24/25 at 11:34 A.M. with DSD #276 stated the goal was to serve the food at 135 degrees F.<br><br>Review of the undated Meal Delivery Timeliness and Temperature Documentation policy revealed the dining services team will ensure proper delivery of food at the proper temperature to the service areas. The policy also stated to check temperatures of all hot foods before delivery. Apply additional heat to any items below goal serving temperature. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interview, and policy review, the facility failed to honor the resident's food requests or preferences. This affected two (Resident #24 and #103) of three residents reviewed for food preferences. The facility census was 51.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #24 revealed an admission date of 05/28/21. Diagnoses included intellectual disabilities and type II diabetes mellitus.<br><br>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had severe cognitive impairment and required partial/moderate assistance for eating,<br><br>Review of the care plan revealed Resident #24 was at risk for altered nutrition status due to a history of a feeding tube that has been removed and a mechanically altered diet. Resident #24 liked small individual bowls for her food. An intervention included foods in individual bowls.<br><br>Observation on 04/23/25 at 6:34 P.M. revealed Resident #24's dinner revealed her food was served on a plate all together and not in bowls. Her dinner meal ticket stated to give food in separate bowls.<br><br>Interview and observation on 04/23/25 at 6:38 P.M. with Dining Operations Manager #290 verified Resident #24 did not receive her food in separate bowls.<br><br>2. Review of the medical record for Resident #103 revealed an admission date of 04/01/25. Diagnoses included chronic obstructive pulmonary disease and morbid obesity.<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #103 was cognitively intact and required setup or clean-up assistance for eating.<br><br>Interview on 04/21/25 at 1:34 P.M. with Resident #103 revealed the kitchen was her biggest issue as they never get her food choices correct 100% of the time.<br><br>Observation on 04/22/25 at 5:50 P.M. revealed Resident #103 received her meal tray and she did not get glazed carrots and received cranberry juice. Her dinner meal ticket had a write in for glazed carrots and the ticket stated Does not want juice.<br><br>Interview and observation on 04/22/25 at 5:54 P.M. with Dining Operations Manager #290 verified Resident #103 does not receive glazed carrots on her meal tray and verified Resident #103 requested the carrots. Dining Operations Manager #290 also confirmed Resident #103 received cranberry juice and her tray ticket stated that she did not want juice.<br><br>Review of the undated Resident Food Choices, Preferences, Alternates, and Portion Sizes policy revealed residents are served meals that comply with their diet restrictions, allergies and food preferences; however, a resident's right to choose menu items must be upheld whenever possible. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, staff interviews, and policy reviews, the facility did not maintain a clean sanitary kitchen, store food in a safe manner, and serve foods to the residents in a sanitary manner. This had the potential to affect all 51 residents in the facility who the facility identified receive food from the kitchen.<br><br>Findings include:<br><br>1. Observation and interview on 04/21/25 at 10:53 A.M. with Dining Services Director (DSD) #276 of the second floor kitchen verified the interior ambient temperature of the sandwich cooler was 52 degrees Fahrenheit (F) .<br><br>Observation and interview on 04/21/25 at 11:01 A.M. with DSD #276 and Dining Operations Manager (DOM) #303 confirmed the food located within the sandwich cooler on the second floor was above the appropriate food holding temperature. The sliced tomatoes were 47 degrees F and the hard boiled eggs were 46 degree F, sliced turkey 50 degrees F, chicken salad 46 degrees F, sliced American cheese was 46 degrees F and skim milk was 61 degrees F.<br><br>Observation and interview on 04/22/25 at 4:46 P.M. with DSD #276 of the second floor sandwich cooler revealed hardboiled eggs were 42 degrees F, egg salad was holding at 43 degrees F, sliced turkey was 42 degrees F, and sliced tomatoes were 43 degrees F.<br><br>Interview on 04/24/25 at 11:34 A.M. with DSD #275 revealed food shall be held in a cooler at 41 degrees F or below.<br><br>Review of the undated Food Storage - Refrigeration (Dining) policy revealed potentially hazardous foods (PHF) and Time/Temperature Control for Safety (TCS) foods must be maintained at or below 41 degrees F, unless otherwise specified by law.<br><br>Review of the undated General Food Preparation, Service and Handling policy revealed all cold meat/fish/poultry salads, potato/vegetable salads, egg salads, cream filled pastries and other TCS foods shall be prepared from chilled products and refrigerated at 41° F or below.<br><br>2. Observations of the kitchen on 04/21/25 from 9:50 A.M. to 10:16 A.M. with Dining Services Director (DSD) #276 and Dining Operations Manager (DOM) #303 revealed in the walk-in cooler, there were cheeses stored with the following issues: a large block of unnamed cheese that was plastic wrapped and did not have a datemark; a large block of fontina cheese was opened and not labeled; another unnamed cheese that was unlabeled and undated; and a package of shaved parmesan cheese was opened and did not have a datemark. There was also pot roast, which was wrapped without a datemark, andouille sausage was dated 02/25/25 and pork loin that was dated 04/19/25 to 05/19/25. The walk-in cooler and walk-in produce cooler walls and ceiling were dirty and flaking rust.<br><br>DSD #276 and DOM #303 confirmed the food items did not have datemarks, some had missing labels, the pot roast did not have a date, the andouille sausage was out of date, and the label was incorrect for the pork loin. DSD #276 stated the datemark shouldn't be a month. DSD #276 confirmed there was a rust issue and they were working on it. DSD #276 also confirmed the ceiling was dusty as well.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation of kitchen on 04/21/25 at 10:15 A.M. with DSD #276 confirmed there was a hole in the floor, under the oven, that was collecting food debris. DSD #276 stated this was an ongoing maintenance issue that has being going on for a few months.<br><br>Review of the undated Cleaning and Sanitation - Contact Surfaces policy revealed nonfood contact surfaces of equipment shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris.<br><br>Review of the undated Food Storage - Refrigeration (Dining) policy revealed all refrigerator units should be always kept clean and in good working condition.<br><br>Review of the undated Food Storage - Refrigeration (Dining) policy revealed all time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored in refrigerator.<br><br>3. Observations on 04/21/25 from 11:05 A.M. to 11:10 A.M. revealed Activities Assistant (AA) #460 was passing out blueberry muffins to the residents attending the activity. While passing out blueberry muffins to the residents, AA #460 had no gloves on. AA #460 was observed giving Resident #14 a muffin; she peeled back the muffin wrapping, touching the muffin with her non-gloved thumbs and then wiped Resident #14's shirt. Then, without washing her hands or putting gloves on her hands, she proceeded to unwrap Residents #32, #22, and #5's muffins with her unwashed, ungloved hands, and touched the muffins with her thumbs. In addition to touching the muffins with unwashed/ungloved hands, AA #460 touched Resident #22's hand to help her hold the muffin.<br><br>Interview on 04/21/25 at 11:11 A.M. with AA #460 confirmed she did not wear gloves, sanitize or wash hands between residents after touching their muffins and touching residents when serving muffins to them.<br><br>Review of undated facility policy titled Hand Hygiene revealed all associates shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Associates are to clean hands: before, during and after preparing food, before and after contact with the resident, and between direct contact with different residents. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Record review revealed Resident #155 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment, dated 04/02/25, revealed Resident #155 was cognitively intact.<br><br>Review of the physician orders dated 04/18/25 revealed Resident #155 received some medications ordered to be administered intravenously including alteplase injection solution reconstituted two milligrams (mg) (used to dissolve blood clots), piperacillin sod-tazobactam intravenous solution reconstituted (antibiotic) 4-0.5 grams for a wound infection, and heparin sodium (anticoagulant) five milliliters (ml). There were no physician orders for Resident #155 to be on EBP until 04/22/25.<br><br>Observations on 04/21/25 at 9:30 A.M. and 2:45 P.M. revealed there were no signs or equipment in or around Resident #155's room to indicate she was on EBP.<br><br>Interview with Registered Nurse (RN) #265 on 04/21/25 at 2:45 P.M. confirmed Resident #155 did not have a physician order, or a sign on Resident #155's door for EBP, and there was personal protective equipment (PPE) at Resident #155's room for staff to wear during resident care. RN #265 confirmed Resident #155 had a wound and was on intravenous antibiotics for a wound infection.<br><br>Interview with Director of Nursing (DON) on 04/23/25 at 3:20 P.M. confirmed there were no orders in place until 04/22/25 for Resident #155 to be on EBP. The DON confirmed there should have been EBP in place on 04/18/25.<br><br>Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.<br><br>Review of the facility's Enhanced Barrier Precautions policy, undated, revealed the definition of EBP was the expansion of the use of PPE and refer to the use of gown and gloves during high contact residents care activities that provide opportunities for transfer of MRDOs to staff hands and clothing. EBP will be implemented for residents with open wounds requiring dressing and indwelling medical devices.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observation, staff interview, medical record review, review of Centers for Disease Control and Prevention (CDC) guidance, and facility policy review, the facility failed to appropriately disinfect equipment during a wound care treatment and ensure the resident's wound did not touch a dirty surface during the wound treatment. The facility also failed to ensure a resident who received medications intravenously and had a wound had enhanced barrier precautions (EBP) in place. This affected one (Resident #13) of one resident reviewed for wound care treatment and one (Resident #155) of one resident reviewed for EBP. The facility identified eight residents (#13, #28, #33, #103, #104, #105, #108 and #155) who received wound dressing changes on the second floor. The facility census was 51.<br><br>Findings include:<br><br>1. Review of Resident #13's medical record revealed she was admitted on [DATE] with diagnoses including diabetes mellitus type II, sternal fracture, multiple rib fractures and moderate protein malnutrition.<br><br>Review of the physician's orders dated April 2025, revealed a treatment order to cleanse the right lateral shin wound with wound cleanser, pat dry, apply Medi honey and calcium alginate and cover with CDD (composite double-layered dressing), change daily.<br><br>Observation of wound treatment on 04/24/25 at 10:35 A.M. revealed Registered Nurse (RN) #321 was going to provide wound care to Resident #13's right lateral shin wound. RN #321 placed treatment supplies along with scissors on Resident #13's bed side table upon entering the room. RN #321 did not clean or disinfect the scissors and began cut off Resident #13's old dressing that had visible drainage seen on the outside of the old calcium alginate dressing. Resident #13 was positioned in her recliner chair with her feet elevated, and the side of the wound area was directly touching the surface of her recliner chair when the soiled dressing was removed. RN #13 did not disinfect the scissors after use and placed the scissors back on Resident #13's bedside tray. During application of the clean dressing, RN #321 used the same scissors that she had used to cut off the soiled dressing, to cut off a piece of the clean calcium alginate and then she applied it to Resident #13's wound. RN #321 did not disinfect the scissors after use with Resident #13's wound and placed them back into the treatment cart.<br><br>Interview with RN #321 on 04/24/25 at 10:55 A.M. confirmed Resident #13's wound touched directly on the uncleaned surface of the recliner chair, and did not disinfect the scissors prior to use, and after the scissors touched Resident #13's dirty dressing and before she used the same scissors for the clean dressing. RN #321 stated she uses the same scissors to complete wound treatments for all eight residents who require wound treatments on her assignment.<br><br>Review of undated facility policy titled Cleaning and Disinfecting Resident Rooms and Medical Equipment revealed reusable equipment such as scissors and clamps should be disinfected before use and after contamination. Disinfect using Environmental Protected Agency (EPA) disinfectant such as a Sanicloth. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>Based on observation, and resident and staff interview, the facility failed to maintain the patient care equipment in safe operating condition. This had the potential to affect 27 residents who resided on the second floor and utilized the second floor spa. The facility census was 51.<br><br>Findings include:<br><br>Interview on 04/21/25 at 5:04 P.M. with Resident #103 revealed the grab bar in the spa room next to the toilet was shaky and coming off the wall.<br><br>Observation and interview on 04/24/25 at 9:37 A.M. with Maintenance Technician (MT) #444 verified the second floor spa room grab bar next to the toilet was very loose. MT #444 stated he doesn't know how to fix it as they have tried all the fasteners they have.<br><br>Interview on 04/24/25 at 1:49 P.M. with Maintenance Director #450 confirmed the grab bar was broken. Maintenance Director #450 stated if he was aware of an issue, it was fixed the same day or the next day as they were on call seven days a week. |