STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Health Care	1320 Mahoning Ave NW Warren, OH 44483

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure the resident's right to self-administer medications was clinically appropriate. This affected one Resident (#78) of eight residents reviewed for medication administration. The facility census was 80. Findings include: Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, cellulitis of the right nd left lower limbs, chronic pressure ulcers with necrosis of the muscle of both feet, gangrene, atrial fibrillation, hypertension, and asthma. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #78 had intact cognition and had asthma. Review of the physician orders revealed an order dated 01/22/24 for albuterol sulfate inhalation aerosol solution 108 (90 base) micrograms (mcg) per actuation, two puffs inhaled orally every six hours as needed for shortness of breath (SOB) related to asthma. Further review of the order revealed the albuterol was to be clinician administered. Review of the medication administration records (MARs) from the last three months revealed no documentation of albuterol administration as needed for SOB. Review of the care plan revealed Resident #78 had the potential for ineffective breathing related to asthma. Interventions included giving medications as ordered and documenting the effectiveness. Review of the resident assessments revealed no assessments titled Medication Self-Administration Safety Assessment. Observation on 05/13/24 at 10:24 A.M. revealed an albuterol inhaler on Resident #78's bedside table. An interview conducted at that time with Resident #78 confirmed the albuterol inhaler belonged to him and that he self-administered two puffs of the inhaler whenever he needed it for SOB. Further interview revealed Resident #78 did not communicate with facility nurses when he used his albuterol inhaler at the bedside. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/24 at 10:21 A.M. with Resident #78 confirmed he self-administered two puffs of albuterol on 05/13/24 because he experienced SOB, but he did not inform the nurse. Interview on 05/15/24 at 10:24 A.M. with licensed practical nurse (LPN) #305 revealed she had no knowledge of any facility residents who self-administered medications. She further confirmed she was aware Resident #78 kept an albuterol inhaler at his bedside. During an observation conducted with the DON on 05/15/24 at 3:34 P.M., the DON confirmed Resident #78 had an albuterol inhaler at his bedside. At the time of this shared observation, Resident #78 confirmed to the DON that the nurses knew he had an inhaler, he used it when needed but did not inform the nurses, and he wished to continue to self-administer his albuterol. Interview on 05/15/24 at 4:00 P.M. with the Director of Nursing (DON) revealed anyone wishing to self-administer medications would be assessed for safety and appropriateness. The assessment titled Medication Self-Administration Safety Assessment would be located under assessments tab in the resident's medical record. Review of the facility generated report of residents who self-administer medications revealed there were no residents in the facility who were currently approved to self-administered medications. Review of the Medication Self-Administration Policy dated June 2018 revealed residents were not permitted to self-administer medications unless the interdisciplinary team determined it was clinically appropriate. Once deemed appropriate, the medication was to be secured properly in the resident's room and the resident must have agreed to notify the nurse each time the medication was administered.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on interview, medical record review, and policy review the facility failed to ensure resident choices related to advanced directives were honored. This affected one resident (Resident #78) of two reviewed for advanced directives. The facility census was 80. Findings include: Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, cellulitis of the right nd left lower limbs, chronic pressure ulcers with necrosis of the muscle of both feet, gangrene, atrial fibrillation, hypertension, and asthma. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on [DATE] revealed Resident #78 had intact cognition and was independent with personal care. Review of the physician orders revealed an active order dated [DATE] designating Resident #78 as a full code. Review of the progress note dated [DATE] revealed the Social Services Designee (SSD) discussed advanced directives with Resident #78 on this date. During the care conference on [DATE], Resident #78 verbalized his wishes to change his code status from full code to Do Not Resuscitate Comfort Care (DNRCC). Review of the care plan dated [DATE] revealed Resident #78 had no advanced directives and was a full code. Review of the advanced directives tab in the paper chart on the nursing unit revealed Resident #78 signed a DNRCC. The DNRCC form was undated and there were no other visual cues in or on the hard chart indicating Resident #78 was not a full code. Interview on [DATE] at 2:56 P.M. with Resident #78 confirmed he made his own medical decisions, signed a DNR, and did not want staff to initiate cardiopulmonary resuscitation (CPR) in the event he stopped breathing, or his heart stopped beating. Interview on [DATE] at 10:24 A.M. with licensed practical nurse (LPN) #305 confirmed Resident #78 was listed as a full code as she verified the order in the electronic medical record. Interview on [DATE] at 11:18 A.M. with SSD #376 revealed care planning meetings are conducted as soon as possible after admission and code status was discussed at beginning of these meetings. According to SSD #376, if a resident wished to change their code status from a full code to a do not resuscitate (DNR), the options are discussed with the resident, a DNR paper would be filled out and signed, then the form would be provided to the physician for signature. At the time of this interview, SSD #376 and the Administrator both verified the DNRCC form for Resident #78 was signed by the physician. (continued on next page)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:27 A.M. with the Administrator confirmed Resident #78's orders listed Full Code as his code status. Review of the Advanced Care Planning Policy, dated 2013, revealed residents were given the opportunity to discuss their goals, including advanced care planning preferences and advanced directives. Further review of the policy revealed meeting outcomes are communicated with the team, interventions are documented on the medical record, and any needed follow-up should be conducted timely. This deficiency represents non-compliance investigated under Complaint Number OH00153197.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on interviews, policy review, and review of the facility's investigation notes, the facility failed to ensure resident medications were not misappropriated. This affected two current residents (Residents #20 and #33) and two former residents (Residents #234 and #332) who resided on the one-hundred hall and had the potential to affect seven additional residents (#26, #50, #54, #59, #67, #68, and #79) the facility identified as receiving controlled substances from the one hundred medication cart. The facility census was 80. Findings include: 1. Review of the medical record for Resident #20 revealed an initial admitted [DATE] and a facility re-entry date of 04/26/24 with diagnoses including non-ST elevation myocardial infarction, heart failure, stage three pressure ulcer of the sacral region, morbid obesity, chronic obstructive pulmonary disease (COPD), cardiomyopathy, and osteoarthritis of the right hip. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had intact cognition, frequently experienced pain that interfered with sleep and participation in day-to-day activities for which she received opioids on an as needed basis. Review of the physician orders revealed an order dated 03/11/24 through 04/05/24 for Resident #20 to receive oxycodone hydrochloride (HCl) 10 milligrams (mg) oral tablet, one tablet by mouth every eight hours as needed for pain. Another order dated 04/06/24 and discontinued on 04/09/24 was noted upon order review for oxycodone HCL five milligram oral tablets, 7.5mg by mouth every eight hours as needed for pain. Further review of the physician orders revealed an order dated 04/09/24 and discontinued on 04/26/24 for oxycodone HCL 10 milligrams (mg) oral tablet, 10 mg by mouth every eight hours as needed for pain for 21 days. Review of the care plan dated 04/28/24 revealed Resident #20 had the potential for acute and chronic pain related to decreased mobility, a history of atypical chest pain and COPD. Interventions included administering medications per physician orders and notifying the physician if ordered pain medications were ineffective. Review of the medication administration record (MAR) from March 2024 through May 2024 revealed Resident #20 received oxycodone at least daily as needed for pain throughout the duration of the orders. Further review of the April 2024 MAR revealed the oxycodone administered by Registered Nurse (RN) #438 on 04/02/24 at 3:20 P.M. and on 04/11/24 at 2:10 P.M. were documented to be ineffective. Other doses administered through the month of April 2024 were listed as effective. Review of the Controlled Drug Record for Resident #20's oxycodone 5 mg tablets revealed RN #438 documented she wasted two of Resident #20's 5 mg tablets on the following dates: 03/14/24, 03/20/24, 03/23/24, 03/24/24, 03/27/24, 03/28/24, 03/29/24, 04/01/24, 04/03/24, 04/06/24, and 04/11/24. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had two concerns with drug diversion, one with oxycodone and one with morphine, both brought to her attention on 04/11/24. Further interview revealed a couple facility nurses reported to the Administrator that when they came on shift after RN #438, they would find that RN #438 had wasted oxycodone during her scheduled shift. The administrator also reported LPN #315 told her that her signature was forged on the controlled substance logs on dates RN #438 wasted oxycodone and she was on duty. During this interview, the Administrator stated it was determined at the closure of the facility investigation that RN #438 was believed to be pocketing the oxycodone, but they were unable to find evidence any of the residents went without their pain medications when needed. Review of the facility investigation notes revealed the following: On 04/11/24, Licensed Practical Nurses (LPNs) #314 and #318 reported concerns that RN #438 wasted oxycodone tablets every time she worked and on 04/11/24, RN #438 had wasted narcotics on four different residents on Unit one (the 100 hall). An incident report was filed with the [NAME] police department on 04/11/24 at 4:46 P.M. alleging controlled substances were diverted from four facility residents. Further review of the police report revealed RN #438 had been noted taking the medication cart into unoccupied rooms and noting narcotic medications were wasted every day she was on duty, but no other nurses had witnessed the drugs being wasted. A report was filed with the Ohio Board of Nursing for concerns related to controlled substances and RN #438's refusal to submit to a drug screening upon suspicion of drug diversion. A witness statement on 04/12/24 revealed LPN #315 confirmed her signature had been forged several times as the co-signer next to RN #438's name on the wasted was documented on the controlled substance records. Human Resources (HR) staff #374 informed the Administrator on 04/12/24 that RN #438 refused to go with her to get a toxicology screening, telling HR staff #374 that her toxicology report would be positive, though she did not report for what substance the report would result in a positive screen. RN # 438 did not provide a written statement but wrote a notice of resignation to take place immediately on 04/12/24. Review of the policy dated January 201, titled: Controlled Drug Policy and Procedure revealed controlled substances were to be counted by the oncoming and off-going nurses every eight hours and recorded and signed off by the nurses to ensure accuracy of the count. Further review of the controlled drug policy revealed any discrepancies were to be reported to the unit manager or supervisor. Review of the undated policy titled Reporting Abuse to Facility Management revealed misappropriation included the deliberate misplacement, use, or misuse of a resident's belongings, money or other resources. 2. Review of the medical record for Resident #33 revealed a facility re-entry date of 04/08/24 with diagnoses including stage three chronic kidney disease, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), attention to colostomy, anxiety, seizures, and atrial fibrillation. Review of the MDS assessment completed on 04/15/24 revealed Resident #33 was cognitively intact and received opioids for pain that frequently interfered with sleep and day-to-day activities. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders revealed an order dated 01/31/24 for Resident #33 to receive oxycodone hydrochloride (HCl) 10 milligram (mg) oral tablet, one by mouth every six hours as needed for pain. Another order, updated on 03/29/24, was for oxycodone HCL 10 mg oral tablet, give one by mouth every six hours as needed for severe pain. Further review of physician orders revealed orders dated 04/10/24 for oxycodone HCL 10 mg oral tablets and oxycodone HCL 5 mg oral tablets, give one 10 mg tablet and one 5 mg tablet for a total of 15 mg oxycodone every six hours as needed for pain for a total of 15 mg per dose. Review of the care plan dated 03/18/24 revealed Resident #33 had the potential for acute and chronic pain related to a colovesical fistula, COPD, and decreased mobility. Interventions included administration of analgesics per orders and notifying if pain management interventions were unsuccessful. Review of the medication administration records (MARs) for March 2024 and April 2024 revealed documentation Resident #33 received oxycodone for pain at least twice daily throughout each month. Review of the MAR also revealed an order for lorazepam one milligram tablets from 03/39/34 through 04/10/24, give 1 tablet by mouth every four hours as needed for anxiety or agitation and another order dated 04/10/24 for one tablet every four hours as needed for agitation for 14 days. Review of the Controlled Drug Record for Resident #33's oxycodone 10 mg tablets were documented as wasted by RN #438 on the following dates: 02/07/24, twice on 02/05/24 (this date was entered between counts logged on 02/11/24 and 02/13/24 for a total of 20 mg), 02/15/24, 02/21/24, 02/2/24, 02/29/24, 03/01/24, 03/04/24, twice on 03/05/24 (total of 20 mg), 03/10/24, 03/14/24, 03/18/24, 03/19/24, 03/20/24, 03/23/24, 03/24/24, 03/27/24, 03/28/24, 03/29/24, 04/01/24, 04/02/24, and twice on 04/03/24 (for 10 mg total this date). Review of the Controlled Drug Record for Resident #33's lorazepam 1mg tablets revealed RN #438 documented one tablet was wasted on 04/11/24. Review of the progress notes revealed no notes related to medication needing wasted or oxycodone refusal. Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had two concerns with drug diversion, one with oxycodone and one with morphine, both brought to her attention on 04/11/24. Further interview revealed a couple facility nurses reported to the Administrator that when they came on shift after RN #438, they would find that RN #438 had wasted oxycodone during her scheduled shift. The administrator also reported LPN #315 told her that her signature was forged on the controlled substance logs on dates RN #438 wasted oxycodone and she was on duty. During this interview, the Administrator stated it was determined at the closure of the facility investigation that RN #438 was believed to be pocketing the oxycodone, but they were unable to find evidence any of the residents went without their pain medications when needed, with the exception that Resident #33 revealed to facility staff the pill he was offered did not look like the oxycodone he typically received from nursing staff. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation notes revealed the following: On 04/11/24, Licensed Practical Nurses (LPNs) #314 and #318 reported concerns that RN #438 wasted oxycodone tablets every time she worked and on 04/11/24, RN #438 had wasted narcotics on four different residents on Unit one (the 100 hall). An incident report was filed with the [NAME] police department on 04/11/24 at 4:46 P.M. alleging controlled substances were diverted from four facility residents. Further review of the police report revealed RN #438 had been noted taking the medication cart into unoccupied rooms and noting narcotic medications were wasted every day she was on duty, but no other nurses had witnessed the drugs being wasted. A report was filed with the Ohio Board of Nursing for concerns related to controlled substances and RN #438's refusal to submit to a drug screening upon suspicion of drug diversion. A witness statement on 04/12/24 revealed LPN #315 confirmed her signature had been forged several times as the co-signer next to RN #438's name on the wasted was documented on the controlled substance records. Human Resources (HR) staff #374 informed the Administrator on 04/12/24 that RN #438 refused to go with her to get a toxicology screening, telling HR staff #374 that her toxicology report would be positive, though she did not report for what substance the report would result in a positive screen. RN # 438 did not provide a written statement but wrote a notice of resignation to take place immediately on 04/12/24. Review of the policy dated January 201, titled: Controlled Drug Policy and Procedure revealed controlled substances were to be counted by the oncoming and off-going nurses every eight hours and recorded and signed off by the nurses to ensure accuracy of the count. Further review of the controlled drug policy revealed any discrepancies were to be reported to the unit manager or supervisor. Review of the undated policy titled Reporting Abuse to Facility Management revealed misappropriation included the deliberate misplacement, use, or misuse of a resident's belongings, money, or other resources. 3. Review of the medical record for Former Resident (FR) #234 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses including atherosclerotic heart disease of coronary artery without angina, aortocoronary bypass graft, postprocedural pain, urinary tract infection, chronic kidney disease, congestive heart failure (CHF), and type 2 diabetes mellitus. Review of the admission MDS 3.0 assessment completed 03/18/24 revealed FR #234 was cognitively intact and required maximal assistance for transfers, ambulation, and personal hygiene. Review of the physician orders revealed an order dated 03/19/24 for oxycodone-acetaminophen 5-325 milligrams (mg) (Percocet), one tablet by mouth every six hours as needed for pain. Review of the progress notes revealed FR #234 would request pain medication for leg pain when needed. Further review of the progress notes revealed no documented refusal of pain medication. Review of the Controlled Drug Record for FR #234's Percocet 5-325mg tablets revealed RN #438 documented she wasted a Percocet tablet on 04/07/24 and on 04/11/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had two concerns with drug diversion, one with oxycodone and one with morphine, both brought to her attention on 04/11/24. Further interview revealed a couple facility nurses reported to the Administrator that when they came on shift after RN #438, they would find that RN #438 had wasted oxycodone during her scheduled shift. The administrator also reported LPN #315 told her that her signature was forged on the controlled substance logs on dates RN #438 wasted oxycodone and she was on duty. During this interview, the Administrator stated it was determined at the closure of the facility investigation that RN #438 was believed to be pocketing the pills, but they were unable to find evidence any Former Resident #234 went without their pain medications when needed. Review of the facility investigation notes revealed the following: On 04/11/24, Licensed Practical Nurses (LPNs) #314 and #318 reported concerns that RN #438 wasted oxycodone tablets every time she worked and on 04/11/24, RN #438 had wasted narcotics on four different residents on Unit one (the 100 hall). An incident report was filed with the [NAME] police department on 04/11/24 at 4:46 P.M. alleging controlled substances were diverted from four facility residents. Further review of the police report revealed RN #438 had been noted taking the medication cart into unoccupied rooms and noting narcotic medications were wasted every day she was on duty, but no other nurses had witnessed the drugs being wasted. A report was filed with the Ohio Board of Nursing for concerns related to controlled substances and RN #438's refusal to submit to a drug screening upon suspicion of drug diversion. A witness statement on 04/12/24 revealed LPN #15 confirmed her signature had been forged several times as the co-signer next to RN #438's name on the wasted was documented on the controlled substance records. Human Resources (HR) staff #374 informed the Administrator on 04/12/24 that RN #438 refused to go with her to get a toxicology screening, telling HR staff #374 that her toxicology report would be positive, though she did not report for what substance the report would result in a positive screen. RN # 438 did not provide a written statement but wrote a notice of resignation to take place immediately on 04/12/24. Review of the policy dated January 201, titled: Controlled Drug Policy and Procedure revealed controlled substances were to be counted by the oncoming and off-going nurses every eight hours and recorded and signed off by the nurses to ensure accuracy of the count. Further review of the controlled drug policy revealed any discrepancies were to be reported to the unit manager or supervisor. Review of the undated policy titled Reporting Abuse to Facility Management revealed misappropriation included the deliberate misplacement, use, or misuse of a resident's belongings, money, or other resources. 4. Review of the medical record for Former Resident (FR) #332 revealed he was admitted to the facility on [DATE] and was discharged to home on 04/08/24. Diagnoses included metabolic encephalopathy, atrial flutter, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, hypertension, adjustment disorder, fusion of the cervical region of the spine, and chronic atrial fibrillation. Review of the last quarterly MDS 3.0 assessment completed 03/09/24 revealed Former Resident #332 had moderately impaired cognition. Further review of the MDS revealed FR #332 was on a scheduled pain regimen and received opioids. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication orders revealed FR #332 had a physician order dated 03/13/24 through 04/18/24 for morphine sulfate oral solution 20 milligrams per milliliter (mg/ml), 0.25 ml by mouth two times a day for pain for 14 days and an additional 0.25 ml by mouth every 12 hours as needed for pain. Review of the MAR from March 2024 and April 2024 revealed no concerns with FR #332 receiving morphine as ordered. Further review of the April 2024 MAR revealed the last dose FR #332 received was on 04/08/24 at 8:32 A.M. Review of the progress notes revealed no concerns related to FR #332 refusing his ordered pain medication or pain medication being spilled or wasted. Review of the Controlled Drug Record for Former Resident #332 revealed the last amount recorded of morphine sulfate was 10 ml on 04/08/24 at 8:30 A.M. by LPN #309. Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had two concerns with drug diversion, one with oxycodone and one with morphine, both brought to her attention on 04/11/24. The administrator further revealed the morphine discrepancy was brought to her attention when an agency nurse refused to take the keys to the narcotic drawer on Unit one (the 100 hall) at change of shift on 04/11/24 when she found a note indicating the morphine count was off for FR #332. Per the Administrator during this interview, Registered Nurse #437, who was also the previous Director of Nursing, was made aware of the discrepancy on 04/08/24 by LPN #309 and did not follow-up. The Administrator further reported there was no concern that the unaccounted-for morphine was diverted away from the resident but that it was noted to be missing when counted at discharge. Interview on 05/15/24 at 3:28 P.M. with Pharmacist #439 confirmed he was called to the facility regarding a two milliliter (equivalent to eight doses) discrepancy when Resident #332 was discharged from the facility. Pharmacist #439 further confirmed that although the liquid morphine is not always exact, there was enough missing medication in the bottle to be concerned that there was medication that was unaccounted for. The interview also revealed FR #332's remaining morphine sulfate was wasted/disposed of in a smart sink by Pharmacist #439, which was witnessed by Pharmacist #440. Review of the facility's investigation notes revealed the 20 mg/ml morphine sulfate count was 8 ml when FR #332 was discharged from the facility on 04/11/24, which was a 2 ml discrepancy from the last dose. Further review of the investigation notes revealed LPN #309 reported the concern to RN #437 and left a note which remained when the concern was reported to the Administrator on 04/11/24. Review of the policy dated January 201, titled: Controlled Drug Policy and Procedure revealed controlled substances were to be counted by the oncoming and off-going nurses every eight hours and recorded and signed off by the nurses to ensure accuracy of the count. Further review of the controlled drug policy revealed any discrepancies were to be reported to the unit manager or supervisor. Review of the undated policy titled reporting Abuse to Facility Management revealed misappropriation included the deliberate misplacement, use, or misuse of a resident's belongings, money, or other resources. This deficiency represents non-compliance investigated under Complaint Number OH00153197 and Complaint Number OH00153138.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Health Care	1320 Mahoning Ave NW Warren, OH 44483

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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 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48565 Based on staff interview, review of personnel files and policy review, the facility failed develop and implement policies and procedures to include checking references of three employees to identify if an employee had a finding concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. This had the potential to affect all 80 residents residing in the facility. The facility census was 80. Findings include: On 05/15/24 between 12:00 P.M. and 12:30 P.M. a review of the personnel file for Licensed Practical Nurse (LPN) # 361 revealed a date of hire of 04/04/24. The personnel file contained no reference checks. Payroll Coordinator (PC) #374 verified there were no reference checks for LPN #361 at the time of the personnel file review. On 05/15/24 between 12:00 P.M. and 12:30 P.M. a review of the personnel file for Licensed Practical Nurse (LPN) # 362 revealed a date of hire of 04/15/24. The personnel file contained no reference checks. Payroll Coordinator (PC) #374 verified there were no reference checks for LPN #362 at the time of the personnel file review. On 05/15/24 between 12:00 P.M. and 12:30 P.M. a review of the personnel file for Social Service Designee (SSD) # 376 revealed a date of hire of 07/05/23. The personnel file contained no reference checks. Payroll Coordinator (PC) #374 verified there were no reference checks for SSD #376 at the time of the personnel file review. A review of the policy titled, Screening/Background Investigations that was undated revealed in subpoint #1 the staff Development Coordinator, or other person designated by the administrator, will conduct employment background checks, reference checks, and criminal conviction checks on persons making application for employment with this facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on interview, record review, facility policy review, and review of the Ohio Department of Health (ODH) facility self-reported incidents (SRIs), the facility failed to file an SRI report related to allegations of misappropriation affecting four residents (Residents #20 and #33 and Former Residents #234, and #332) out of five residents reviewed for misappropriation. The facility census was 80. Findings include: 1. Review of the medical record for Resident #20 revealed an initial admitted [DATE] and a facility re-entry date of 04/26/24 with diagnoses including non-ST elevation myocardial infarction, heart failure, stage three pressure ulcer of the sacral region, morbid obesity, chronic obstructive pulmonary disease (COPD), cardiomyopathy, and osteoarthritis of the right hip. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had intact cognition, frequently experienced pain that interfered with sleep and participation in day-to-day activities for which she received opioids on an as needed basis. Review of the physician orders revealed an order dated 03/11/24 through 04/05/24 for Resident #20 to receive oxycodone hydrochloride (HCl) 10 milligrams (mg) oral tablet, one tablet by mouth every eight hours as needed for pain. Another order dated 04/06/24 and discontinued on 04/09/24 was noted upon order review for oxycodone HCL five mg oral tablets, 7.5 mg by mouth every eight hours as needed for pain. Further review of the physician orders revealed an order dated 04/09/24 and discontinued on 04/26/24 for oxycodone HCL 10 mg oral tablet, 10 mg by mouth every eight hours as needed for pain for 21 days. Review of the care plan dated 04/28/24 revealed Resident #20 had the potential for acute and chronic pain related to decreased mobility, a history of atypical chest pain and COPD. Interventions included administering medications per physician orders and notifying the physician if ordered pain medications were ineffective. Review of the Controlled Drug Record for Resident #20's oxycodone 5 mg tablets revealed Registered Nurse (RN) #438 documented she wasted two of Resident #20's 5 mg tablets on the following dates: 03/14/24, 03/20/24, 03/23/24, 03/24/24, 03/27/24, 03/28/24, 03/29/24, 04/01/24, 04/03/24, 04/06/24, and 04/11/24. Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had concerns with drug diversion reported to her on 04/11/24. During this interview, the Administrator confirmed the facility conducted an internal investigation but did not file an SRI with ODH because they believed the nurse was pocketing the medication and did not believe Resident #20 went without needed doses of oxycodone. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation notes revealed Licensed Practical Nurses (LPNs) #314 and #318 reported concerns to the Administrator on 04/11/24 that RN #438 wasted oxycodone tablets every time she worked. The investigation further revealed an incident report was filed with the [NAME] police department on 04/11/24 at 4:46 P.M. alleging controlled substances were diverted from four facility residents, as well as a report to the Ohio Board of Nursing for concerns related to inappropriate use of controlled substances prescribed to residents and RN #438's refusal to submit to a drug screening upon suspicion of drug diversion. Review of facility SRIs on the ODH Gateway website revealed no reported allegations related to misappropriation of Resident #20's medication. Review of the undated policy titled Abuse Investigations revealed an immediate (within 24 hours) ODH SRI (Self-Reported Incident Report) will be submitted to the Ohio Department of Health (ODH) with the initial information surrounding the allegation and a final SRI report will be submitted to ODH within five working days of the self-reported incident. 2. Review of the medical record for Resident #33 revealed a facility re-entry date of 04/08/24 with diagnoses including stage three chronic kidney disease, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), attention to colostomy, anxiety, seizures, and atrial fibrillation. Review of the MDS 3.0 assessment completed on 04/15/24 revealed Resident #33 was cognitively intact and received opioids for pain that frequently interfered with sleep and day-to-day activities. Review of the physician orders revealed an order dated 01/31/24 for Resident #33 to receive oxycodone hydrochloride (HCl) 10 mg oral tablet, one by mouth every six hours as needed for pain. Another order, updated on 03/29/24, was for oxycodone HCL 10 mg oral tablet, give one by mouth every six hours as needed for severe pain. Further review of physician orders revealed orders dated 04/10/24 for oxycodone HCL 10 mg oral tablets and oxycodone HCL 5 mg oral tablets, give one 10 mg tablet and one five mg tablet for a total of 15 mg oxycodone every six hours as needed for pain for a total of 15 mg per dose. Review of the care plan dated 03/18/24 revealed Resident #33 had the potential for acute and chronic pain related to a colovesical fistula, COPD, and decreased mobility. Interventions included administration of analgesics per orders and notifying if pain management interventions were unsuccessful. Review of the medication administration records (MARs) for March 2024 and April 2024 revealed documentation Resident #33 received oxycodone for pain at least twice daily throughout each month. Review of the MAR also revealed an order for lorazepam one mg tablets from 03/29/24 through 04/10/24, give 1 tablet by mouth every four hours as needed for anxiety or agitation and another order dated 04/10/24 for one tablet every four hours as needed for agitation for 14 days. Review of the Controlled Drug Record for Resident #33's oxycodone 10 mg tablets were documented as wasted by RN #438 on the following dates: 02/07/24, twice on 02/05/24 (this date was entered between counts logged on 02/11/24 and 02/13/24 for a total of 20 mg), 02/15/24, 02/21/24, 02/25/24, 02/29/24, 03/01/24, 03/04/24, twice on 03/05/24 (total of 20mg), 03/10/24, 03/14/24, 03/18/24, 03/19/24, 03/20/24, 03/23/24, 03/24/24, 03/27/24, 03/28/24, 03/29/24, 04/01/24, 04/02/24, and twice on 04/03/24 (for 10mg total this date). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Controlled Drug Record for Resident #33's lorazepam 1mg tablets revealed RN #438 documented one tablet was wasted on 04/11/24. Review of the progress notes revealed no notes related to medication needing wasted or oxycodone refusal. Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had concerns with drug diversion reported to her on 04/11/24. During this interview, the Administrator confirmed the facility conducted an internal investigation but did not file an SRI with ODH because they believed the nurse was pocketing the medication and did not believe Resident #33 went without needed doses of oxycodone, with the exception of one incident where Resident #33 reported the pill offered to him did not look like his oxycodone that he typically received from facility nurses. Review of the facility investigation notes revealed LPNs #314 and #318 reported concerns to the Administrator on 04/11/24 that RN #438 wasted oxycodone tablets every time she worked. The investigation further revealed an incident report was filed with the [NAME] police department on 04/11/24 at 4:46 P.M. alleging controlled substances were diverted from four facility residents, as well as a report to the Ohio Board of Nursing for concerns related to inappropriate use of controlled substances prescribed to residents and RN #438's refusal to submit to a drug screening upon suspicion of drug diversion. Review of facility SRIs on the ODH Gateway website revealed no reported allegations related to misappropriation of Resident #33's medication. Review of the undated policy titled Abuse Investigations revealed an immediate (within 24 hours) ODH SRI (Self-Reported Incident Report) will be submitted to the Ohio Department of Health (ODH) with the initial information surrounding the allegation and a final SRI report will be submitted to ODH within five working days of the self-reported incident. 3. Review of the medical record for Former Resident (FR) #234 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses including atherosclerotic heart disease of coronary artery without angina, aortocoronary bypass graft, postprocedural pain, urinary tract infection, chronic kidney disease, congestive heart failure (CHF), and type two diabetes mellitus. Review of the admission MDS 3.0 assessment completed 03/18/24 revealed FR #234 was cognitively intact and required maximal assistance for transfers, ambulation, and personal hygiene. Review of the physician orders revealed an order dated 03/19/24 for oxycodone-acetaminophen 5-325 mg (Percocet), one tablet by mouth every six hours as needed for pain. Review of the progress notes revealed FR #234 would request pain medication for leg pain when needed. Further review of the progress notes revealed no documented refusal of pain medication. Review of the Controlled Drug Record for Former Resident #234's Percocet 5-325 mg tablets revealed RN #438 documented she wasted a Percocet tablet on 04/07/24 and on 04/11/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had concerns with drug diversion reported to her on 04/11/24. During this interview, the Administrator confirmed the facility conducted an internal investigation but did not file an SRI with ODH because they believed the nurse was pocketing the medication and did not believe any affected resident went without needed doses of oxycodone. Review of the facility investigation notes revealed Licensed Practical Nurses (LPNs) #314 and #318 reported concerns to the Administrator on 04/11/24 that RN #438 wasted oxycodone tablets every time she worked. The investigation further revealed an incident report was filed with the [NAME] police department on 04/11/24 at 4:46 P.M. alleging controlled substances were diverted from four facility residents, as well as a report to the Ohio Board of Nursing for concerns related to inappropriate use of controlled substances prescribed to residents and RN #438's refusal to submit to a drug screening upon suspicion of drug diversion. Review of facility SRIs on the ODH Gateway website revealed no reported allegations related to misappropriation of Former Resident #234's medication. Review of the undated policy titled Abuse Investigations revealed an immediate (within 24 hours) ODH SRI (Self-Reported Incident Report) will be submitted to the Ohio Department of Health (ODH) with the initial information surrounding the allegation and a final SRI report will be submitted to ODH within five working days of the self-reported incident. 4. Review of the medical record for Former Resident (FR) #332 revealed he was admitted to the facility on [DATE] and was discharged to home on 04/08/24. Diagnoses included metabolic encephalopathy, atrial flutter, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, hypertension, adjustment disorder, fusion of the cervical region of the spine, and chronic atrial fibrillation. Review of the last quarterly MDS assessment completed 03/09/24 revealed FR #332 had moderately impaired cognition. Further review of the MDS revealed FR #332 was on a scheduled pain regimen and received opioids. Review of the medication orders revealed FR #332 had a physician order dated 03/13/24 through 04/18/24 for morphine sulfate oral solution 20 milligrams per milliliter (mg/ml), 0.25 ml by mouth two times a day for pain for 14 days and an additional 0.25 ml by mouth every 12 hours as needed for pain. Review of the progress notes revealed no concerns regarding FR #332 refusing his ordered pain medication or pain medication being spilled or wasted. Review of the Controlled Drug Record for FR #332 revealed the last amount recorded of morphine sulfate was 10 ml on 04/08/24 at 8:30 A.M. by LPN #309. Interview on 05/15/24 at 2:25 P.M. with the Administrator confirmed the facility had concerns with drug diversion reported to her on 04/11/24. During this interview, the Administrator confirmed the facility conducted an internal investigation but did not file an SRI with ODH because they were unable to determine FR #332 ever went without his ordered pain medication. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/15/24 at 3:28 P.M with Pharmacist #439 confirmed he was called to the facility regarding a two milliliter (equivalent to eight doses) discrepancy when Resident #332 was discharged from the facility. Pharmacist #439 further confirmed that although the liquid morphine is not always exact, there was enough missing medication in the bottle to be concerned that there was medication that was unaccounted for. Review of the facility's investigation notes revealed the 20 mg/ml morphine sulfate count was 8 ml when FR #332 was discharged from the facility on 04/11/24, which was a 2 ml discrepancy from the last dose. Further review of the investigation notes revealed LPN #309 reported the concern to RN #437 and left a note which remained when the concern was reported to the Administrator on 04/11/24. Review of facility SRIs on the ODH Gateway website revealed no reported allegations related to misappropriation of Resident #332's medication. Review of the undated policy titled Abuse Investigations revealed an immediate (within 24 hours) ODH SRI (Self-Reported Incident Report) will be submitted to the Ohio Department of Health (ODH) with the initial information surrounding the allegation and a final SRI report will be submitted to ODH within five working days of the self-reported incident. This deficiency represents non-compliance investigated under Complaint Number OH00153197 and Complaint Number OH00153138.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on observation, interview, and record review the facility failed to change nasal cannula oxygen tubing in a timely manner. This affected one resident (#39) of one resident reviewed for oxygen use. The facility identified 18 residents (#2, #14, #21, #22, #24, #27, #30, #33, #39, #41, #50, #51, #52, #60, #63, #67, #76 and #132) utilizing oxygen. The facility census was 80. Findings include: A review of medical records for Resident #39 revealed a date of admission of 02/13/23. Significant diagnoses included chronic obstructive pulmonary disease and heart failure. Significant orders included, change oxygen tubing weekly (Tuesdays) and oxygen at two liters per minute per nasal cannula (a tubing system with two prongs inserted in the nose for oxygen delivery) as needed for shortness of breath. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had severe cognitive impairment. A care plan dated 04/12/24 revealed Resident #39 was at risk for ineffective breathing related to heart failure and chronic obstructive pulmonary disease. Interventions included monitoring for restlessness and change in mentation which could indicate hypoxia (a low oxygen level) and administer oxygen as ordered by physician. On 05/13/24 at 10:22 A.M. an observation of Resident #39 revealed the resident up in a wheelchair with oxygen on at two liters per minute via nasal cannula. The date on the oxygen tubing was 04/13/24. Licensed Practical Nurse #310 verified the date on the oxygen tubing at the time of the observation. LPN #310 stated oxygen tubing was to be changed weekly. A review of the policy titled, Oxygen Tubing/Equipment Change Schedule dated 11/2015 revealed oxygen masks, nasal cannulas and aerosol set ups were to be changed every week.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48565 Based on observation, interview and policy review, the facility failed to maintain a sanitary kitchen to prepare food in a manner to prevent contamination and food borne illness. This had the potential to affect 80 residents who receive food from the kitchen. The facility identified zero residents who did not eat by mouth. The facility census was 80. Findings include: On 05/13/24 at 8:15 A.M. a tour of the kitchen revealed a floor with built up dirt and debris in the dry storage area underneath the shelves. There was a half of a five-pound bag of macaroni opened and unlabeled, a quarter bag of shell macaroni opened and unlabeled. There was cornstarch in a 20-gallon lidded receptacle with a pan in it for scooping. The three-sink sanitation station had two containers of Hydrion strips (test strips to test the chemical levels for proper sanitization) with expiration dates of 07/01/20 and 05/31/19. The standup refrigerator located in the kitchen revealed one half of a five-pound brick of queso cheese that was opened and unlabeled. There was a 500-milliliter bottle of Pepsi that was opened and unlabeled and a can of Arizona iced tea 22 ounces also located in the stand-up refrigerator. The Dietary Manager (DM) #402 verified the Pepsi and Arizona tea belonged to staff and was not to be stored with resident food sources in the kitchen. DM #402 also verified all the aforementioned findings during the tour. On 05/13 24 at 11:00 A.M. observation of the tray line revealed Dietary Aide (DA) #406 with a full beard preparing coffee by pouring it into cups and DA #406 did not have a cover over his beard. DM #402 verified DA #406 should have had a beard cover to prevent facial hair from contaminating the coffee. A review of the Hydrion Test Strip instructions on www.essentiallab.com revealed the test strips remain accurate until the expiration date. A review of the policy titled, Food Storage that was undated, revealed in point #6, Scoops are not to be stored in food containers. It also revealed in point #13, Leftover food is stored in covered containers or wrapped carefully and securely. Each item is to be clearly labeled and dated. A review of the policy titled, Uniform Dress Code for Dietary dated 10/22/02 revealed staff is to wear a hair net and or face/beard covering.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774 Based on observation, interviews, record reviews, review of the memorandum from the Department of Health & Human Services and review of guidelines from the Centers for Disease Control and Prevention, the facility failed to ensure proper infection control practices were followed for Resident #14, #27, #41, #53, #69 and #78 who required enhanced barrier precautions (EBP) and Resident #55 who required blood glucose monitoring. This affected seven residents (#14, #27, #53,#69, #55 and #78) out of 80 residents observed for infection control. The facility census was 80. Findings include: 1. Observation on 05/13/24 at 10:23 A.M. of Resident #27 in the resident room revealed Resident #27 had an indwelling urinary cathetar. There was personal protective equipment (PPE) available in a hanging storage unit over the door and a unit to the left of the entrance door which contained PPE. Containers for used PPE were located outside of the room to the right of the entrance door. There was no visible sign to denote the type of transmission-based precaution (TBP) required. Interview with Activity Director #366 at the time of the observation confirmed there was no sign in place but believed it was necessary to wear a gown and gloves because of something with Resident #27's urine. She was unaware of the exact type of precaution needed and verified Resident #27 had a urinary cathetar bag visible next to his wheelchair. Observation on 05/13/24 at 10:24 A.M. of Resident #78 revealed the resident had ulcers to both heels and received wound dressings daily. There was no EBP posted and no PPE available at the room entrance. Observation on 05/13/24 at 10:34 A.M. of STNA #337 putting on gloves, gown, and an N95 mask prior to entering Resident #27's room to fix Resident #27's catheter bag. Interview with STNA #337 at the time of the observation, verified there was no TBP sign but stated she was informed by the nurse that Resident #27 had something additional in his urine, so she put on PPE to change the urinary catheter bag to a leg bag. Interview on 05/13/24 at 10:37 A.M. with housekeeper #417 confirmed there was no sign on Resident #27's door outlining the TBP and because of that, she was unsure of which precautions to use. She had previously asked the nurse and believed a gown and gloves were needed but only when touching the resident. Observation 05/13/24 at 10:39 A.M. of Resident #69 revealed a urinary catheter was in place and the resident had ulcers on her heels and buttocks and received wound care dressings. There was no EBP posted and no PPE available at the room entrance. Observation on 05/13/24 at 11:04 P.M. of Resident #41 revealed resident had wounds. There was no EBT posted and no PPE available at the room entrance. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/13/24 at 11:09 A.M. with Infection Preventionist #361 confirmed there was no EBP in place for any resident in the facility and no sign was in place for Resident #27 to denote the type of precautions, which were conveyed to be contact precautions. Observation on 05/13/24 at12:10 P.M. of Resident #53 revealed a urinary catheter was in place. There was no EBP posted and no PPE available at the room entrance. Observation on 05/13/24 at 12:30 P.M. of Resident #14 revealed a urinary catheter was in place. There was no EBP posted and no PPE available at the room entrance. Observation on 05/16/24 at 08:00 A.M. of Resident #27's catheter care performed by STNA #337 revealed no gown was put on to perform the catheter care. Interview on 05/16/24 at 08:05 A.M. with STNA #337 confirmed there was no PPE or signage denoting the resident was in EBP. Further interview revealed she was uncertain as to whether the EBP were in effect for residents with indwelling catheters. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with multidrug resistant organisms (MDRO). The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. 48567 3. Review of the medical record for Resident #55 revealed an admitted [DATE] with diagnoses including chronic diastolic (congestive) heart failure, hypertensive heart disease with heart failure, type 2 diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, unspecified, dysphagia, and depression. Review of the quarterly Minimum Data Set (MDS) assessment completed on 03/09/24 revealed Resident #55 had intact cognition. Further review of the MDS revealed Resident #55 had diabetes mellitus and received daily insulin injections. Review of the physician orders revealed an order dated 01/30/24 for Resident #55 to receive Humalog 100 units per milliliter (ml) by KwikPen injector subcutaneously per sliding scale before meals and at bedtime as follows: for blood sugar between zero to 149 milligrams per deciliter (mg/dl) , administer zero units; for blood sugar between 150 mg/dl and 200 mg/dl, administer one unit; for blood sugar 201mg/dl to 250 mg/dl, administer to units; for blood sugar 251 mg/dl to 300 mg/dl, administer three units; for blood sugar 301 mg/dl to 350 mg/dl, administer four units; for blood sugar 351 mg/dl to 400 mg/dl, administer five units and call the provider if blood sugar was greater than 400 mg/dl. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	05/16/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/14/24 at 11:17 A.M. revealed licensed practical nurse (LPN) #305 completed a finger-stick blood sugar (FSBS) test at the bedside of Resident #55 and carried the blood glucose meter (BGM) with the used test strip still in the BGM out of the room, across the hall, and two doors down from Resident #55's room then disposed of the test strip and laid the BGM on top of the medication cart as she prepared Resident #55's Humalog for injection. Continued observation on 05/14/24 revealed LPN #305 picked the BGM off the top of the medication cart and placed it inside the top drawer of the medication cart without cleaning or disinfecting the device. Interview on 05/14/24 at 11:26 A.M. with LPN #305 confirmed she placed BGM in the top drawer of the mediation cart and confirmed the BGM was not cleaned or disinfected prior to placing it back into the drawer. LPN #305 further confirmed she was unaware whether there were any specific processes for cleaning the BGM between residents and her typical process would have been to reuse the same BGM on the next resident, if needed, adding I guess I could use a wipe, then also confirming there were no disinfecting wipes on that medication cart. Interview on 05/14/24 at 12:42 P.M. with the Director of Nursing (DON) confirmed blood glucose meters should be cleaned between every resident use. Review of the owner manual for the facility's blood glucose monitoring system revealed the blood glucose meter must be cleaned prior to being disinfected. Further review of the manufacturer instructions for proper disinfection of the device revealed the entire surface of the meter was to be wiped down with a new germicidal disposable wipe, the meter was to be kept wet for two minutes, then air dried once the two minutes had passed. Review of the Centers for Disease Control (CDC) and Prevention website's Summary of recommendations for blood glucose monitoring revealed BGM's were to be cleaned and disinfected per the manufacturer's recommendations after every use in order to prevent the spread of bloodborne pathogens and infectious agents.