

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Square Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 W Market St Akron, OH 44313	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>Based on review of the medical record and interview with the staff the facility failed to ensure Resident #5 received his medication as ordered by the physician. This affected one resident (Resident #5) of three reviewed for medication administration. The facility census was 58.</p> <p>Findings included:</p> <p>Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included diabetes, pain in leg, psychoactive substance abuse, asthma, and muscle weakness.</p> <p>Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #5 had intact cognition. He had no upper or lower extremity impairment and he was receiving physical and occupational therapy.</p> <p>Review of the physician's progress notes dated 07/22/24 revealed Resident #5 was seen in the office for epigastric pain and was ordered pantoprazole (stomach acid reducer) 40 milligrams (mg) once daily.</p> <p>Review of the physician's orders revealed Resident #5 was not ordered pantoprazole 40 mg once daily until 08/08/24.</p> <p>Review of the medication administration records revealed Resident #5 received his first dose of pantoprazole 40 mg on 08/08/24.</p> <p>Review of the pharmacy delivery sheets revealed Resident #5 received three tablets of pantoprazole on 08/10/24.</p> <p>Review of the progress note dated 09/14/24 at 10:00 A.M. revealed Resident #5 was complaining of nausea and vomiting, feeling hot, and his tonsils were sore. He vomited liquid. The physician was notified and new orders were given.</p> <p>Review of the physician's progress note date 09/14/24 revealed staff called the physician due to the resident was complaining of nausea and vomiting, onset was one to two days ago, and denied the nausea and vomiting increased after eating. The plan was for laboratory tests and continue Zofran four mg every six hours as needed.</p> <p>(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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the September 2024 physician's order revealed Resident #5 did not have an order for Zofran four mg every six hours as needed.</p> <p>Review of the September 2024 Medication Administration Record revealed Resident #5 was never ordered or administered Zofran 4 mg every six hours as needed</p> <p>Review of the progress note dated 09/16/24 at 3:00 P. M. revealed Resident #5 went to a doctors' appointment with his mother regarding his sore throat. He was later admitted to the hospital for tonsilitis.</p> <p>On 09/25/24 at 4:45 P.M. an interview with Regional Director of Clinical Services #403 verified there was an order for pantoprazole 40 mg for Resident #5 however they were not given the progress notes from the physician's visit. She stated she did not know if any of the staff reached out to the physician's office to see if there were any new orders.</p> <p>On 09/26/24 at 9:38 A.M. an interview with Family Member #500 revealed the facility knew Resident #5 had an appointment on 07/22/24 with his physician. She sated because their van was broken down and she had to take him. She stated she had to get permission from his facility counselor to take him. She stated the doctor gave her a prescription for Pantoprazole for his acid reflux and she went to the drug store to have it filled. She stated when she got to the facility, she handed it to Receptionist #522. She stated Receptionist #522 told her she would get the Administrator. She stated the Administrator told her the facility had their own pharmacy, she explained she would have to order them through their pharmacy and she would take the medication just in case they could not get it in. She stated she did not know they could not use another pharmacy. She stated one week later Resident #5 told her he still had not received the medication. She stated she spoke to the Administrator again and the Administrator told her Resident #5 was receiving the medication. She explained to the Administrator Resident #5 would know if he was getting the medication and the Administrator stated she would look into it. She stated another week went by and Resident #5 had not received his medication. She stated her and her son called the ombudsman and explained to her what was going on. She stated the Ombudsman went to the facility and the Administrator told her the medication was lost but they would get it taken care of that day.</p> <p>On 09/26/24 at 09/26/24 at 10:35 A.M. with Resident #5 revealed he did not receive his medication for his acid reflux for about two weeks after he brought it to the facility.</p> <p>On 09/26/24 at 11:10 A.M. an interview with Regional Director of Clinical Service # 403 revealed the facility was aware Resident #5 was going out to physician's appointments and they had sent paperwork with him to those appointments. She verified again none reached out to the physician's office to see if there was any paperwork or new orders.</p> <p>On 09/26/24 at 1:50 P.M. an interview with the Director of Nursing confirmed no order for Zofran was written on 09/14/24 and she would speak to the nurse who worked that day to find out why.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/26/24 at 2:05 P.M. an interview with Ombudsman Supervisor #530 revealed the Ombudsman covering the facility was on vacation however he had access to her notes. He stated the notes indicated that Resident #5 and his mother reached out to the Ombudsman, stated Resident #5 was ordered a medication for acid reflux and had not received it and it had been over two weeks. He stated the notes indicated the Ombudsman spoke to the Administrator about the issue and she verified the administrator stated they had received his mediation and it was in the medication cart however she would not say how long of a gap there was between receiving the medications and him actually getting the medication.</p> <p>Observation of medication with Licensed Practical Nurse #400 on 09/30/24 at 2:50 P.M. revealed the staff was using a bottle of 90 tablets of pantoprazole 40 mg from a local drug store.</p> <p>Review of the facility policy titled, Administering Medications, dated 12/12 revealed medication would be administered in a safe and timely manner and as prescribed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157506 and OH00157525.</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>Based on review of the medical record, review of therapy notes, and interview with staff the facility failed to provide therapy services to Resident #5 after he won his appeal. This affected one resident (Resident #5) of three reviewed for therapy services. The facility census was 58.</p> <p>Findings Included:</p> <p>Review of the medical record revealed Resident #5 was admitted to the facility on [DATE]. Diagnoses included diabetes, pain in leg, psychoactive substance abuse, asthma, and muscle weakness.</p> <p>Review of the physician's orders revealed Resident #5 had orders for physical therapy (PT) to evaluate and treat four times a week for four weeks and occupational therapy (OT) would evaluate and treat four times a week for four weeks dated 07/08/24.</p> <p>Review of the OT evaluation and plan of treatment dated 07/08/24 revealed Resident #5 was certified from 07/08/24 through 08/06/24 for four times per week for four weeks.</p> <p>Review of the PT evaluation and plan of treatment dated 07/08/24 revealed Resident #5 was certified from 07/08/24 to 08/05/24 for four times a week for four weeks.</p> <p>Review of the skilled review dated 07/11/24 revealed Resident #5 was due to be reviewed for further skilled services on 07/18/24 at 8:30 A.M. Items needed included medication administration records, treatment administration records, last seven days of narrative notes, physician's documentation, therapy notes target dated for discharge, and care conference notes.</p> <p>Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #5 had intact cognition. He had no upper or lower extremity impairment and he was receiving physical and occupational therapy.</p> <p>Review of the occupation therapy notes revealed Resident #5 last day of OT was on 07/30/24.</p> <p>Review of the physical therapy notes revealed Resident #5 last of PT was on 07/31/24.</p> <p>Review of the appeal letter from Anthem dated 08/06/24 revealed Resident #5 was approved for more therapy days from 08/06/24 to 08/10/24 however he never received those extra four days of therapy he was approved for.</p> <p>On 09/26/24 at 09/26/24 at 10:35 A.M. with Resident #5 revealed he was cut from therapy at the end of July. He stated he appealed and won but never received anymore days. He stated therapy cut him because he refused to use the weight machine anymore because he felt something move in his back every time, he used it and he was not hurting himself.</p> <p>On 09/26/24 at 2:35 P.M. an interview with Regional Director of Operation #483 revealed the therapy department stated Resident #5 did not need any more therapy so they did not pick him up from 08/06/24 to 08/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/30/24 at 1:13 P.M. an interview with Director of Therapy #464 revealed Resident #5 last covered day was 07/31/24. However , he appealed and won more time. She stated she did not believe he needed more therapy due to he was up walking around with a walker independently. She verified normally when a resident appeals and wins they would continue therapy for the certification period but they did not for Resident #5. She stated his therapy was only approved for discharged purposes.</p> <p>On 09/30/24 at 4:40 P.M. an interview with Regional Director of Operations #483 verified the facility had no documentation indicating the certification period from 08/06/24 through 08/10/24 were for discharge planning only and not therapy. She verified he had not received therapy at this time.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157525.</p>		