STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365354	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longmeadow Care Center	565 Bryn Mawr Ravenna, OH 44266

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview, record review, and review of the facility policy, the facility failed to deliver all resident mail and personal packages to them unopened. This affected two residents reviewed (Resident #1 and #24) and had the potential to affect all residents. The facility census was 78. Findings include: 1. Record review for Resident #1 revealed an admitted [DATE] and a transfer to hospital date of 08/08/24. Diagnosis included respiratory failure with hypoxia, morbid severe obesity due to excessive calories, atrial fibrillation, and dependence on respirator (ventilator) status. Review of the annual Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed Resident # #1 was cognitively intact. Resident #1 used a wheelchair for mobility. Phone interview on 08/19/24 at 2:22 P.M. with Resident #1 revealed while she was at the facility, she received mail and packages delivered by the staff that were opened without her permission prior to her receiving them. Interview on 08/19/24 at 2:34 P.M. with Licensed Practical Nurse (LPN) #295 revealed Activity Director #305 delivered residents mail. If a parcel arrived for a resident, the nurses opened it prior to delivering it because residents had paraphernalia/liquor delivered in the past. Interview on 08/19/24 at 3:26 P.M. with Activity Director #305 revealed she delivered all residents mail daily. Activity Director #305 revealed the mail was delivered to the receptionist at the front entrance daily Monday through Saturday. The receptionist would sort the mail then place the residents personal mail in her mailbox to be delivered to the residents. Observation of Activity Director #305's mailbox with Activity Director #305 revealed the department head mailboxes were in a room behind a closed door next to the nurses station. Observation revealed all department heads mailbox was on the wall and residents hard charts were on racks located in the room. Activity Director #305 revealed she never opened residents personal mail herself, but she found opened mail in her box that belonged to Resident #1. Activity Director #305 revealed Resident #1 ordered packages and she also found several packages of Resident #1's opened prior to delivery to her room. Activity Director #305 revealed she asked staff, but no one knew who was doing it. She also talked to the previous Administrator about the concern with no resolution. (continued on next page)

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #24 revealed an admitted [DATE]. Diagnosis included acute respiratory failure, heart failure and morbid obesity. Review of the quarterly MDS dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 had no impairment of the upper or lower extremities. Resident used a walker and wheelchair for mobility. Interview on 08/20/24 at 4:00 P.M. with Resident #24 revealed they obviously go through his packages he ordered prior to giving them to him because he had a delivery from Wal Mart the previous evening at 8:00 P. M. and they removed the hot dogs he ordered and returned them to him the next day. Observation revealed Resident #24 had a small refrigerator in his room. Resident #24 revealed he ordered food items in and would keep them in his refrigerator. Resident #24 revealed he preferred the staff didn't go through his stuff. Review of the facility policy titled, Resident Rights undated revealed the resident had the right to be free of involuntary searches of both body and personal possessions. This deficiency represents non-compliance investigated under Complaint Number OH00155925.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview, record review, and review of the facility policy, the facility failed to assure one resident, Resident #5 received routine showers/baths per the resident preference and the facility schedule. This affected one resident (Resident #5) of three residents reviewed for bathing. The facility census was 78. Findings include: Record review for Resident #5 revealed an admitted [DATE]. Diagnosis included autistic disorder, morbid obesity, and malignant neuroleptic syndrome. Record review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was moderately cognitively impaired. Resident #5 had no impairment of the upper or lower extremities, used a wheelchair for mobility, required set up or clean up assist for meals and was dependent for showers. Review of the care plan dated 01/22/24 for Resident #5 revealed assistance needed for activities of daily living (ADL) related to cognitive impairment, impaired mobility, Autism, and intellectual disability. The resident required weight-bearing assistance (including holding, lifting, or supporting trunk or limbs) for: showering, upper body dressing. Staff would assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly. Review of the shower schedule revealed Resident #5 was scheduled to receive showers on day shift Monday's and Thursday's. Interview on 08/19/24 at 3:20 P.M. with Resident #5 revealed he did not always receive his showers as scheduled, and he wanted his routine showers. Resident #5 denied refusing showers. Interview on 08/20/24 at 10:54 A.M. and review of the daily shower sheets with Director of Nursing (DON) for June, July and August 2024 completed by State tested Nursing Assistants (STNA's) for Resident #5 revealed from 06/04/24 through 06/09/24 revealed there was no shower sheet completed or evidence Resident #5 received a shower or bath during that period. From 06/12/24 through 06/26/24 there was no shower sheet completed or evidence Resident #5 received a shower or bath during that period. From 06/28/24 through 07/03/24 there was no shower sheet completed or evidence Resident #5 received a shower or bath during that period. From 07/05/24 through 07/14/24 there was no shower sheet completed or evidence Resident #5 received a shower or bath during that period. From 07/16/24 through 07/22/24 there was no shower sheet completed or evidence Resident #5 received a shower or bath during that period and from 08/02/24 through 08/14/24 revealed no shower sheet or evidence Resident #5 received a shower or bath during that period. DON revealed residents were to be offered a minimum of two showers or baths a week. The resident could determine if they preferred a shower or bath. DON confirmed when a shower or bath was given or offered, a shower sheet would be completed by the STNA. If the resident refused, Refused would be documented on the shower sheet and signed by the STNA. DON confirmed there was no further evidence Resident #5 received or was offered a shower or bath during those times. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Resident Care revised 06/18 revealed Residents will be bathed or assisted to shower or bathe routinely and as needed per their preference with foot care given per order/need. This deficiency represents non-compliance investigated under Complaint Number OH00155925.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, and record review, the facility failed to timely report and address a Resident #21's change in skin condition. This affected one resident (Resident #21) of three residents reviewed for change in condition. Findings include: Record review for Resident #21 revealed an admitted [DATE]. Diagnosis included schizoaffective disorder, HIV, and Alzheimer's disease. Review of the physician orders for Resident #21 revealed an order dated 10/17/22 to apply zinc oxide cream to bilateral buttocks every shift and as needed for skin integrity. Review of the quarterly Minimum Data set (MDS) dated [DATE] revealed Resident #21 was rarely or never understood. Resident #21 had no impairment in functional limitations in range of motion to the upper or lower extremities, Resident #21 was dependent for personal hygiene. Resident #21 was always incontinent of bowel and bladder. Resident # received applications of ointments. Resident #21 required supervision or touch assist with walking 10 feet. Review of the care plan for Resident #21 dated 06/24/24 revealed assistance needed for activities of daily living (ADL) related to cognitive impairment, decreased mobility, and potential for pain. Apply house moisture barrier cream after each incontinence episode. Inspect skin condition daily during personal care and report any impaired areas to charge nurse. Observation on 08/19/24 at 9:11 A.M. of incontinence care for Resident #21 completed by State tested Nursing Assistant (STNA) #275 and STNA #600 revealed Resident #21's entire peri area including the penis, scrotum, under the scrotal area, upper thighs, and the fold between the buttocks was deep red. The area under the scrotum had multiple small white crusty particles. STNA #275 and #600 confirmed the deep red areas and revealed they apply zinc oxide skin protectant. Resident #21 did not verbally respond to surveyors questions. Observation revealed Resident #5 was compliant to instructions of STNA #275 and #600. Observation revealed when STNA #275 began washing the reddened peri area, Resident #21 began jerking his body slightly with each wipe. When STNA #275 used a cloth and wiped under the scrotum, Resident #21 yelled an incoherent word loudly and swung his arm to stop STNA #275. STNA #275 and #600 again explained to Resident #21 the need for completion of the peri care, Resident #21 calmed down and permitted completion of care. Observation revealed a 16-ounce jar of zinc oxide ointment on Resident #21's bedside stand. Observation revealed STNA #275 applied the zinc oxide ointment on and over the entire penis, peri area and buttocks. Record review of Resident #21's medical record revealed no documentation of Resident #21's peri/rectal area or any area being red. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/19/24 at 4:37 P.M. with Registered Nurse (RN) #601 confirmed he was Resident #21's primary care nurse and had been since 7:00 A.M. at the beginning of his shift. RN #601 revealed STNA #275 and #600 left the facility for the day due to it was the end of their shift. RN #601 revealed no one reported anything to him regarding Resident #21's peri/rectal area being red. RN #601 revealed STNA's routinely apply zinc to residents peri areas as a moisture barrier only and revealed it would be ineffective to treat a skin infection. RN #601 and revealed the STNA's should have reported to him if there was a change and Resident #21 was red. Review of the progress note for Resident #21 dated 08/19/24 at 5:10 P.M. completed by RN #601 revealed assessed resident's perineal area and discovered reddened and excoriated areas throughout perineal area bilaterally and under the scrotum. Review of the progress note for Resident #21 dated 08/19/24 at 6:17 P.M. completed by RN #601 revealed they received instruction from physician to start Diflucan 200 mg (used for yeast infection) one time a day for three days. Interview on 08/19/24 at 4:51 P. M. with STNA #690 revealed she worked with Resident #21 all the time and revealed, he was red like that for about a month, they use the zinc barrier cream and they put it on heavy because he was so red and they have told the nurses, and they just said put the cream on.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure Resident #21, who had a history of Alzheimer's disease, had proper interventions in place to prevent consumption of poisonous substances. This affected one resident (Resident #21) of one resident reviewed for dementia care. The facility census was 78. Findings include: Record review for Resident #21 revealed an admitted [DATE]. Diagnosis included schizoaffective disorder and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was rarely or never understood. Resident #21 had no impairment in functional limitations in range of motion to the upper or lower extremities, Resident #21 required set up or clean up assist with eating and was dependent for personal hygiene. Resident #21 was always incontinent of bowel and bladder. Resident #21 received applications of ointments. Resident #21 required supervision or touch assist with walking 10 feet. Review of the care plan for Resident #21 dated 06/24/24 revealed assistance needed for activities of daily living (ADL) related to cognitive impairment, decreased mobility, and potential for pain. Amount of assistance required/how much (Resident #21) can complete fluctuates with moods. Apply house moisture barrier cream after each incontinence episode. Observation on 08/19/24 at 9:11 A.M. of incontinence care for Resident #21 completed by State tested Nursing Assistant (STNA) #275 and STNA #600. Observation revealed a 16-ounce jar of zinc oxide ointment on top of Resident #21's bedside stand. The zinc oxide was within reach for Resident #21. Observation revealed STNA #275 applied the zinc oxide ointment after incontinence care was completed and replaced the zinc oxide ointment to the bedside stand. Interview on 08/19/24 at 4:51 P.M. with STNA #690 revealed she was scheduled a different hall this day, but she worked with Resident #21 all the time. STNA #690 stated, You got to be careful with that cream, zinc, he will eat it, I caught him before eating it several times, that's why I put it in the bathroom. STNA #690 revealed Resident #21 transferred himself at times, and could walk about 10 feet or so, he does take himself to the bathroom sometimes. STNA #690 revealed she did tell the nurse about Resident #21 eating the zinc cream but did not recall who because it was a while ago. Interview on 08/19/24 at 4:58 P.M. with STNA #691 revealed she was assigned to Resident #21. Observed with STNA #691 the 16-ounce zinc oxide container on Resident #21's nightstand next to his bed. Resident #21 was in bed resting quietly. STNA #691 revealed she hardly ever worked with Resident #21, she just kept the zinc oxide cream on the stand next to him because that's where she found it. STNA #691 revealed she was unaware Resident #21 would eat the cream. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/19/24 at 5:00 P.M. with Director of Nursing (DON) revealed the facility used zinc oxide on residents routinely as a barrier cream. DON revealed it was ok to keep the zinc oxide cream in residents rooms but it would not be ok if they were eating it. Review of the zinc oxide pamphlet information provided by DON revealed warnings to include - For external use only, avoid contact with eyes, if swallowed, get medical help or contact a poison control center immediately. Keep out of reach of children. Review of the facility policy titled; Dementia Care revised 07/01/24 revealed if needed the environment will be modified to accommodate individual resident care needs.

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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** 42011 Based on interview, record review, and review of the facility policy, the facility failed to ensure Resident #1 was free from significant medication error. This affected one resident (Resident #1) of three residents reviewed for medication administration. The facility census was 78. Findings include: Record review for Resident #1 revealed an admitted [DATE] and a transfer to hospital date of 08/08/24. Diagnosis included respiratory failure with hypoxia and atrial fibrillation. Review of the annual Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed Resident #1 was cognitively intact. Review of the physician orders for Resident #1 dated 07/08/24 revealed an order for Midodrine (used to increase blood pressure) hcl 10 milligrams (mg) one tablet by mouth three times a day for blood pressure, hold if systolic blood pressure (SBP) above 120. Review of the Medication Administration Record (MAR) for Resident #1 for 07/08/24 through 08/07/24 revealed Resident #1's blood pressure was monitored prior to Midodrine hcl medication administration three times a day. Review of the MAR revealed on 07/08/24 Resident #1 blood pressure at 7:00 P.M. was assessed and results were 128/76. Review of the MAR revealed Midodrine was signed as given. Additionally, on 07/09/24 during A.M. medication administration, Resident #1 blood pressure was 128/74, on 07/10/24 at A.M. the blood pressure was 122/74, on 07/11/24 during lunch administration, the blood pressure was 152/93, on 07/13/24 at A.M. the blood pressure was 122/64, on 07/14/24 at A.M. Resident #1 blood pressure was 122/68, 07/16/24 at lunch Resident #1's blood pressure was 165/149, on 07/22/24 at lunch administration Resident #1's blood pressure was 128/68. On 08/01/24 during the A.M. Resident #1 blood pressure was 121/76 and on 08/07/24 at 7:00 P.M. administration, Resident's blood pressure was documented as 130/71. The medication Midodrine hcl 10 mg was documented as given after the blood pressure assessment for each of the identified systolic blood pressures above 120. Interview on 08/19/24 at 2:34 P.M. with Licensed Practical Nurse (LPN) #295 revealed if a medication was held for a resident, then the appropriate code would be documented on the MAR indicating the medication was held or not given. If the medication was given, the MAR would have a check mark indicating the medication was given. Interview and record review on 08/20/24 at 8:37 A.M. with Director of Nursing (DON) of the MAR for July and August 2024 for Resident #1 confirmed the MAR indicated Resident #1 received the medication Midodrine hcl 10 mg when the medication should have been held per the physicians orders after the blood pressure assessment for each of the documented blood pressures that were higher than 120 systolic. DON confirmed when the medication was held, a separate code would be documented indicating the medication was held. Review of the facility policy titled, Medication Administration revised 08/22/22 revealed obtain and record vital signs, when applicable, or per physician orders. When applicable, hold medications for those vital signs outside the physicians prescribed parameters.