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COURTYARD AT LEXINGTON THE	2345 LEXINGTON AVENUE SALEM, OH 44460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments Total Capacity: 32 Total Census: 23 County: Columbiana Administrator: Lindy Hutton Survey Type: Initial Survey and Complaint Investigation Master Complaint OH00115629 and Complaint Number OH00115607 in regards to the allegation of operating of an un-licensed Residential Care Facility. Licensure for 32 beds is not recommended. An initial tour of the facility and kitchen on 09/10/20 beginning at 8:30 A.M. revealed unlocked chemicals in resident common area, unlicensed staff administering medication, and an unlocked and unattended medication cart. Interview on 09/10/20 at 11:17 A.M. with Administrative Staff #3 verified the facility did not have a fire watch policy and had not been inspected by the state fire marshal. Review of the facility policies and procedures on 09/12/20 at 3:40 P.M. revealed there was not appropriate staff or staff plan, no policy and procedure regarding a grievance committee, no tuberculosis risk assessment or policy, no policy and procedure for residents who entered into risk agreements, no policy and procedure for admission, transfer, discharge; no policy on resident incidents and incident log and fire and disaster drill were not completed as required. Interview with Administrative Staff #2 revealed he was unaware the policies were required.	R 000		
R 026	O.A.C. 3701-16-02 (K) General Provisions O.A.C. 3701-16-02 (K) An applicant for a license	R 026		

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R 026	Continued From page 1 to operate a residential care facility shall not accept more than two residents who need personal care services, medication administration, supervision of therapeutic diets, application of dressings or skilled nursing care before receiving a license. This Rule is not met as evidenced by: Based on facility census, staff interviews and review of the facility's Ohio Department of Mental Health and Addiction Services license revealed the facility had more residents living in the facility than allowed prior to receiving a residential care facility license. This affected 23 residents in the facility. The facility census was 23. Findings Include: Review of the handwritten census sheet revealed the facility has 23 residents living in the facility. Review of the Ohio Department of Mental Health and Addiction Services license revealed an expiration date on 10/11/19. Interview on 09/10/20 at 10:00 A.M.,with Administrative Staff #3 indicated the facility's Ohio Department of Mental Health and Addiction Services license had expired and they had not renewed the license because they were applying for a residential care facility (RCF) license. Administrative Staff #3 verified at this time the facility did not an active license to operate and the facility census was 23.	R 026		
R 027	O.A.C. 3701-16-02 (L) General Provisions O.A.C. 3701-16-02 (L) In addition to the above provisions, no person, firm, partnership,	R 027		

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R 027	Continued From page 2 association, or corporation shall: (1) Operate a residential care facility as defined in section 3721.01 of the Revised Code and paragraph (GG) of rule 3701-16-01 of the Administrative Code without obtaining a license from the director; (2) Violate any of the conditions or requirements necessary for licensing after the license has been issued; (3) Operate a residential care facility after the license for such has been revoked by the director; (4) Interfere with the inspection of a licensed residential care facility by any state or local official when he or she is performing duties required of him or her by Chapter 3721. of the Revised Code. All licensed residential care facilities shall be open for inspection. (5) Violate any applicable provision of Chapter 3721. of the Revised Code or rules 3701-16-01 to 3701-16-18 of the Administrative Code. This Rule is not met as evidenced by: Based on observations, staff interviews, review of plans of care, review of resident list of assist required per supervisor revealed the facility failed to ensure they were licensed to operate a residential care facility in accordance with Ohio Revised Code 3721.01 and the Ohio Administrative Code 3701-16-01 paragraph (GG) as evidence by but not limited to: providing 24 hour nursing services to residents including assistance with all activities of daily living, medication administration, assistance with application of assistive devices, maintaining	R 027		

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R 027	Continued From page 3	R 027		

medical records, providing emergency call system This deficient practice had the potential to affect all 23 residents residing in the facility. The facility census was 23.

Finding include:

Observation on 09/10/20 at 8:30 A.M. revealed three residents in the dining room eating breakfast and two personal attendants (PA). Resident # 18 was sitting in a dining room chair with a clip style personal alarm secured to the chair and Resident #13 was sitting in a wheelchair with a clip style personal alarm attached to the back of her shirt.

1. Observation on 09/10/20 at 8:32 A.M. revealed PA #8 was administering medication to Resident #24 (who resides in a condominium across the street). PA #8 had a bubble packaged card of medications; she popped the medication out of the medication card into the resident's hand and the resident took the medication.

Review of the bubble package medication card revealed the Medication given to Resident #24 by PA #8 were: acetylsalicylic (Aspirin) 81milligrams (mg), Olanzapine 5mg (antipsychotic), Clonazepam 0.5mg (antianxiety, narcotic), Clopidogrel 75mg (antiplatelet), Omeprazole 20mg (proton pump inhibitor), Metformin HCL 100mg (antidiabetic), Magnesium oxide 400mg (electrolyte), and Lisinopril 5mg (blood pressure).

Interview on 09/10/20 at 8:40 A.M. with PA#8 indicated there was not a nurse on duty. She indicated she would assist the residents in taking their medication if they asked. She verified she had popped the backing on the medication card and put them in the resident's hand. She

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R 027	Continued From page 4 indicated they were trained to assist with medication, but she was not a medication technician. 2. Observation on 09/10/20 at 8:45 A.M. revealed the medication cart was unlocked and unattended in the back corner of the dining room in a makeshift nurse's station. PA #8 verified it was unlocked, and it should have been locked. PA #8 indicated she had the key to the medication cart including narcotics. 3. Review of the plan of care (POC) dated 01/22/20 revealed Resident #1 required partial assistance with bathing, hair care, mouth care, dressing , toileting, transfers, and ambulation. Review of resident list of assist required per supervisor revealed Resident #1 required assistance with medication administration and morning/evening care. 4. Review of the medical record revealed Resident #7 was admitted to the facility on 12/09/18 with the diagnoses of hypothyroidism, chronic, pain, constipation, chronic obstructive pulmonary disease, and depression. Review of the POC dated 12/09/18 revealed Resident #7 required partial assistance with bathing, dressing and transfer. Review of resident list of assist required per supervisor revealed Resident #7 required assistance with bathing the upper half of his body. 5. Review of the POC dated 08/19 revealed Resident #8 required partial assistance with transfer, ambulation and medications.	R 027		

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R 027	Continued From page 5 Review of resident list of assist required per supervisor revealed Resident #8 required assistance with transfers, morning/evening care. The resident calls for help when needs incontinent care. 6. Review of the POC dated 11/08 revealed Resident #10 required partial assistance with mouth care, toilet use, transfer, ambulation and medications. The resident was total care for bathing and dressing. Review of resident list of assist required per supervisor revealed Resident #10 required assistance with transfers, bathing, and medications. 7. Review of the medical record revealed Resident #11 was admitted to the facility on 11/11/17 with the diagnoses of cataracts, vertigo, osteoarthritis, fall risk, incontinence, hypertension, and diabetes. Review of the POC dated 11/11/17 revealed Resident #11 required partial assistance with hair care, mouth care, dressing, transfer, ambulation and medications. The resident was fall risk and was partial weight bearing. Review of resident list of assist required per supervisor revealed Resident #11 required assistance with morning/evening care and medication administration. 8. Review of the medical record revealed Resident #12 was admitted to the facility on 12/18/19 with the diagnoses cerebrovascular accident, hypothyroidism, and depression. Review of resident list of assist required per	R 027		

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R 027	Continued From page 6	R 027		

supervisor revealed Resident #12 required assistance with morning/evening care, medication administration and transfer. The resident was to be provided incontinence care every two hours.

9. Review of the medical record revealed Resident #13 was admitted to the facility on 02/24/20 with the diagnoses of anxiety disorder, confusion, disorientation, obsessive compulsive disorder, dementia, depression, and irritable bowel disorder.

Review of resident list of assist required per supervisor revealed Resident #13 required assistance with morning/evening care, transfers and medication administration.

10. Review of resident list of assist required per supervisor revealed Resident #14 required assistance with morning/evening care, medication administration and transfer. The resident was to be provided incontinence care every two hours.

11. Review of the medical record revealed Resident #18 was admitted to the facility on 07/12/20.

Review of the POC dated 07/20 revealed Resident #18 required partial assistance with bathing and toileting. The resident wore a brief.

Review of resident list of assist required per supervisor revealed Resident #18 required assistance with morning/evening care, medication administration and bathing.

12. Review of the medical record revealed Resident #19 was admitted to the facility on 11/07/16 with the diagnose of hyperlipidemia, hypertension and gastro-esophageal reflux

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R 027	Continued From page 7 disease. Review of resident list of assist required per supervisor revealed Resident #19 required assistance with morning/evening care, medication administration and bathing. 13. Review of resident list of assist required per supervisor revealed Resident #20 required assistance with morning/evening care, medication administration and bathing. Interview on 09/10/20 at 10:00 A.M. with Administrative Staff #3 indicated the facility's Ohio Department of Mental Health and Addiction Services license had expired and they had not renewed the license because they were applying for a residential care facility (RCF) license. He indicated Mental Health and Addiction Services had been in the facility three times to check things out. Owner #2 verified at this time the facility did not an active license to operate. Interview on 09/10/20 at 1:40 A.M. with PA #8 indicated care they performed in the facility was all activities of daily living, showers, transfers, partial assists, laundry, toileting. She indicated they do not have anyone they have to assist with eating, but they have in the past. She indicated they have two residents who have alarms because of falls (Resident #13 and Resident #18), two on thickened liquids (Resident #12 and Resident #14), and one on fluid restrictions (Resident #4). Interview on 09/12/20 at 1:20 P.M. with Supervisor #1 indicated the facility had three residents who were incontinent of bowel and bladder (Resident #8, Resident #12 and Resident #14).	R 027		

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R 027	Continued From page 8 This violation substantiates Master Complaint Control Number OH00115629 and Complaint Control Number OH00115607..	R 027		
R 070	O.R.C. 3721.12 (A)(1) License Prohibitions O.R.C. 3721.12(A)(1) The administrator of a home shall, with the advice of residents, their sponsors, or both, establish and review at least annually, written policies regarding the applicability and implementation of residents' rights under sections 3721.10 to 3721.17 of the Revised Code, the responsibilities of residents regarding the rights, and the home's grievance procedure established under division (A)(2) of this section. The administrator is responsible for the development of, and adherence to, procedures implementing the policies. This Rule is not met as evidenced by: Based on review of facility policies and staff interview the facility failed to have a policy for admission, transfer and discharge, a policy on resident incidents or a log of residents incidents. This had the potential to affect all 23 residents in the facility. Findings include: Review of the facility policies and procedures on 09/12/20 at 3:40 P.M. revealed the facility did not have a policy on admission, transfer and discharge, and failed to have a policy on incidents or a log of resident's incident.	R 070		

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R 070	Continued From page 9 Interview on 09/12/20 at 3:40 P.M., with Administrative Staff #2 verified the facility did not have policies on admission, transfer and discharge, incidents or an incident log.	R 070		
R 103	O.A.C. 3701-16-05 (C)(2) Personnel Requirements O.A.C. 3701-16-05 (C)(2) Each residential care facility shall have the following staff members who are competent to perform the duties they are assigned: (2) Sufficient additional staff members who meet the applicable qualifications of rule 3701-16-06 of the Administrative Code for the services they perform and appropriate scheduling of sufficient staff time to adequately do all of the following: (a) Meet, in a timely manner, the residents' total care, supervisory and emotional needs as determined by the resident assessment required under rule 3701-16-08 of the Administrative Code and consistent with the resident agreement required under rule 3701-16-07 of the Administrative Code and reasonable and appropriate requests for services, including monitoring in excess of supervision of residents with increased emotional needs or presenting behaviors that cause problems for the resident or other residents, or both; (b) Properly provide dietary, housekeeping, laundry, and facility maintenance services and recreational activities for the residents in accordance with the rules of this chapter; (c) Assist, when necessary, with prompt	R 103		

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R 103	Continued From page 10 evacuation of nonambulatory residents. The additional staff members needed to implement the facility's evacuation plan required by paragraph (J) of rule 3701-16-13 of the Administrative Code shall be present in the facility at all times; and (d) Provide or arrange for resident activities required under rule 3701-16-11 of the Administrative Code. This Rule is not met as evidenced by: Based on review of facility policies and staff interview the facility failed to have a staffing plan. This had the potential to affect all 23 residents in the facility. Findings include: Review of the facility policies and procedures on 09/12/20 at 3:40 P.M. revealed the facility did not have a staffing plan in place. Interview on 09/12/20 at 3:40 P.M., Administrative Staff #2 verified the facility did not have a staffing plan in place.	R 103		
R 108	O.A.C. 3701-16-05 (F) Personnel Requirements O.A.C. 3701-16-05 (F) Each residential care facility which elects to administer medication shall have one of the following individuals on duty who shall administer medications in accordance with paragraphs (G) and (H) of rule 3701-16-09 of the Administrative Code and remain on duty for a sufficient amount of time to observe medication	R 108		

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R 108	Continued From page 11 acceptance and reaction: (1) A registered nurse; (2) A licensed practical nurse holding proof of successful completion of a course in medication administration approved by the Ohio board of nursing pursuant to Chapter 4723. of the Revised Code who shall administer medication only at the direction of a registered nurse or physician; (3) A physician; or (4) A person authorized by law to administer medication. This Rule is not met as evidenced by: Based on observations, staff interviews and review of the staff schedules the facility failed to have appropriate staff available to administer medications. This affected 13 residents (Residents #1, #3, #4, #10, #11, #12, #13, #14, #15, #16, #17, #18 and #19) who received assistance with medication administration. The facility census was 23. Findings include: Observation on 09/10/20 at 8:30 A.M. revealed two personal attendants (PA) working in the facility. There was no licensed professional nursing staff working in the facility. Review of the staff schedules revealed from 07/05/20 to 09/12/20 no licensed nursing staff was scheduled to work in the facility.	R 108		

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R 108	Continued From page 12 Interview on 09/10/20 at 8:40 A.M. with PA#8 indicated there was not a nurse on duty. She indicated she would assist the resident in taking their medication if they asked. She indicated they were trained to assist with medication, but she was not a medication technician. She verified there were no nurse's working in the facility. Interview on 09/10/20 at 9:05 A.M. with PA #9 indicated she would help give the residents their medication if they asked her to. She stated she has given insulin shots to the resident if they have not been able to do so themselves. She stated she was not aware she could not give them their insulin. She verified there were no nurses working in the facility. Interview on 09/10/20 at 10:00 A.M., with Administrative Staff #3 verified the facility did not have a nurse employed, however they did have a nurse consultant. Interview on 09/10/20 at 10:23 A.M. with Registered Nurse (RN) Consultant #15 indicated she only came into the facility when they needed her to do in-services and consult. She verified she has not worked in the facility since March 2020 when the COVID pandemic started. Interview on 09/12/20 at 10:54 A.M. with Supervisor #1 indicated Supervisor #16 did the schedules however, she has been off since COVID started in March. She stated Supervisor #16 would email the schedule to her. She stated there has not been a nurse employed in the facility for about three years. Review of the list of residents requiring assist per supervisor revealed Resident #1, #3, #4, #10,	R 108		

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R 108	Continued From page 13 #11, #12, #13, #14, #15, #16, #17, #18 and #19 received assistance with administering their medications. Residents #11 and #17 received insulin injections.	R 108		
R 306	O.A.C. 3701-16-07 (G) Resident Agreement: Admission; Risk Agreement O.A.C. 3701-16-07 (G) A residential care facility may enter into a risk agreement with a resident or the resident's sponsor with the consent of the resident. Under a risk agreement, the resident or sponsor and the facility agree to share responsibility for making and implementing decisions affecting the scope and quantity of services provided by the facility to the resident. The facility shall identify the risks inherent in a decision made by a resident or sponsor not to receive a service provided by the facility. A risk agreement is valid only if it is made in writing. The residential care facility shall maintain a copy of any risk agreement in the resident's record. This Rule is not met as evidenced by: Based on review of facility policies and staff interview the facility failed to have a policy and procedure for risk agreements. This had the potential to affect all 23 residents in the facility. Findings include: Review of the facility policies and procedures on 09/12/20 at 3:40 P.M. revealed the facility did not have a policy and procedure for risk agreements in place. Interview on 09/12/20 at 3:40 P.M., Administrative Staff #2 verified the facility did not have a policy	R 306		

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R 306	Continued From page 14 and procedure for risk agreements in place.	R 306		
R 337	O.A.C. 3701-16-09 (G) Personal Care Services O.A.C. 3701-16-09 (G) Medication shall be administered in accordance with accepted standards of practice to a resident in a residential care facility only by the following persons authorized by law to administer medication: (1) A registered nurse; (2) A licensed practical nurse holding proof of successful completion of a course in medication administration approved by the Ohio board of nursing pursuant to Chapter 4723. of the Revised Code who shall administer medication only at the direction of a registered nurse or physician; (3) A physician; or (4) A person authorized by law to administer medication. This Rule is not met as evidenced by: Based on observations, staff interviews and resident interview the facility failed to ensure medication were administered by qualified licensed staff. This affected 13 Residents (Resident #1, #3, #4, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and an individual that lived in an apartment across the street, #24) being assisted with medications administration. The facility census was 23. Findings include: Observation on 09/10/20 at 8:32 A.M. revealed	R 337		

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R 337	Continued From page 15 Personal Attendant (PA) #8 was administering medication to Resident #24 who resided in an apartment building across the street from the facility. PA #8 had a bubble packaged card of medications; she popped the medication out of the medication card into the resident's hand and the resident took the medication. Review of the bubble package medication card revealed the Medication given to Resident #24 by PA #8 were: acetylsalicyclic (aspirin) 81 milligrams (mg), Olanzapine 5 mg (antipsychotic), Clonazepam 0.5 mg (antianxiety, narcotic), Clopidogrel 75 mg (antiplatelet), Omeprazole 20 mg (proton pump inhibitor), Metformin HCL 100 mg (antidiabetic), Magnesium oxide 400 mg (electrolyte), and Lisinopril 5 mg (blood pressure). Interview on 09/10/20 at 8:40 A.M. with PA #8 indicated there was not a nurse on duty. She indicated she would assist the residents in taking their medication if they asked. She verified she had popped the backing on the medication card and put them in Resident #24's hand. She indicated they were trained to assist with medication, but she was not a medication technician. Interview on 09/10/20 at 9:05 A.M. with PA #9 indicated she would help give the residents their medication if they asked her to. She stated she has given insulin shots to the resident if they have not been able to do so themselves. She stated she was not aware she could not give them their insulin. She verified there were no nurses working in the facility. Interview on 09/10/20 at 9:07 A.M. with PA #8 indicated she has given residents their medication if they have asked and she has also	R 337		

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R 337	Continued From page 16	R 337		

given insulin to a resident if they have asked her to.

Interview on 09/10/20 at 10:00 A.M. with Administrative Staff #3 verified the facility did not have a nurse employed, however they did have a nurse consultant.

Interview on 09/10/20 at 10:23 A.M. with Registered Nurse (RN) Consultant #15 indicated she only came into the facility when they needed her to do in-services and consult. She verified she has not worked in the facility since March 2020 when the COVID pandemic started.

Observation on 09/10/20 at 10:49 A.M. with PA #8 and RN Consultant #15, revealed PA #8 unlocked the medication cart with a key she took out of her pocket and opened the narcotic box to revealed a card with 59 tablets of Clonazepam 0.5 mg for Resident #19. Interview at this time, PA #8 verified they always have the keys to the narcotic drawer but there was also some narcotics in the office.

Interview on 09/10/20 at 12:20 P.M. with Family Member #17 indicated she would bring her mother's medications in and the staff would give them to her. She indicated her mother could not give herself her medications or her eye drops. The staff had to do it for her.

Interview on 09/10/20 at 2:45 P.M. with PA #8 indicated she has to help a few of the residents take their blood sugar fingersticks because they are not able to do it themselves.

Interview on 09/10/20 at 3:00 P.M. with PA #8 indicated she did not know what a medication administration record was and was unaware if the

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resident had a list of medication anywhere. She indicated she would just give the medication out by what the bubble packed medication cards said. She indicated she did not even know what the medications were she was giving.

Interview on 09/12/20 at 10:54 A.M. with Supervisor #1 indicated Supervisor #16 did the schedules, however, she has been off since COVID-19 started in March. She stated Supervisor #16 would email the schedule to her. She stated there has not been a nurse employed in the facility for about three years.

Observation on 09/12/20 at 11:50 A.M. revealed PA #8 assisting Resident #17 with her blood glucose testing and insulin injection. PA #8 gave Resident #17 an alcohol preparation pad and explained to her she needed to clean her finger off. She explained to her how to put the lancet in the lancet device, how to stick her finger, how to place the glucose testing strip in the glucometer, how to place the drop of blood on the glucose testing strip, how to put the needle on the insulin pen, how many units she was to receive, how to uncap the needle, how to wipe her abdomen with the alcohol preparation pad and how to give herself the injection. She had not wiped off the insulin pen hub prior to placing the needle on the insulin pen and she had not primed the pen prior to injection.

Interview on 09/12/20 at 11:55 A.M. with Resident #17 indicated she did not know how many units of insulin she was to receive, and she never did her own blood glucose testing or gave herself her own insulin. She indicated the staff always did it for her and she did not have to ask them to do it, they would just do it for her.

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R 337	Continued From page 18 Interview on 09/12/20 at 4:13 P.M. with PA #12 indicated when she passed out medication she would look at the bubble medication card to make sure she had the right card for the resident, she would pop the medication out of the package into the residents hand and she would stay in the room until they completely took the medications. She indicated she has given insulin injections and has checked the residents blood glucose tests if they were unable to do it themselves. Observation of a blood glucose test and insulin administration on 09/12/20 at 4:37 P.M. revealed PA #12 preformed a blood glucose test and administered insulin to Resident #11. PA #12 had to stick the resident four times in the fingers to get enough blood for the test strip, she did not use an alcohol preparation pad on the insulin pen hub to clean it and she did not prime the needle prior to administration. Interview at this time, PA #12 verified the resident was confused and was unable to do the tasks for herself. She verified she did not know she was to clean the insulin pen hub prior to placing the needle on it or she had to prime the needle prior to administration. She indicated she was not trained as a medication technician. Review of the staff schedule revealed from 07/06/20 to 09/12/20 no licensed nursing staff was scheduled to work in the facility. Review of the list of residents requiring assist per supervisor revealed Resident #1, #3, #4, #10, #11, #12, #13, #14, #15, #16, #17, #18 and #19 received assistance with administering their medications. Residents #11 and #17 received insulin injections.	R 337		

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R 337	Continued From page 19 .	R 337		
R 347	O.A.C. 3701-16-09 (I)(5) Personal Care Services O.A.C. 3701-16-09 (I)(5) Residential care facilities that handle residents' medication shall: (5) If controlled substances are used, order, dispense, administer, and dispose of controlled substances in accordance with state and federal laws and regulations; This Rule is not met as evidenced by: Based on observation, staff interviews and review of narcotic count sheets revealed the facility failed to properly store, document and administer narcotic medications. This affected four residents (Resident #4, #14 #16, #19) receiving narcotic medications. Finding include: Observation on 09/10/20 at 10:49 A.M. with PA #8 and RN Consultant #15, revealed PA #8 unlocked the medication cart with a key she took out of her pocket and opened the narcotic box to reveal a card with 59 tablets of Clonazepam 0.5 mg for Resident #19. Interview at this time, PA #8 verified they always have the keys to the narcotic drawer but there was also some narcotics in the office. 1. Review of the medication list attached to the bubbled medication cards for Resident #4 revealed she was to receive alprazolam (antianxiety, narcotic) 0.25 mg twice a day. Interview on 09/12/20 at 11:10 A.M. with Supervisor #1 verified the medication was not	R 347		

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R 347	Continued From page 20 being counted and accounted for. 2. Review of the medication list attached to the bubbled medication cards for Resident #14 revealed he was to receive alprazolam 0.5 mg three times daily and tramadol (pain medication, narcotic) 50 mg three times daily. Interview on 09/12/20 at 11:10 A.M. with Supervisor #1 verified the medication was not being counted. 3. Review of the medications list for Resident #16 revealed she was to receive a narcotic medication Klonopin (antianxiety, narcotic) 0.5 milligram (mg) twice daily. Observation on 09/12/10 at 10:15 A.M. revealed Resident #3 had her medication set up by the facility in medication containers. Interview on 09/12/20 at 11:10 A.M.with Supervisor #1 indicated she set the medications up in the medication containers and the Klonopin was in the container. She verified the medication was not being counted. 4. Review of the medication list attached to the bubbled medication cards for Resident #19 revealed she was to receive Klonopin 0.5 mg twice daily. Interview on 09/12/20 at 11:10 A.M. with Supervisor #1 verified the medication was not being counted. Interview on 09/10/20 at 3:00 P.M. Personal Attendant #8 indicated she did not know what a medication administration record was and was unaware if the resident had a list of medication anywhere. She indicated she would just give the medication out by what the medication cards said. She indicated she did not even know what the medications were she was giving from the cards.	R 347		

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R 391	Continued From page 21	R 391		
R 391	O.A.C. 3701-16-12 (B) Changes in resident health status; incident O.A.C. 3701-16-12 (B) As used in this paragraph, "incident" means any accident or episode involving a resident, staff member, or other individual in a residential care facility which presents a risk to the health, safety, or well-being of a resident. In the event of an incident, the facility shall do both of the following: (1) Take immediate and proper steps to see that the resident or residents involved receive necessary intervention including, if needed, medical attention or transfer to an appropriate medical facility; and (2) Investigate the incident and document the incident and the investigation. The facility shall maintain an incident log separate from the resident record which shall be accessible to the director and shall contain the time, place, and date of the occurrence; a general description of the incident; and the care provided or action taken. The facility shall maintain a notation about the incident in the resident's record. This Rule is not met as evidenced by: Based on record review, hospital reports and staff interview the facility failed to appropriately assess and provide timely emergency care to Resident #13 after a fall. This affected one resident reviewed for falls. Findings include: Review of the medical record revealed Resident #13 was admitted to the facility on 02/24/20 with the diagnoses of anxiety disorder, confusion,	R 391		

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R 391	Continued From page 22 disorientation, obsessive compulsive disorder, dementia, depression, and irritable bowel disorder. Review of the personal attendants (PA) charting in the PA books revealed on 08/23/20 at 5:15 P.M. Resident #13 fell in the dining room, the PA checked her because she said her right hip was hurting. The resident was limping a little and the supervisor was notified. Review of the PA charting revealed on 09/03/20 (no time), Resident #13 was walking with a limp, PA noticed it walking her to the bathroom for morning care. The resident was saying that her leg hurt bad. The PA texted the supervisor to let her know. Review of the PA charting in the the PA books revealed on 09/03/20 (no time), Resident #13 was given one Tylenol at 8:15 A.M. The resident had a bruise on her right hip area, yellowish in color. There was no knowledge of her falling. The doctor was called to get an x-ray and they were waiting for a response. The x-ray vendor called and would be coming in later tonight or first thing Friday morning 09/04/20. Review of x-ray results dated 09/03/20 a 4:20 P.M. revealed Resident #13 had an acute fracture of the mid coccyx and acute fracture of the right proximal femur. Review of the PA charting in the PA books revealed on 09/04/20 (no time), the doctor's office called and stated for this type of fracture there was nothing that could be done, just give her Tylenol for pain and keep her as still as possible. A body alarm was put on her so if she tried to get up, they could get to her quickly.	R 391		

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R 391	Continued From page 23 Interview on 09/12/20 11:32 A.M.,with Supervisor #1 indicated there should have been an incident report, however she could not find one. Interview on 09/12/20 at 3:15 P.M. with Supervisor #1 indicated she did not know about the fall on 08/23/20 for Resident #13. She indicated she had not been complaining of pain.	R 391		
R 392	O.A.C. 3701-16-12 (C)(1) Changes in resident health status; incident O.A.C. 3701-16-12 (C)(1) Each residential care facility shall establish and implement appropriate written policies and procedures to control the development and transmission of infections and diseases which, at minimum, shall provide for the following: (1) Individuals working in the facility shall wash their hands vigorously for ten to fifteen seconds before beginning work and upon completing work, before and after eating, after using the bathroom, after covering their mouth when sneezing and coughing, before and after providing personal care services or skilled nursing care, when there has been contact with body substances, after contact with contaminated materials, before handling food, and at other appropriate times; This Rule is not met as evidenced by: Based on review of facility policies and staff interview the facility failed to have a policy and procedure for tuberculosis or a facility tuberculosis risk assessment completed. This had the potential to affect all 23 residents in the	R 392		

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R 392	Continued From page 24 facility. Findings include: Review of the facility policies and procedures on 09/12/20 at 3:40 P.M. revealed the facility did not have a policy and procedure for tuberculosis or a tuberculosis risk assessment completed. Interview on 09/12/20 at 3:40 P.M., Administrative Staff #2 verified the facility did not have a policy and procedure for tuberculosis or a tuberculosis risk assessment completed.	R 392		
R 607	O.A.C. 3701-16-13 (H) Building, plumbing, fire & CO safety requirem O.A.C. 3701-16-13 (H) Each residential care facility shall be inspected for fire safety in accordance with paragraph (A) of rule 3701-16-04 of the Administrative Code. This Rule is not met as evidenced by: Based on review of facility documentation and staff interview the facility failed to have the facility inspected by the State Fire Marshall for licensure. This had the potential to affect all 23 residents in the facility. Findings include: Review of the facility documentation on 09/10/20 at 10:00 A.M. revealed the State Fire Marshall had last inspected the facility on 08/14/19. Interview on 09/10/20 at 10:00 A.M. with	R 607		

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R 607	Continued From page 25 Administrative Staff #3 verified the facility had not been inspected by the State Fire Marshall however, he was going to do a virtual tour this week.	R 607		
R 610	O.A.C. 3701-16-13 (J)(2) Building, plumbing, fire & CO safety requirem O.A.C. 3701-16-13 (J)(2) Each residential care facility shall develop and maintain a written disaster preparedness plan to be followed in case of emergency or disaster. A copy of the plan shall be readily available at all times within the residential care facility. Such plan shall include the following: (2) A plan for protection of all persons in the event of fire and procedures for fire control and evacuation, including a fire watch and the prompt notification of the local fire authority and state fire marshal's office when a fire detection, fire alarm, or sprinkler system is impaired or inoperable. For purposes of this rule, "fire watch" means the process required in the Ohio fire code for detecting and immediately alerting residents, staff, and the responding fire department of a fire or other emergency while the building's fire alarm or sprinkler system is impaired, inoperable or undergoing testing; This Rule is not met as evidenced by: Based on review of facility documentation and staff interview they facility failed to have a fire watch policy and procedure in place. This had the potential to affect all 23 residents in the facility. Findings Include:	R 610		

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R 610	Continued From page 26 Review of the facility documentation on 09/10/20 at 11:17 A.M. revealed the facility did not have a fire watch policy and procedure in place. Interview on 09/10/20 at 11:17 A.M. with Administrative Staff #3 verified the facility did not have a fire watch policy and he was not aware he needed one.	R 610		
R 614	O.A.C. 3701-16-13 (K)(1) Building, plumbing, fire & CO safety requirem O.A.C. 3701-16-13 (K)(1) Each residential care facility shall conduct the following drills unless the state fire marshal allows a home to vary from this requirement and the residential care facility has written documentation to this effect from the state fire marshal: (1) Twelve fire exit drills, one conducted on each shift at least every three months to familiarize staff members and residents with signals, evacuation procedures and emergency action required under varied times and conditions. Fire exit drills shall include the transmission of a fire alarm signal to the appropriate fire department or monitoring station, verification of receipt of that signal, and simulation of emergency fire conditions except that the movement of infirm and bedridden residents to safe areas or to the exterior of the structure is not required. Drills conducted between nine p.m. and six a.m. may use a coded announcement instead of an audible alarm. Residential care facilities that have an alarm system that is not capable of sending a fire alarm signal if an audible alarm is not used shall transmit a fire alarm signal and verify receipt of that signal no more than twelve hours after the	R 614		

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R 614	Continued From page 27 coded announcement. Fire drills shall meet the following requirements. (a) Each staff member shall participate in at least one fire drill annually. (b) One staff member with knowledge of the disaster preparedness plan and the fire evacuation routes shall be designated to observe and evaluate each drill and shall not participate in that drill. (c) Residents capable of self-evacuation shall be actually evacuated to safe areas or to the exterior of the residential care facility in at least two fire drills a year on each shift. Movement of non-ambulatory residents to safe areas or to the exterior of the facility is not required. This Rule is not met as evidenced by: Based on review of facility documentation and staff interview the facility failed to complete the required number of fire drills annually. This had the potential to affect all 23 residents in the facility. Findings include: Review of the facility fire drills on 09/12/20 at 3:40 P.M. revealed the facility had only completed fire drills on all three shifts on 01/27/20, 04/15/20 and 08/28/20. Interview on 09/12/20 at 3:40 P.M., Administrative	R 614		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2824R	A. BUILDING: _____ B. WING _____	09/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT LEXINGTON THE	2345 LEXINGTON AVENUE SALEM, OH 44460

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R 614	Continued From page 28 Staff #2 verified the facility did not have all the required fire drills.	R 614		
R 615	O.A.C. 3701-16-13 (K)(2) Building, plumbing, fire & CO safety requirem O.A.C. 3701-16-13 (K)(2) Each residential care facility shall conduct the following drills unless the state fire marshal allows a home to vary from this requirement and the residential care facility has written documentation to this effect from the state fire marshal: At least two disaster preparedness drills per year, one of which shall be a tornado drill which shall occur during the months of March through July. This Rule is not met as evidenced by: Based on review of facility documentation and staff interview the facility failed to complete the required number of disaster drills annually. This had the potential to affect all 23 residents in the facility. Findings include: Review of the facility documentation on 09/12/20 at 3:40 P.M. revealed the facility had not completed disaster drills. Interview on 09/12/20 at 3:40 P.M., Administrative Staff #2 verified the facility failed to complete the required disaster drills in the facility.	R 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 701	Continued From page 29	R 701		
R 701	O.R.C. 3721.12 (A)(2) Duties of Administrator O.R.C.3721.12 (A)(2) The administrator of a home shall establish a grievance committee for review of complaints by residents. The grievance committee shall be comprised of the home's staff and residents, sponsors, or outside representatives in a ratio of not more than one staff member to every two residents, sponsors, or outside representatives. This Rule is not met as evidenced by: Based on review of facility policies and staff interview the facility failed to have a policy for grievances or the grievance committee. This had the potential to affect all 23 residents in the facility. Findings include: Review of the facility policies and procedures on 09/12/20 at 3:40 P.M. revealed the facility did not have a policy for grievances or the grievance committee. Interview on 09/12/20 at 3:40 P.M., Administrative Staff #2 verified the facility did not have policies on grievances or the grievance committee.	R 701		
R 710	O.R.C. 3721.13 (A)(1) Rights of Residents O.R.C. 3721.13 (A)(1) The rights of residents of a home shall include, but are not limited to, the following: The right to a safe and clean living environment pursuant to Titles XVIII and XIX of the "Social Security Act", 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and applicable state	R 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2824R	A. BUILDING: _____ B. WING _____	09/12/2020

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R 710	Continued From page 30 laws and regulations prescribed by the public health council. This Rule is not met as evidenced by: Based on observation and staff interviews the facility failed provide a safe environment for residents in regard to hazardous chemicals not stored securely. This had the potential to affect all 23 residents in the facility. Findings include: Observation on 09/10/20 at 9:00 A.M. revealed five bottles of glass cleaner and one spray bottle of disinfectant sitting on the railings in the hallways. Residents were observed ambulating in the hallways. Interview on 09/10/20 at 11:30 A.M. observation and interview with Personal Attendant #8 revealed the bottles of glass cleaner and spray disinfectant were still on the railings. Personal Attendant #8 indicated the bottles were hand sanitizer and should have hand sanitizer written on them but they did not.	R 710		