STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365163	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northcrest Rehab and Nursing Center	240 Northcrest Drive Napoleon, OH 43545

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 15816 Based on observation, medical record review, and staff interview, the facility failed to obtain blood glucose levels as ordered. This affected one (#11) of three residents observed during medication administration. The facility census was 59. Findings include: Observation on 10/01/24 at 10:51 A.M. noted Licensed Practical Nurse (LPN) #300 obtained Resident #11's medications from the medication cart. Medications included the administration of Novolog insulin determined by sliding scale blood glucose levels. At the time of the observation, LPN #300 stated she was unable to locate Resident #11 when the resident's insulin coverage was due at 7:00 A.M. and confirmed the 7:00 A.M. blood glucose lever was not obtained at that time. LPN #300 proceeded to Resident #11's room and obtained a blood sugar reading of 204 milligrams per deciliter (mg/dL). LPN #300 returned to the medication cart and obtained four (4) units of insulin via syringe, returned to the resident's room, and injected the dose of insulin into the resident. Review of Resident #11's medical record noted a physician order dated 09/24/24 for the administration of Novolog insulin via sliding scale as follows: for blood glucose levels between 150 mg/dL and 199 mg/dL, give two units; between 200 mg/dL and 249 mg/dL, give 4 units; between 250 mg/dL and 299 mg/dL, give six units; between 300 mg/dL and 349 mg/dL, give eight units; and between 350 mg/dL and 399 mg/dL, give 10 units subcutaneously (SQ) before meals and at bedtime related to type II diabetes mellitus with hyperglycemia. The physician prescribed administration times were set for 7:00 A.M., 11:00 A.M., 4:30 P.M., and 8:00 P.M. Review of Resident #11's October 2024 medication administration record revealed no documented blood glucose level was obtained on 10/01/24 at 7:00 A.M. On 10/01/24 at 11:00 A.M. interview with LPN #300 verified Resident #11's blood glucose level was not obtained as ordered at 7:00 A.M. and was not obtained until the next scheduled time. This deficiency represents an incidental finding discovered during the complaint investigation.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to maintain resident indwelling urinary catheters in an effective and sanitary manner. This affected one (#3) of one residents reviewed for urinary catheter care and function. The facility census was 59. Findings include: Review of the medical record for Resident #3 revealed the resident was admitted to the facility on [DATE] with the diagnoses including type II diabetes mellitus, neuropathy, xerosis cutis, neurofunction dysfunction of bladder, urinary retention, morbid obesity, acquired buried penis, chronic respiratory failure, chronic obstructive pulmonary disease, erythema intertrigo, congestive heart failure, hypertension, lymphedema, adult failure to thrive, and major depression. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #3 with intact cognition, was dependent on staff for the provision of activities of daily living, utilized a indwelling urinary catheter, was incontinent of bowel, experienced hallucinations and delusions, had no behaviors regarding refusal of care, and was at risk for pressure ulcer development with no skin breakdown. Review of Resident #3's medical record revealed on 11/06/23 the physician ordered the placement of an indwelling (Foley) urinary catheter 16 French (Fr) with a 10 cubic centimeter (cc) balloon. In addition, and order was given for catheter care to be completed every shift on day and night shift. On 11/10/23 the facility physician ordered the resident to have the Foley catheter changed monthly as indicated by the resident's urologist. On 02/25/24 a physician order was acquired for the Foley catheter change every month to be completed by the Director of Nursing (DON) on day shift every month starting on the 25th. There was no documentation contained in the medical record indicating the urologist was informed of the resident's Foley catheter function. Review of a nursing plan of care dated 11/06/23 revealed the care plan was initiated to address Resident #3's risk for bladder incontinence related to urinary retention, neuromuscular dysfunction of bladder, acute renal failure, acquired buried penis, and admitted with urinary tract infection (UTI) from a catheter. On 08/06/24 the plan of care was revised with interventions to provide catheter care as ordered; clean the peri-area with each incontinence episode; monitor/document for signs and symptoms of UTI including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns; monitor, document, and report as needed any possible causes of incontinence including bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects; and urology/DON to change the catheter monthly. Review of the treatment administration record (TAR) noted Resident #3's Foley catheter was changed on 08/25/24. On 09/25/24 an entry on the TAR indicated a progress note was placed into the medical record regarding the changing of the Foley catheter. Review of the medical record was silent to an entry or evidence the Foley catheter was changed in September 2024. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurses notes on 08/08/24 at 11:00 P.M. revealed Resident #3 was started on the antibiotic Bactrim double strength (DS) for UTI. On 09/18/24 at 6:07 P.M. Resident #3's bedding visibly soiled and there was concern that the catheter may not be draining as it should after seeing soiling to bed. Resident #3 refused to allow the bedding to be changed, and refused to allow an assessment of catheter. The physician was provided with an update and no new orders were obtained. On 10/01/24 at 4:03 P.M. Resident #3 was seen by the physician and received new orders for treatment of cellulitis due to redness, warmth, and drainage noted to the left side of the abdomen. No interventions to address the leaking catheter were initiated. On 10/02/24 at 8:00 P.M. Resident #3's linens were soiled with drainage and the resident refused to allow staff to change linens which was attempted several times. No documentation indicating the physician was notified of the leaking Foley catheter. On 10/03/24 at 6:25 A.M. interview with State tested Nurse Aide (STNA) #400 revealed she assumed Resident #3's care at 6:00 P.M. the previous night with the shift ending at 6:00 A.M. on 10/03/24. STNA #400 stated Resident #3 required catheter care during the shift and refused. The resident had soiled the bed with a leaking indwelling urinary catheter and would not allow the bed linen or catheter care to be provided the entire shift. STNA #400 stated the urinary catheter had been leaking for an undetermined amount of time and the resident refused care. STNA #400 reported the resident condition and refusal to Licensed Practical Nurse (LPN) #301. Observation on 10/03/24 at 6:35 A.M. discovered Resident #3 in bed soiled with a yellowish-brown stain under the right leg leading to the foot of the bed. Interview with Resident #3 at that time stated refusal of staff to change the linens due to leaking of catheter occurring frequently for an undetermined time and did not want to be bothered during the night. Resident #3 stated the DON changed the catheter yesterday and was still having drainage. On 10/03/24 at 6:42 A.M. interview with LPN #301 confirmed assuming Resident #3's care on 10/02/24 at 7:00 P.M. until 10/03/24 at 7:00 A.M. LPN #301 stated staff made attempts during the night to change the resident's bed linen and he refused to be disturbed. LPN #301 confirmed the indwelling urinary catheter has been leaking for an undetermined amount of time. Interview with LPN Unit Manager #302 on 10/03/24 at 7:40 A.M. confirmed ongoing concerns with Resident #3's indwelling urinary catheter and verified Resident #3 was heavily soiled in bed with urine draining under him. On 10/03/24 at 7:50 A.M. interview with the DON revealed Resident #3's indwelling catheter was changed on 10/01/24 and confirmed the catheter was still leaking. Due to the resident's anatomical condition the placement of the catheter was difficult. Further interview with the DON during review of the medical record confirmed no current documentation related to Resident #3's catheter being changed on 10/01/24. Additional interview verified no additional interventions had been implemented to address the leaking catheter other than attempting to change the catheter. The DON also verified no documentation indicated the catheter was changed as ordered during the month of September 2024 and the TAR on 09/25/24 indicated a progress note was placed into the record and the medical record was silent to an entry on 09/25/24. The DON confirmed no attempts to contact the urologist have occurred since the resident was admitted to the facility. This deficiency represents non-compliance investigated under Complaint Number OH00157794.

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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. 15816 Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure medications were administered as ordered by the physician, and within prescribed time frames, resulting in a medication error rate above five (5) percent (%). This affected two (#9 and #10) of three residents observed during medication administration. A total of two medications errors were observed out of 29 opportunities for a medication administration error rate of 6.9%. The facility census was 59. Findings include: 1. Observation on 10/01/24 at 10:13 A.M. noted Licensed Practical Nurse (LPN) #300 preparing Resident #9's medications for administration. At 10:22 A.M., LPN #300 proceeded into Resident #9's room and provided the resident's medications contained inside a medication cup. One medication included the antidepressant Cymbalta 30 milligram tablet. Resident #9 consumed the medications and LPN #300 exited the room. Review of Resident #9's medical record revealed a physician order dated 07/17/24 for the administration of Cymbalta oral capsule delayed release particles 30 mg by mouth every morning and at bedtime for depression related to major depressive disorder. The physician prescribed administration times were designated for 7:00 A.M. and 8:00 P.M. and listed on the 10/01/24 medication administration record (MAR). 2. On 10/01/24 at 10:24 P.M. LPN #300 obtained Resident #10's medications from the medication cart. The medications included budesonide-formoterol fumarate inhalation aerosol 160-4.5 micrograms per actuation (mcg/act). At 10:36 A.M., LPN #300 proceeded into Resident #10's room and the resident took two inhalations (puffs) from the inhaler. LPN #300 then exited the resident room. Review of the medical record discovered a physician order for the administration of budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act two puffs inhaled orally two times a day related to pulmonary fibrosis and chronic obstructive pulmonary disease (COPD). The physician prescribed administration times were documented as 8:00 A.M. and 8:00 P.M. and indicated on the 10/01/24 MAR. On 10/01/24 at 11:00 A.M. interview with LPN #300 verified Resident #9's Cymbalta and Resident #10's budesonide-formoterol fumarate inhaled medication were not administered within prescribed times. Review of facility administering medications policy, revised April 2019, revealed medications including insulin and any oral or subcutaneous hypoglycemic, are administered in accordance with prescriber orders, including any required time frame and medications are administered within one hour of their prescribed time, unless otherwise specified. This deficiency represents an incidental finding discovered during the complaint investigation.