STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365305	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Willoughby	37603 Euclid Ave Willoughby, OH 44094

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on interview, record review, and facility policy review, the facility failed to administer an antiparkinsonian medication as ordered by the prescriber to ensure Resident #118 was free from significant medication error. This affected one resident (#118) out of three residents reviewed for medication administration. Findings include: Review of the medical record for Resident #118 revealed an admitted [DATE]. Diagnoses included hereditary spastic paraplegia, secondary parkinsonism, degenerative disease of nervous system, contracture of muscle multiple sites, and idiopathic progressive neuropathy. The Quarterly Minimum Data Set (MDS) assessment completed 08/16/24 indicated no cognitive impairment. Review of Resident #118's physician orders effective September 2024 revealed Rytary (antiparkinsonian medication) 48.75-195 milligrams, two capsules four times daily. Review of Resident #118's medication administration record for August 2024 to September 2024 revealed Rytary was scheduled four times daily at 8:00 A.M., 12:00 P.M., 5:00 P.M. and 10:00 P.M. Review of Resident #118's medication administration report from 08/17/24 to 08/24/24 revealed Rytary was administered late. On 08/18/24 the 8:00 A.M. dose was administered at 10:44 A.M. and the 12:00 P.M. dose was administered at 1:20 P.M. On 08/20/24 the 8:00 A.M. dose was administered at 9:36 A.M. On 08/21/24 the 5:00 P.M. dose was administered at 7:25 P.M. On 08/22/24 the 8:00 A.M. dose was administered at 9:40 A.M. and the 12:00 P.M. dose was administered at 1:37 P.M. On 08/23/24 the 8:00 A.M. dose was administered at 10:59 A.M. and the 12:00 P.M. dose was administered at 1:53 P.M. On 08/24/24 the 8:00 A.M. dose was administered at 10:41 A.M. Additional review of the administration report indicated on 08/24/24 both the 5:00 P.M. dose and the 10:00 P.M. dose were administered together at 10:07 P.M. On 09/12/24 at 8:30 A.M. interview with Resident #118 revealed concerns with staff administering his antiparkinsonian medication, which he was to receive four times a day, late. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/12/24 at 12:12 P.M. with Director of Nursing (DON) verified the above medication administration findings. The DON stated she believed the nurses were likely not signing off medication administration at the actual time it was given but waiting until later in the shift to do it although that was not the proper procedure for medication administration. The DON revealed the nurses had one hour prior to one hour after the scheduled dose times to complete medication administration as ordered. Review of facility policy, Medication Administration - General Guidelines, revised December 2019 revealed the right resident, right drug, right dose, right route and right time were applied for each medication being administered. Medications were administered within 60 minutes of the schedule time. The individual who administered the medication dose recorded the administration on the medication administration record directly after the medication was given. This deficiency represents noncompliance investigated under Complaint Number OH00157103.