

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365085 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/13/2026 |
| NAME OF PROVIDER OR SUPPLIER Life Care Center of Medina | | STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Columbia Rd Medina, OH 44256 | |

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) |
|--|---|
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure appropriate infection control measures were maintained during wound care for Resident #91, who required Enhanced Barrier Precautions (EBP). This affected one resident (#91) of three residents reviewed for infection control. The facility identified seven residents residing in the Memory Care Unit who required EBP. The facility census was 105. Findings include: Record review for Resident #91 revealed an admission date of 12/09/25. Diagnoses included encounter for orthopedic aftercare following surgical amputation, diabetes mellitus, infection and inflammatory reaction due to indwelling urethral catheter, urinary retention, long term use of antibiotics, peripheral vascular disease, and acquired absence of left toes. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 was cognitively intact. Resident #91 used a walker and had impairment on one side of the lower extremity, had a pressure ulcer, one unstageable wound and two deep tissue injuries. Resident #91 also had an indwelling catheter. Review of the care plan dated 12/10/25 revealed Resident #91 had an indwelling foley catheter. Interventions included Enhanced Barrier Precautions (EBP). Resident #91 also had a care plan focus dated 01/19/26 which revealed Resident #91 was admitted with a surgical wound to his left foot related to amputation, unstageable pressure ulcer to the left heel and deep tissue injury to the left and right buttocks. Resident #91 was at risk for pain, infections, and delayed healing. Interventions included to provide treatment as ordered. Review of the physician orders revealed Resident #91 had an order dated 03/05/26 for wound care to the left heel. The order included to apply dressing of betadine, adaptic, abd (abdominal pad, absorbent dressing), kerlix (gauze wrap) and apply an ace (compression) wrap every day shift every other day. The order specified the area was to be washed with soap and water or vashe (wound cleansing solution) soaked gauze for three to five minutes. For the left lateral surgical site, the treatment order was for staff to apply a dressing of betadine, xeroform (a non-adherent dressing used to maintain a moist wound environment), kerlix and ace wrap. Observation and interview on 03/13/26 at 12:58 P.M. of Licensed Practical Nurse (LPN) #211 provide wound care For Resident #91 with the assistance of Certified Nursing Assistant (CNA) #214 revealed wound care of the pressure ulcer and surgical site to the left foot was completed by LPN #211 while CNA #214 assisted with positioning of the leg and foot. Observation revealed LPN #211 did not wash her hands or use hand sanitizer after removing the soiled dressings, before cleansing the wounds, nor before applying a new dressing. Observation revealed neither LPN #211 nor CNA #214 donned an isolation gown during the wound care and treatment. Observation revealed Resident #91's indwelling catheter was intact. A sign was on the wall outside the entrance door of Resident #91's room. Interview with LPN #211 immediately following the completion of wound care revealed LPN #211 confirmed the EBP sign was there and revealed that was only for the foley catheter. LPN #211 confirmed she never donned an isolation gown and confirmed she never washed her hands nor used hand sanitizer after removing the soiled dressings nor before applying clean dressings to Resident #91's wounds. LPN #211 exited the room. Interview with CNA #214 confirmed she did not wear an isolation gown while assisting with positioning Resident #91 during wound care. CNA #214 revealed she was not sure if she was (continued on next page)</p> |

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 |
|---|-------|-----------|

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365085 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/13/2026 |
| NAME OF PROVIDER OR SUPPLIER Life Care Center of Medina | | STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Columbia Rd Medina, OH 44256 | |
| 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>supposed to and confirmed there were no isolation gowns available in or near Resident #91's room. Observation with CNA #214 on 03/13/26 at 1:18 P.M. of the Memory Care Unit where Resident #91 resided revealed revealed the EBP supplies were supposed to be kept in a bag on the back of resident doors and confirmed Resident #98 and #99's shared room was the only room in the Memory Care Unit with the available supplies. Interview on 03/13/26 at 1:29 P.M. with LPN #211 (CNA #214 was present) again confirmed she did not don an isolation gown during wound care for Resident #91. LPN #211 instructed CNA #214 she only needed to use EBP if she had contact with urine but if she was doing just patient care, it was not required. Interview on 03/13/26 at 1:44 P.M. with DON revealed when a resident was on EBP the staff were required to wear an isolation gown and gloves when doing hands on care. DON revealed Personal Protective Equipment (PPE) which included gowns, gloves, and masks were located in the supply room and if staff ran low on the floor, they should notify the Central Supply staff and they would provide the PPE needed. DON revealed when doing wound care, the staff member should wash their hands after removing the soiled dressing and before applying a clean dressing. Review of the facility policy titled, Enhanced Barrier Precautions revised 08/19/25 revealed EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted Multi-Drug Resistant Organism (MDRO) when contact precautions do not otherwise apply or wounds and indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices included urinary catheters. PPE for EBP is only necessary when performing high-contact care activities. Examples of high-contact care activities included wound care - any skin opening requiring a dressing. Review of the facility policy titled, Wound Care Management-Dressing Change and Wound Assessment undated included remove the old dressing carefully by pushing the skin away from the dressing. Discard the dressing in a plastic bag. Remove and discard your gloves, perform hand hygiene, and put on new gloves. Cleanse the wound as ordered, cleanse the peri wound. Remove and discard your gloves, perform hand hygiene, and put on new gloves. Apply the treatment as ordered. This deficiency represents an incidental finding identified during the course of the complaint investigation.</p> | | |