STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366023	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Towers	5343 Hamilton Avenue Cincinnati, OH 45224

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. Based on staff interview, medical record review, and facility policy review, the facility failed to notify the physician related to bleeding during indwelling urinary catheter changes for one (Resident #49) of three sampled residents reviewed for urinary catheters. The census was 72. Findings included: Review of a profile face sheet revealed the facility admitted Resident #49 on 10/26/22. According to the profile face sheet, the resident had a medical history that included diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms and obstructive and reflux uropathy. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/04/24, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated the resident had an indwelling urinary catheter. Review of Resident #49's physician orders contained an order dated 04/23/24 to change F/C (Foley catheter) #18 French size (Fr), a universal gauge system used to measure the diameter of indwelling catheters, with a 10 milliliter (mL) balloon (used to hold the indwelling urinary catheter in the bladder), every month and pro re nata (prn; which means as needed). Review of Resident #49's interdisciplinary notes, documented by Licensed Practical Nurse (LPN) #1 on 04/23/24 at 6:05 A.M., revealed Resident #49's indwelling urinary catheter was changed and had a clear red return. The notes revealed no documentation the physician was notified regarding the clear red return. Review of Resident #49's interdisciplinary notes dated 05/20/24 at 2:52 P.M. revealed Resident #49 was observed with the indwelling urinary catheter in their hand with the bulb deflated, and a small amount of blood was noted at the urethra. The note revealed a Foley catheter #18 Fr with a 10 mL balloon was re-inserted, with blood strands noted in the resident's urine. The notes revealed no documentation that the physician was notified of the blood in Resident #49's urine. Review of Resident #49's interdisciplinary notes, documented by LPN #1 on 06/26/24 at 6:17 A.M., revealed Resident #49's indwelling urinary catheter was changed with a return of clear yellow urine with small blood clots. The notes revealed the resident tolerated the procedure with mild pain rated at four out of 10. The notes revealed no documentation that the physician was notified of the blood clots in Resident #49's urine. (continued on next page)

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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(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	Review of Resident #49's interdisciplinary notes, documented by LPN #1 on 07/25/24 at 6:13 A.M., revealed Resident #49's indwelling urinary catheter was changed with an initial visualization of hematuria (blood in urine), yellow urine with a tinge of red and a small clot. The notes revealed no documentation that the physician was notified of the blood in Resident #49's urine. Review of Resident #49's interdisciplinary notes, documented by LPN #1 on 08/27/24 at 7:47 A.M., revealed Resident #49's indwelling urinary catheter was changed with visualized hematuria in the catheter tubing. The notes indicated Resident #49 tolerated the indwelling urinary catheter change with some discomfort during insertion. The notes revealed no documentation that the physician was notified of the blood in Resident #49's urine. During an interview on 08/30/24 at 9:13 A.M., LPN #1 stated she was the nurse who changed out Resident #49's catheter on a regular basis. LPN #1 stated the resident had prostate issues and bled when the catheter was changed. During a follow-up interview on 08/30/24 at 5:09 P.M., LPN #1 stated she did not call the physician about Resident #49 bleeding with the indwelling urinary catheter changes. During an interview on 08/30/24 at 4:37 P.M., Physician #2 stated the staff had not made him aware of Resident #49 bleeding with catheter changes for the last several months. Review of an undated facility policy titled, Notification and Reporting of Changes in Health Status, Illness, Injury and Death of a Resident, revealed, it is the policy of the facility to notify the Resident, the Resident's physician, and Resident Representative as required by state and federal regulation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interview, medical record review, and facility policy review, the facility failed to ensure staff followed physician orders for indwelling urinary catheter care for one (Resident #49) of three sampled residents reviewed for urinary catheters. The census was 72. Findings included: Review of a profile face sheet revealed the facility admitted Resident #49 on 10/26/22. According to the profile face sheet, the resident had a medical history that included diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms and obstructive and reflux uropathy. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/04/24, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated the resident had an indwelling urinary catheter. Review of Resident #49's physician orders contained an order dated 04/23/24 to change F/C (Foley catheter) #18 French size (Fr), a universal gauge system used to measure the diameter of indwelling catheters) with a 10 milliliters (mL) balloon (used to hold the indwelling urinary catheter in the bladder), every month and pro re nata (prn, which meant as needed). Review of Resident #49's interdisciplinary notes, documented by Licensed Practical Nurse (LPN) #1 on 08/27/24 at 7:47 A.M., revealed Resident #49's indwelling urinary catheter was changed, the catheter was removed, and was a #18 Fr with a 30 mL balloon. The note revealed a #18 Fr catheter was inserted with visualized hematuria (blood in the urine), and a 30 mL balloon was inflated with the resident experiencing discomfort. During an observation on 08/29/24 at 4:27 P.M., Registered Nurse (RN) #3 checked the label of Resident #49's indwelling urinary catheter that was currently in place and stated it was a #18 Fr with a 30 mL balloon. During a phone interview on 08/30/24 at 9:13 A.M., LPN #1 stated she was the nurse who normally changed Resident #49's urinary catheter and had changed the resident's catheter on 08/27/24. She stated that as she entered the urethra, the patient said, Oh, oh, and grimaced. She stated the resident usually bled when changing the catheter, and as she advanced the catheter in the urethra, no urine return was noted, only blood in the catheter. LPN #1 stated she continued to advance the catheter until it would not advance anymore and inflated the balloon. She stated she asked the resident if they were doing okay after the procedure, and Resident #49 stated, Oh, I am not sure. LPN #1 stated the resident had dementia and could not always express themselves. She further stated she knew what size catheter to anchor based on the physician's order. When informed by this surveyor the physician's order stated the catheter was to be a #18 Fr 10 mL balloon, she stated she had looked and did not have a #18 Fr 10 mL balloon available, so she used what she had and that was a #18 Fr 30 mL balloon and inflated the balloon to the full 30 mL. LPN #1 then stated, I should have just ordered one instead of using the bigger balloon. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/30/24 at 11:28 A.M., the Director of Nursing (DON) stated she was unsure why the nurse would use a larger size indwelling urinary catheter without a physician's order. She stated there was a difference between a 10 mL balloon and a 30 mL balloon, and there was a stock supply of items on site that should have been used. The DON stated LPN #1 could have called the physician and gotten an order to delay the catheter change until the right size arrived if she did not have what she needed. She stated her expectation was for the nurse to check the order, follow the physician's order exactly as it was written, and insert the catheter per the urinary catheter policy and protocol. During an interview on 08/30/24 at 2:59 P.M., the Administrator stated she expected the nurses to follow the physician's orders for the changing indwelling urinary catheters, use the right size catheter and provide the appropriate care. During an interview on 08/30/24 at 4:37 P.M., Physician #2 stated he had not been made aware of the use of a larger catheter balloon or bleeding from catheter insertion for Resident #49. He stated the catheter size needed to remain a #18 Fr with 10 mL balloon unless the catheter was spontaneously falling out, and he doubted it was. He also stated the catheter size and balloon size should not be changed simply out of convenience to the staff, as that was not how the process should work. Physician #2 stated specific catheter sizes were used for specific reasons and should not be for the convenience of the staff and what was available to them at the time. Review of an undated facility policy titled, Catheter Care, revealed the section titled Purpose included to provide person-centered care for residents to ensure proper hygiene procedures. The policy further indicated residents with indwelling catheters will receive catheter care daily and as needed in order to maintain adequate personal hygiene and reduce or prevent complications such as urinary tract infections.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on staff interview and medical record review, the facility failed to ensure nursing staff possessed and demonstrated competencies and skill set necessary to provide indwelling urinary catheter care for one (Resident #49) of the sampled residents reviewed for urinary catheters. The census was 72. Findings included: Review of a profile face sheet revealed the facility admitted Resident #49 on 10/26/22. According to the profile face sheet, the resident had a medical history that included diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms and obstructive and reflux uropathy. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/04/24, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated the resident had an indwelling urinary catheter. Review of Resident #49's physician orders contained an order dated 04/23/24 to change F/C (Foley catheter) #18 French size (Fr), a universal gauge system used to measure the diameter of indwelling catheters) with a 10 milliliter (mL) balloon (used to hold the indwelling urinary catheter in the bladder), every month and pro re nata (prn, meant as needed). During an observation on 08/29/24 at 4:27 P.M., Registered Nurse (RN) #3 checked the label of Resident #49's indwelling urinary catheter that was currently in place and stated it was a #18 Fr with a 30 mL balloon. Review of Resident #49's interdisciplinary notes, documented by Licensed Practical Nurse (LPN) #1 on 08/27/24 at 7:47 A.M., revealed Resident #49's indwelling urinary catheter was changed, the catheter was removed, and was a #18 Fr with a 30 mL balloon. The note revealed a #18 Fr catheter was inserted with visualized hematuria (blood in the urine), and a 30 mL balloon was inflated with the resident experiencing discomfort. During a phone interview on 08/30/24 at 9:13 A.M., LPN #1 stated she was the nurse who normally changed Resident #49's urinary catheter and had changed the resident's catheter on 08/27/24. She stated that as she entered the urethra, the resident said, Oh, oh, and grimaced. She stated the resident usually bled when changing the catheter, and as she advanced the catheter in the urethra, no urine return was noted, only blood in the catheter. LPN #1 stated she continued to advance the catheter until it would not advance anymore and inflated the balloon. She stated she asked the resident if they were doing okay after the procedure, and Resident #49 stated, Oh, I am not sure. LPN #1 stated the resident had dementia and could not always express themselves. She further stated she knew what size catheter to anchor based on the physician's order. When informed by this surveyor the physician's order stated the catheter was to be a #18 Fr 10 mL balloon, she stated she had looked and did not have a #18 Fr 10 mL balloon available, so she used what she had and that was a #18 Fr 30 mL balloon and inflated the balloon to the full 30 mL. LPN #1 then stated, I should have just ordered one instead of using the bigger balloon. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/30/24 at 11:28 A.M., the Director of Nursing (DON) stated she was unsure why the nurse would use a larger size indwelling urinary catheter without a physician's order. She stated there was a difference between a 10 mL balloon and a 30 mL balloon, and there was a stock supply of items on site that should have been used. The DON stated LPN #1 could have called the physician and gotten an order to delay the catheter change until the right size arrived if she did not have what she needed. She stated her expectation was for the nurse to check the order, follow the physician's order exactly as it was written, and insert the catheter per the urinary catheter policy and protocol. During an interview on 08/30/24 at 3:10 P.M., the DON stated she did not have a nursing competency for LPN #1, as the facility did not do them regularly. She also confirmed there had been no recent in-services for nursing staff on indwelling urinary catheter insertion and care. During an interview on 08/30/24 at 5:02 P.M., the DON stated the facility did not do annual competencies with the staff; their education was mostly based on the computer, including orientation. The DON also stated the facility did not have a policy for staff competencies.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, medical record review, and facility policy review, the facility failed to ensure pharmacy recommendations were implemented for two (Resident #58 and Resident #72) of five sampled residents reviewed for unnecessary medications. The census was 72. Findings included: 1. Review of a profile face sheet revealed the facility admitted Resident #58 on 09/20/23. According to the profile face sheet, the resident had a medical history that included diagnoses of Alzheimer's disease and dementia with other behavioral disturbance. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/24/24, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS assessment revealed the resident received antipsychotic and antidepressant medications during the assessment period. Review of Resident #58's care plan included a category for psychotropic drug use, initiated 10/03/23, that indicated the resident had the potential for drug related complications associated with the use of psychotropic medications related to antipsychotic use. Interventions directed the pharmacy to review medications and make recommendations monthly, as needed. Review of Resident #58's pharmacy medication reconciliation and admission/readmission drug regimen review (DRR) dated 06/14/24, revealed a recommendation by the pharmacist to discontinue the resident's order of hormone supplement melatonin three (3) milligrams (mg) and olanzapine (an antipsychotic) 2.5 mg. The review revealed the physician agreed with the recommendation on 07/23/24. Review of Resident #58's physician's orders contained an order dated 02/10/24 for olanzapine 2.5 mg by mouth at dinner for mood disorder. Further review revealed no stop date for olanzapine 2.5 mg. The physician's orders contained an order dated 02/10/24 for Melatonin 3 mg by mouth at dinner for insomnia. Further review revealed no stop date for melatonin 3 mg. During an interview on 08/30/24 at 4:40 P.M., Physician #2 stated Resident #58 transitioned from assisted living to the skilled nursing facility, and part of the reason for the move was due to increased anxiety and behaviors. Physician #2 stated Resident #58 receive a psychiatric consultation and was put on melatonin and olanzapine based on recommendations from them. Physician #2 stated he would not order residents on an antipsychotic without a recommendation from a psychiatrist. Physician #2 indicated there should be psychiatric notes available for Resident #58's usage of melatonin and olanzapine; however, no notes were provided at the time of the survey. 2. Review of a profile face sheet revealed the facility admitted Resident #72 on 05/06/24. According to the profile face sheet, the resident had a medical history that included diagnoses of Alzheimer's disease, depression, and cognitive communication deficit. Review of an admission MDS assessment, with an ARD of 05/10/24, revealed Resident #72 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. The MDS assessment revealed the resident received antipsychotic and antidepressant medications during the assessment period. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #72's care plan included a category for psychotropic drug use, initiated 07/03/24, that indicated the resident had the potential for drug related complications associated with use of psychotropic medications related to antidepressant, antipsychotic use. Interventions directed the pharmacy to review medications and make recommendations monthly, as needed. Review of Resident #72's pharmacy document titled, Note to Attending Physician/Prescriber, dated 08/01/24, revealed the resident was receiving an antipsychotic agent but lacks an allowable diagnosis. The following Diagnostic and Statistical Manual of Mental Disorders (DSM) -[illegible] are considered appropriate diagnoses or conditions: schizophrenia, schizoaffective disorder schizophreniform disorder, delusional disorder, brief psychotic disorder, mania, bipolar disorder, depression with psychotic features refractory major depression, atypical psychosis, related psychosis, mania, psychosis not otherwise specified (NOS), psychosis without dementia, dementing illnesses with associated behavioral symptoms, medical illnesses (delirium with manic, psychotic symptoms and treatment), dementing illnesses with associated behavioral symptoms, medical illnesses, delirium with manic, psychotic symptoms and treatment, hiccups, and nausea and vomiting (N and V) with cancer (CA) or chemotherapy (chemo). Further review revealed documentation of, To note: antipsychotics by themselves are not approved for singular treatment of depression. Review of Resident #72's physician's orders contained an order, dated 05/06/24, for Zyprexa (an antipsychotic) five (5) mg by mouth daily for depression. During an interview on 08/30/24 at 11:35 A.M., the Director of Nursing (DON) stated the pharmacist made recommendations, but it would be up to the physician or nurse practitioner to change the resident's medications. The DON indicated the expectation was for recommendations to be followed. During an interview on 08/30/24 at 11:37 A.M., the Assistant Director of Nursing (ADON) stated once a pharmacy recommendation was received, it was provided to the physician or nurse practitioner. The ADON stated it would then go to nursing staff to make the changes and notify the family. During an interview on 08/30/24 at 12:33 P.M., the Pharmacist stated he performed the DRR and during the reviews, he would look for psychotropic medication reductions, laboratory values, and if doctors were doing what they said they would do. The Pharmacist stated he would generally look at the diagnoses of each resident and if he saw that a medication was being given for a diagnosis that the resident did not have, he would request a diagnosis from the physician. The Pharmacist stated he did an DRR on Resident #72 in July 2024 and asked for another diagnosis for the antipsychotic medication. The Pharmacist stated he did not get a response back from July 2024, so he did another DRR in August and requested the diagnosis again. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled, Medication Regimen Review, dated 01/2019, indicated, the consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regiment review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. The MRR also involves a thorough review of the resident records, and may include collaboration with other members of the interdisciplinary team, collaboration with the resident, family members or other resident representatives. The MRR also involves reporting of findings with recommendations for improvement. All findings and recommendations are reported to the director of nursing and the attending physician/extender. The policy also indicated, recommendations are acted upon and documented by the facility staff and/or the prescriber. The Prescriber accepts and acts upon suggestion, and the Director of Nursing or designated licensed nurse address and document recommendations that do not require a physician intervention, e.g. (exempli gratia, for example), monitor blood pressure.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, medical record review, and facility policy review, the facility failed to ensure the medication error rate was less than five percent (%). There were five errors out of 31 opportunities, which resulted in a medication error rate of 16.13% for two (Resident #29 and Resident #49) of three residents observed for medication administration. The census was 72. Findings included: 1. Review of a profile face sheet revealed the facility admitted Resident #29 on 09/18/23. According to the profile face sheet, the resident had a medical history that included diagnoses of chronic kidney disease stage three and urinary tract infections. Review of Resident #29's physician's orders included an order dated 08/07/24 for the supplement cranberry concentrate 500 milligram (mg) capsule by mouth daily for recurrent urinary tract infections. During an observation of medication administration on 08/28/24 at 8:36 A.M., Registered Nurse (RN) #14 administered Azo-Cranberry for urinary tract health. During an observation and interview on 08/28/2024 at 3:32 P.M., RN #14 read the cranberry concentrate order and then pulled the box of Azo-Cranberry for urinary tract health and read the ingredients, which were 900 mg of powdered concentrated cranberry in two tablets, vitamin C 60 mg, calcium phosphate 50 mg, phosphorous 38 mg and 100 million colony forming units (CFUs) of probiotic. RN #14 verified it was a medication error and should have been clarified prior to administration, even though it was a supplement. During a telephone interview on 08/30/24 at 1:08 P.M., the Pharmacist stated cranberry concentrate 500 mg and Azo-Cranberry for urinary tract health were not the same medication. The Pharmacist stated Azo had additional additives to help ease the pain of a urinary tract infection, such as vitamin C, phosphorus, and at times probiotics. 2. Review of a profile face sheet revealed the facility admitted Resident #49 on 10/26/22. According to the profile face sheet, the resident had a medical history that included diagnoses of heart failure, hypertension (high blood pressure), and mild cognitive impairment. Review of Resident #49's physician's orders included an order dated 02/07/23 for supplemental calcium 600 with vitamin D3 600 milligrams (mg) (1,500 mg) - 200-unit tablet by mouth daily for calcium deficiency, an order dated 02/07/23 for supplemental ferrous gluconate 324 mg by mouth daily with breakfast for anemia, an order dated 03/23/23 for supplemental vitamin C 500 mg capsule, extended release by mouth daily for wound healing and skin support, and an order dated 03/23/23 for Stress B with Zinc tablet, one tablet by mouth daily for wound healing and skin support. During an observation of medication administration on 08/28/24 at 9:13 A.M., RN #14 administered Resident #49 the following medications including; calcium 600 mg/10 mcg (micrograms) with vitamin D3, one tablet; ferrous sulfate 224 mg, one tablet; vitamin C 500 mg, one tablet; and Stress formula multivitamin with zinc. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 08/28/24 at 8:32 A.M., RN #14 looked at the electronic medication administration record (EMAR) for the calcium order and stated the order was confusing. However, she thought she had pulled the right medication because it had 600 mg of calcium and vitamin D3 in it. She then looked at the EMAR and pulled out a box of medication from the third drawer of the medication cart for ferrous gluconate. She stated she had given Resident #49 ferrous sulfate 224 mg from the top drawer. RN #14 looked at the EMAR and pulled the vitamin C 500 mg and acknowledged it did not say extended release. She then looked at the EMAR and pulled the Stress formula multivitamin bottle and acknowledged there was no B on the bottle. RN #14 agreed the above four medications passed were medication errors and she should have clarified the medications prior to administration, even if they were supplements. During an interview on 08/30/24 at 11:13 A.M., the Director of Nursing (DON) stated she was upset because the facility had an overabundance of supplements available for the nurses to use during medication pass. She stated she wished RN #14 had looked before giving the medication and not just gave it, If it was close, and if she did not have the right medication or supplement, got the order clarified with the physician or changed to what was available in-house stock. The DON stated her expectation was for nurses to look at the EMAR and give the right medications following the five rights of medication administration as well as the physician's order. She stated that in the event the nurses did not have the medication/supplement they needed, to look for it first in the stock room and then get the orders clarified with the physician and change to a medication/supplement that was available. During an interview on 08/30/24 at 2:53 P.M., the Administrator stated her expectation was for the nurses to give the medications per physician's orders and to follow protocol. During a telephone interview on 08/30/24 at 1:08 P.M., the Pharmacist stated the order for calcium 600 with vitamin D3 600 mg (1,500 mg) - 200-unit tablet was not an accurate medication order, and he was not sure what medication the staff were trying to describe. However, it was not the calcium 600 mg with 10 mcg of D3, that had been given, and it was a medication error. He stated ferrous sulfate 224 mg was not the same medication as ferrous gluconate 324 mg, and it was a medication error. The Pharmacist stated there was a big difference between vitamin C 500 mg and vitamin C 500 mg extended release. He stated the extended release was given to residents to help ease stomach upset, with the full dose coated to release slowly into their digestive system, and it was a medication error. He also stated being given a Stress formula multivitamin with zinc instead of a Stress B with zinc multivitamin would be a medication error as well. The Pharmacist further stated although there were only subtle differences in the medication names, the effects and types of medications were different, and all examples given were medication errors. Review of an undated facility policy titled, Medication Administration, revealed the section titled Purpose included to administer medications in a safe and effective manner. The policy specified nurses will administer medications safely and effectively following the five rights of medication administration and follow the five rights of medication administration to ensure the right patient, right drug, right dose, right route, and right time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366023	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Towers	5343 Hamilton Avenue Cincinnati, OH 45224

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to ensure staff properly stored frozen foods and staff with beards wore beard guards during preparation of food to prevent contamination. The failure had the potential to affect 72 residents who received meals from the kitchen. The census was 72. Findings included: 1. During an observation on 08/26/24 at 9:09 A.M., Preparation (Prep) [NAME] #6 was observed preparing food with a full beard and no beard cover. During an interview on 08/26/24 at 9:35 A.M., Prep [NAME] #6 stated he was preparing the ham and putting up buns when the surveyor entered the kitchen. He stated he did not know if he should have been wearing a beard cover. During an interview on 08/26/24 at 9:40 A.M., the Dietary Manager (DM) stated Prep [NAME] #6 should have had a beard cover on while preparing food. During an interview on 08/29/24 at 10:18 A.M., the Administrator stated beard covers should be worn when preparing food. Review of a facility policy titled, Orientation and Education, revised 01/2024, revealed in the section titled, Associates Working with Food, included to restrain all facial hair with a beard net/restraint. 2. During an observation on 08/26/24 at 9:17 A.M., the freezer was observed. There was a hamburger patty observed lying in a box and left open to air. There was one box of chicken tenders which was left open to air. During a concurrent interview the DM stated the food should be sealed and not left open to air. During an interview on 08/29/24 at 10:18 A.M., the Administrator stated the hamburger patty was left open to air, but it was one and they did not realize one was left in the bag. She stated the food stored in the freezer should be sealed. Review of a facility policy titled, Production, Purchasing, Storage, revised 01/2024, revealed in the section titled, Procedures, included to cover, label, and date unused portions and open packages. The section titled, Frozen Storage, included to wrap food tightly to prevent cross contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366023	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Towers	5343 Hamilton Avenue Cincinnati, OH 45224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interview, and facility policy review, the facility failed to ensure that staff were fit tested for a respirator required for respiratory protection when working with Coronavirus Disease 2019 (COVID-19) positive residents. This had the potential to affect all 72 residents that resided in the facility. The census was 72. Finding included: During an observation on 08/26/24 at 1:48 P.M., State Tested Nurse Aide (STNA) #8 was observed coming out of a COVID-19 positive resident's room with a bag of soiled items. STNA #8 had on a surgical mask and gloves. During a concurrent interview STNA #8 stated, when entering the room with a COVID-19 positive resident, she would put an N95 (respirator) mask on top of a surgical mask, gown, face shield, and gloves. STNA #8 stated there was a bin inside the room to discard all the personal protective equipment (PPE). STNA #8 stated she would discard everything and when she would exit the room, she would just have on a surgical mask and would put new gloves on when she came out. STNA #8 stated she had not been fit tested for a respirator. During an interview on 08/26/24 at 2:21 P.M., Licensed Practical Nurse (LPN) #9 stated she worked at the facility for 32 years and had not been fit tested for a respirator. During an interview on 08/27/24 at 9:59 A.M., LPN #10 stated she had not been fit tested for a respirator. During an interview on 08/27/24 at 12:02 P.M., the Administrator stated fit testing was done by corporate and they were not able to provide any records. The Administrator stated there had been some changes in staff and they were not sure where the records were. During an interview on 08/28/24 at 11:40 A.M., the Director of Nursing (DON) stated there had been a lot of turnover in the past year in administration and the fit testing was handled by corporate. The DON stated she did not handle the fit testing, so she would not be able to speak on what may have happened to the records. During an interview on 08/30/24 at 11:35 A.M., the DON stated her expectation was for staff to wear PPE that was appropriate for the precautions and that fit testing be performed on staff upon hire and annually thereafter. During an interview on 08/30/24 at 2:38 P.M., the Administrator stated her expectation was for staff to wear the appropriate PPE and for fit testing to be done according to the policy. Review of a facility policy titled, Respiratory Protection Procedure, dated 04/21/2021 revealed, under section Six - Fit Testing, revealed fit testing is conducted to determine how well the seal of a respirator 'fits' on an individual's face and that a good seal can be obtained. Respirators that do not seal do not offer adequate protection. The policy revealed fit testing will be conducted at least annually and prior to any associate being allowed to wear any respirator. A record of fit testing for each associate will be recorded on a fit testing log to serve as record of the individual test. Records of fit testing shall be maintained by the Respiratory Protection Program Administrator, or their designee, for at least six years.