

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/18/2024
NAME OF PROVIDER OR SUPPLIER  Lake Pointe Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Parrish Road Conneaut, OH 44030	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526</b></p> <p>Based on observation, record review, and interview the facility failed to treat residents with dignity and respect by maintaining uncovered urinary catheter drainage bags in public view. This affected two residents (#15 and #37) of six residents with urinary catheters. The facility census was 56.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, chronic kidney disease stage III, and obstructive and reflux uropathy.</p> <p>Review of the physician orders effective June 2024 revealed Resident #15 required routine urinary catheter related care daily.</p> <p>Observation on 06/17/24 at 8:20 A.M. revealed Resident #15 lying in bed with an uncovered urinary catheter drainage bag hanging on the bed frame facing the doorway which was visible from the hallway outside of the room.</p> <p>Observation on 06/17/24 at 8:58 A.M. revealed Resident #15 lying in bed with an uncovered urinary catheter drainage bag hanging on the bed frame facing the doorway visible from the hallway outside of the room. Interview at the time of the observation with the Director of Nursing (DON) verified Resident #15 had an uncovered drainage bag hanging in public view.</p> <p>2. Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type II with chronic kidney disease.</p> <p>Review of the baseline care plan dated 06/14/24 revealed an indwelling urinary catheter with catheter care required daily and as needed.</p> <p>Observation on 06/18/24 at 8:36 A.M. revealed Resident #37 lying in bed with an uncovered urinary catheter drainage bag hanging on the bed frame facing the doorway visible from the hallway outside of the room. Interview at the time of the observation with State tested Nursing Assistant (STNA) #344 verified Resident #37 had an uncovered drainage bag hanging in public view.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41526</p> <p>Based on interview, record review, and facility policy review the facility failed to report an allegation of misappropriation by medication diversion involving Residents #2, #16 and #42. This affected three residents (#2, #16 and #42) of four residents reviewed for abuse, neglect, and misappropriation. The facility census was 56.</p> <p>Findings include:</p> <p>Interview on 06/17/24 at 9:52 A.M. with Licensed Practical Nurse (LPN) #358 indicated gossip was circulating with facility staff about controlled medications being misused but denied knowledge of any details.</p> <p>Interview on 06/17/24 at 10:50 A.M. with the Director of Nursing (DON) confirmed an allegation was made by Registered Nurse (RN) #333 against an agency nurse, LPN #369, on 06/09/24. RN #333 reported feeling a couple of the controlled medication signatures were forged by LPN #369. Immediately LPN #369 was removed from the schedule and the facility worked with the pharmacy on an investigation. RN #333 submitted copies of controlled medication records which she believed to be questionable. One of the records involved Resident #16. The DON verified an SRI (self-reported incident) was not filed but indicated the pharmacy was first trying to determine if it was misappropriation. RN #333 had claimed someone else was signing out narcotics so the pharmacy looked at it and determined it was not misappropriation because forged signatures could not be proved. The DON stated that normally an SRI was completed, but RN #333 had all the facility nurses upset and questioning signatures so too many nurses were getting involved. The facility did not usually question allegations but it was because so many were getting involved. The DON verified that abuse allegations including misappropriation should not be filtered through to determine validity before being reported.</p> <p>Interview on 06/17/24 at 11:05 A.M. with the Administrator confirmed knowledge of the misappropriation allegation on 06/09/24 and indicated people investigated it. The Administrator described the reported allegation as hearsay but agreed allegations were not known to be credible unless investigated, so the allegation should have been reported as required.</p> <p>Review of the facility investigation for the misappropriation allegation reported on 06/09/24 revealed an incident report dated 06/11/24 at 12:12 P.M. The incident report described a nurse alleged a controlled medication was signed out with a forged signature. Immediate actions taken were removing both the accused nurse and reporting nurse from the schedule. The pharmacy was notified on 06/10/24 who confirmed and accounted for all controlled medication deliveries. The medical director and DON reviewed the allegation, and it was unsubstantiated as misappropriation. The pharmacy was scheduled to return to the facility on [DATE]. The plan was to educate and monitor staff on appropriate use of controlled medication records and wean residents from controlled medications when able.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the written statement from RN #333, dated 06/08/24, revealed when looking at the controlled medication sheets for the assignment, there was a sheet for Resident #16 in which her signature dated 05/25/24 appeared forged because it was misspelled, despite having worked on that date and assignment. RN #333 reported it to the DON and Administrator and submitted highlighted controlled medication sheets with questionable signatures involving Residents #2, #16, and #42.</p> <p>Review of the written statement from the DON, dated 06/10/24, revealed the agency nurse, LPN #369, was contacted as the accused and refused to discuss the allegation, but the agency stated they would do an independent investigation through quality assurance.</p> <p>Interview on 06/17/24 at 2:39 P.M. with the DON reported all questionable signatures identified by RN #333 on controlled medication sheets for Residents #2, #16 and #42 were not forged. The one misspelled signature made on 05/25/24 was not proven to be made by any other individual. The accused agency nurse, LPN #369, had no access to the facility and did not work on any of the dates in question. The DON verified the misappropriation allegation and investigation results were not reported to the state agency as required.</p> <p>Review of the facility policy, Identifying Exploitation, Theft and Misappropriation of Resident Property, dated April 2021, revealed examples of misappropriation of resident property, including drug diversion (the taking of a resident's medication). Staff and providers were expected to report suspected misappropriation of resident property.</p> <p>Review of the undated facility policy, Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure revealed the facility had a duty to report all alleged violations of abuse, neglect, exploitation, or mistreatment and misappropriation of resident property. The facility must report the alleged violation to the state survey agency immediately for alleged violations which involved abuse, neglect, exploitation or mistreatment, and misappropriation of resident property but not later than two hours if the alleged violation involved abuse or resulted in serious bodily injury, or 24 hours if the alleged violation did not involve abuse and did not result in serious bodily injury. The results of all investigations of alleged violations would be reported within five working days of the incident.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154716.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41526</p> <p>Based on observation, interview, and record review the facility failed to obtain physician orders and provide sufficient care for an indwelling urinary catheter. This affected one resident (#37) of four residents reviewed for urinary catheters. The facility census was 56.</p> <p>Findings include:</p> <p>Observation on 06/18/24 at 8:36 A.M. revealed Resident #37 lying in bed with an uncovered urinary catheter drainage bag hanging on the bed frame facing the doorway visible from the hallway outside of the room.</p> <p>Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type II with chronic kidney disease, and benign prostatic hyperplasia without lower urinary tract symptoms. There was no evidence of a diagnosis or justification for use of an indwelling urinary catheter.</p> <p>Review of the physician orders for June 2024 revealed no orders to monitor, maintain, or care for a urinary catheter.</p> <p>Review of the medication and treatment administration records for June 2024 revealed no evidence of monitoring, maintaining, or caring for a urinary catheter.</p> <p>Review of the nursing progress notes for June 2024 revealed an indwelling catheter was in place upon admission on 06/13/24. There was no evidence of justification for or the monitoring, maintaining, or caring for the urinary catheter.</p> <p>Review of the baseline care plan dated 06/14/24 revealed an indwelling urinary catheter was in place with catheter care required daily and as needed.</p> <p>Review of the activities of daily living flow records for June 2024 revealed Resident #37 was to receive catheter care on every shift. Catheter care was documented as provided from 06/14/24 to 06/17/24 daily on day shift and from 06/15/24 to 06/17/24 daily on night shift. There was no evidence catheter care was provided on 06/13/24 day or night shift nor on 06/14/24 night shift.</p> <p>Interview on 06/18/24 at 1:22 P.M. with the Director of Nursing (DON) verified the above findings and confirmed there remained no justification for Resident #37's continued use of an indwelling urinary catheter.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41526</p> <p>Based on interview, record review, and facility policy review the facility failed to prevent significant medication errors for Residents #16 and #42 when medications were signed out from the controlled drug records without evidence of administering the medication on the medication administration record (MAR) and verifying the medication was being administered as ordered by the physician. This affected two residents (#16 and #42) reviewed for controlled drug administration and had the potential to affect 25 additional residents (#2, #6, #10, #12, #15, #18, #19, #21, #23, #24, #25, #27, #28, #29, #30, #31, #37, #39, #41, #44, #47, #48, #49, #52 and #56) who received controlled medications. The facility census was 56.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included low back pain and chronic pain.</p> <p>Review of Resident #16's physician orders revealed an order dated 09/06/23 for oxycodone 10-325 mg (milligrams) (opioid pain medication) every eight hours as needed for moderate to severe pain and no more than two administrations within 24 hours which was discontinued on 05/23/24.</p> <p>Review of the MAR and controlled drug records (CDR) for Resident #16's oxycodone from 04/11/24 to 05/23/24 revealed oxycodone 10-325 mg was signed out of the CDR and signed as administered on the MAR as follows:</p> <p>04/11/24 at 11:30 P.M. from the CDR and MAR and at 8:00 A.M. from the CDR only.</p> <p>04/12/24 at 8:00 A.M. from the CDR only</p> <p>04/13/24 at 2:40 (AM/PM not specified) from the CDR only</p> <p>04/14/24 at 6:15 A.M. from the CDR only</p> <p>04/15/24 at 8:00 A.M. from the CDR only and at 8:54 P.M. from the CDR and MAR</p> <p>04/16/24 at 9:00 P.M. from the CDR only</p> <p>04/17/24 at 8:00 A.M., 4:00 P.M., and 9:00 P.M. from the CDR only (the medication was administered sooner than every eight hours as ordered and exceeded the maximum ordered doses of twice daily)</p> <p>04/18/24 at 9:00 P.M. from the CDR only</p> <p>04/19/24 at 8:00 A.M. and 3:00 P.M. from the CDR only (the medication was administered sooner than every eight hours as ordered)</p> <p>04/20/24 at 3:59 A.M. from the CDR and MAR and at 8:18 P.M. from the CDR only</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>04/22/24 at 9:30 (AM/PM not specified) from the CDR only</p> <p>04/23/24 at 8:00 A.M. and 8:00 P.M. from the CDR only</p> <p>04/24/24 at 8:00 A.M. from the CDR only</p> <p>04/25/24 at 8:00 P.M. from the CDR only</p> <p>04/29/24 at 3:12 P.M. from the CDR and MAR</p> <p>04/30/24 at 8:38 P.M. from the CDR and MAR</p> <p>05/01/24 at 3:00 A.M. from the CDR only and at 4:20 P.M. from the CDR and MAR (the medication was administered sooner than every eight hours as ordered)</p> <p>05/02/24 at 8:00 A.M. and 8:00 P.M. from the CDR only</p> <p>05/03/24 at 1:30 A.M. from the CDR only and at 10:30 P.M. from the CDR and MAR (the medication was administered sooner than every eight hours as ordered)</p> <p>05/06/24 at 8:00 A.M. from the CDR only</p> <p>05/07/24 at 7:49 P.M. from the CDR and MAR</p> <p>05/08/24 at 3:00 A.M. and 8:00 A.M. from the CDR only and at 5:07 P.M. from the CDR and MAR (the medication was administered sooner than every eight hours as ordered and exceeded the maximum ordered doses of twice daily)</p> <p>05/09/24 at 10:00 A.M. and 8:00 P.M. from the CDR only</p> <p>05/10/24 at 8:00 P.M. from the CDR only</p> <p>05/11/24 at 2:30 A.M. and 10:00 A.M. from the CDR only (the medication was administered sooner than every eight hours as ordered)</p> <p>05/12/24 at 12:34 P.M. from the CDR and MAR and at 9:00 P.M. from the CDR only</p> <p>05/13/24 at 3:00 A.M. and 9:10 A.M. from the CDR only and at 5:21 P.M. from the CDR and MAR (the medication was administered sooner than every eight hours as ordered and exceeded the maximum ordered doses of twice daily)</p> <p>05/14/24 at 11:32 A.M. from the CDR and MAR and at 9:00 P.M. from the CDR only</p> <p>05/15/24 at 8:00 A.M. and 9:00 P.M. from the CDR only</p> <p>05/16/24 at 8:00 A.M., 2:00 P.M. and 10:00 P.M. from the CDR only (the medication was administered sooner than every eight hours as ordered and exceeded the maximum ordered doses of twice daily)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>05/17/24 at 8:00 A.M. from the CDR only</p> <p>05/18/24 at 2:22 P.M. from the CDR and MAR and at 8:00 P.M. from the CDR only (the medication was administered sooner than every eight hours as ordered)</p> <p>05/19/24 at 9:00 A.M. and 10:15 P.M. from the CDR only and at 4:15 P.M. from the CDR and MAR (the medication was administered sooner than every eight hours as ordered and exceeded the maximum ordered doses of twice daily)</p> <p>05/20/24 at 7:48 A.M. and 11:55 P.M. from the CDR only and at 3:53 P.M. from the CDR and MAR (the medication was administered sooner than every eight hours as ordered and exceeded the maximum ordered doses of twice daily)</p> <p>05/21/24 at 8:15 A.M. from the CDR only and at 4:21 P.M. from the CDR and MAR</p> <p>05/22/24 at 9:00 A.M. and 12:30 P.M. from the CDR only and at 7:58 P.M. from the CDR and MAR (the medication was administered sooner than every eight hours as ordered and exceeded the maximum ordered doses of twice daily)</p> <p>05/23/24 at 8:00 A.M. and 8:00 P.M. from the CDR only</p> <p>Review of Resident #16's physician orders revealed an order dated 05/23/24 for oxycodone 10-325 mg once daily at bedtime for pain which was discontinued on 06/13/24.</p> <p>Review of the MAR and CDR for Resident #16's oxycodone from 05/24/24 to 06/04/24 revealed oxycodone 10-325 mg was signed out of the CDR and signed as administered on the MAR as follows:</p> <p>05/24/24 at 8:00 A.M. and 4:15 P.M. from the CDR only and at 8:16 P.M. from the CDR and MAR (the medication was administered twice without a physician's order)</p> <p>05/25/24 at 9:00 A.M. from the CDR only and at 9:00 P.M. from the CDR and MAR (the medication was administered once without a physician's order)</p> <p>05/26/24 at 8:00 A.M. and 4:30 P.M. from the CDR only and at 9:30 P.M. from the CDR and MAR (the medication was administered twice without a physician's order)</p> <p>05/27/24 at 7:35 A.M. and 3:45 P.M. from the CDR only and at 8:30 P.M. from the CDR and MAR (the medication was administered twice without a physician's order)</p> <p>05/28/24 at 8:00 A.M. from the CDR only and at 8:00 P.M. from the CDR and MAR (the medication was administered once without a physician's order)</p> <p>05/29/24 at 3:00 A.M. and 9:00 A.M. from the CDR only and at 5:10 P.M. from the CDR and MAR (the medication was administered twice without a physician's order and ordered dose was administered too early)</p> <p>05/30/24 at 4:00 A.M. and 1:00 P.M. from the CDR only and at 9:00 P.M. from the CDR and MAR (the medication was administered twice without a physician's order)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>05/31/24 at 6:00 A.M. and 1:11 P.M. from the CDR only and at 8:00 P.M. from the CDR and MAR (the medication was administered twice without a physician's order)</p> <p>06/01/24 at 8:00 P.M. from the CDR and MAR</p> <p>06/02/24 at 2:00 P.M. from the CDR only and at 8:00 P.M. from the CDR and MAR (the medication was administered once without a physician's order)</p> <p>06/03/24 at 8:00 A.M. and 4:00 P.M. from the CDR only and at 8:00 P.M. from the CDR and MAR (the medication was administered twice without a physician's order)</p> <p>06/04/24 at 8:00 A.M. and 4:11 P.M. from the CDR only and at 9:00 P.M. from the CDR and MAR (the medication was administered twice without a physician's order)</p> <p>Interview on 06/17/24 at 2:39 P.M. with the Director of Nursing (DON) verified the above findings. The DON indicated the nurses used the CDR to administer medications instead of the required MAR to verify the order and it caused multiple medication errors and an inaccurate administration record. The DON confirmed the errors had occurred with multiple other residents who received controlled medications and by multiple nurses.</p> <p>2. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included arthritis, closed displaced intertrochanteric fracture of left femur, multiple bilateral rib fractures, and pain in left shoulder.</p> <p>Review of Resident #42's physician orders revealed an order dated 04/30/24 for oxycodone 2.5 mg every four hours as needed for moderate to severe pain which was discontinued on 05/03/24.</p> <p>Review of the MAR and CDR for Resident #42's oxycodone from 04/30/24 to 05/03/24 revealed oxycodone 2.5 mg was signed out of the CDR and signed as administered on the MAR as follows:</p> <p>04/30/24 at 3:30 A.M. and 3:00 P.M. from the CDR only</p> <p>05/01/24 at 11:55 P.M. from the CDR and MAR</p> <p>05/02/24 at 7:30 A.M. 11:30 A.M. and 4:00 P.M. from the CDR only and at 8:52 P.M. from the CDR and MAR</p> <p>05/03/24 at 6:12 A.M. from the CDR and MAR and at 10:00 A.M., 2:00 P.M. and 10:00 P.M. from the CDR only (the medication was administered sooner than every four hours as ordered)</p> <p>Review of Resident #42's physician orders revealed an order dated 05/03/24 for oxycodone 5 mg every four hours for moderate to severe pain which was discontinued on 05/16/24.</p> <p>Review of the MAR and CDR for Resident #42's oxycodone from 05/04/24 to 05/16/24 revealed oxycodone 5 mg was signed out of the CDR and signed as administered on the MAR as follows:</p> <p>05/04/24 at 5:00 A.M. and 10:00 P.M. from the CDR only and at 1:30 P.M. from the CDR and MAR</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>05/05/24 at 5:00 P.M. from the CDR only</p> <p>05/06/24 at 7:15 A.M., 10:50 A.M., 3:00 P.M. and 7:00 P.M. from the CDR only (the medication was administered sooner than every four hours as ordered)</p> <p>05/07/24 at 6:15 A.M. and 8:00 P.M. from the CDR only</p> <p>05/08/24 at 12:10 A.M., 2:00 A.M., 3:00 A.M., 6:00 A.M., 10:00 A.M., 2:11 P.M. and 10:30 P.M. from the CDR only and at 6:14 P.M. from the CDR and MAR (the medication was administered sooner than every four hours as ordered and exceeded the maximum ordered doses six daily)</p> <p>05/09/24 at 4:00 A.M., 10:00 A.M. and 2:30 P.M. from the CDR only</p> <p>05/10/24 at 11:03 A.M. from the CDR and MAR and at 9:30 P.M. from the CDR only</p> <p>05/11/24 at 4:00 A.M. and 11:00 A.M. from the CDR only and at 3:47 P.M. and 7:51 P.M. from the CDR and MAR</p> <p>05/12/24 at 3:00 A.M. and 5:41 P.M. from the CDR only</p> <p>05/13/24 at 6:52 A.M., 5:47 P.M. and 10:30 P.M. from the CDR and MAR and at 9:45 A.M. and 1:45 P.M. from the CDR only (the medication was administered sooner than every four hours as ordered)</p> <p>05/14/24 at 8:30 A.M. from the CDR only</p> <p>05/15/24 at 3:30 P.M. from the CDR only</p> <p>05/16/24 at 4:35 A.M. from the CDR and MAR and at 8:30 A.M., 12:30 P.M. and 4:30 P.M. from the CDR only (the medication was administered sooner than every four hours as ordered)</p> <p>Review of Resident #42's physician orders revealed an order dated 05/16/24 for oxycodone 5 mg three times daily and must be given at least six hours apart for moderate to severe pain which was discontinued on 05/30/24.</p> <p>Review of the MAR and CDR for Resident #42's oxycodone from 05/17/24 to 05/30/24 revealed oxycodone 5 mg was signed out of the CDR and signed as administered on the MAR as follows:</p> <p>05/17/24 at 5:25 A.M. from the CDR and MAR and at 11:00 A.M. and 10:00 P.M. from the CDR only (the medication was administered sooner than every six hours as ordered)</p> <p>05/18/24 at 4:00 A.M., 8:14 A.M., 12:21 P.M. and 4:51 P.M. from the CDR only (the medication was administered sooner than every six hours as ordered and exceeded the maximum ordered doses of three daily)</p> <p>05/19/24 at 6:18 A.M. and 6:31 P.M. from the CDR and MAR and at 10:30 A.M. and 6:30 P.M. from the CDR only (the medication was administered sooner than every six hours as ordered and exceeded the maximum ordered doses of three daily)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/18/2024
NAME OF PROVIDER OR SUPPLIER  Lake Pointe Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  22 Parrish Road Conneaut, OH 44030	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>05/20/24 at 7:00 A.M. and 1:00 P.M. from the CDR only and at 7:00 P.M. from the CDR and MAR</p> <p>05/21/24 at 1:30 A.M., 10:30 A.M. and 2:30 P.M. from the CDR only and at 6:11 A.M. and 6:30 P.M. from the CDR and MAR (the medication was administered sooner than every six hours as ordered and exceeded the maximum ordered doses of three daily)</p> <p>05/22/24 at 8:15 A.M. and 2:48 P.M. from the CDR and MAR</p> <p>05/23/24 at 8:47 A.M. from the CDR and MAR and at 2:48 P.M. and 9:00 P.M. from the CDR only</p> <p>05/24/24 at 3:00 A.M., 9:04 A.M. and 9:00 P.M. from the CDR only and at 3:11 P.M. from the CDR and MAR (the medication was administered sooner than every six hours as ordered and exceeded the maximum ordered doses of three daily)</p> <p>05/25/24 at 4:00 A.M., 10:00 A.M. and 3:00 P.M. from the CDR only (the medication was administered sooner than every six hours as ordered)</p> <p>05/26/24 at 7:31 A.M., 1:33 P.M. and 7:30 P.M. from the CDR only (the medication was administered sooner than every six hours as ordered)</p> <p>05/27/24 at 7:20 A.M., 1:00 P.M. and 7:00 P.M. from the CDR only (the medication was administered sooner than every six hours as ordered)</p> <p>05/28/24 at 11:39 A.M. from the CDR and MAR</p> <p>05/30/24 at 5:30 A.M. and 11:30 P.M. from the CDR only and at 11:35 A.M. and 5:45 P.M. from the CDR and MAR (the medication was administered sooner than every six hours as ordered and exceeded the maximum ordered doses of three daily)</p> <p>Review of Resident #42's physician orders revealed an order dated 06/01/24 for oxycodone 5 mg every six hours as needed for pain which was discontinued on 06/06/24.</p> <p>Review of the MAR and CDR for Resident #42's oxycodone from 06/01/24 to 06/06/24 revealed oxycodone 5 mg was signed out of the CDR and signed as administered on the MAR as follows:</p> <p>06/01/24 at 8:10 A.M. from the CDR only</p> <p>06/01/24 at 3:15 P.M. from the CDR and MAR</p> <p>06/02/24 at 8:00 A.M. and 2:00 P.M. from the CDR only</p> <p>06/03/24 at 8:00 A.M. from the CDR only</p> <p>06/04/24 at 8:10 A.M. from the CDR only</p> <p>Interview on 06/18/24 at 10:02 A.M. with the DON verified the above findings. The DON indicated the nurses were required to administer controlled medications using both the MAR and CDR and verify the current physician's order on the MAR to prevent medication errors.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Controlled Substances, revised November 2022, revealed the system of reconciling the receipt, dispensing and disposition of controlled substances included using medication administration records and declining inventory records.</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41526</p> <p>Based on interview, record review, and facility policy review, the facility failed to accurately document controlled drug administration for Resident #1 to prevent a potential significant medication error. This affected one resident (#1) of three residents reviewed for controlled drug administration. The facility identified 30 residents (#1, #3, #7, #8, #9, #10, #12, #14, #15, #16, #17, #23, #24, #26, #28, #35, #36, #39, #40, #41, #42, #43, #44, #45, #46, #48, #50, #54 and #55) who received controlled medications. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #1 revealed an admitted [DATE] with a diagnosis of chronic pain syndrome.</p> <p>Review of Resident #1's physician orders revealed an order dated 01/10/24 for morphine 15 milligrams (mg) (opioid pain medication) twice daily for pain, and an order dated 06/13/24 for morphine 15 mg every eight hours as needed (PRN) for pain.</p> <p>Review of the medication administration record (MAR) and controlled drug records (CDR) for Resident #1's morphine from 06/20/24 to 07/10/24 revealed administration of morphine 15 mg was documented as follows:</p> <p>06/21/24 at 2:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>06/22/24 at 2:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>06/22/24 at 3:00 P.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR until 4:22 P.M.</p> <p>06/22/24 at 8:30 P.M. it was removed for PRN administration on the CDR but documented on the MAR as administered on 06/23/24 at 12:00 A.M. A corresponding progress note which documented administration was created on 06/23/24 at 5:09 A.M. with an effective date of 06/23/24 at 12:00 A.M.</p> <p>06/24/24 at 4:00 P.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>06/25/24 at 3:00 A.M. it was administered PRN on the MAR but documented as removed on the CDR on 06/24/24 at 3:00 A.M.</p> <p>06/25/24 at 2:30 P.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>06/26/24 at 2:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>06/26/24 at 8:30 P.M. it was administered routinely on the MAR but documented as removed for administration on the CDR on 06/27/24 at 9:00 P.M.</p> <p>06/28/24 at 2:30 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>06/29/24 at 2:30 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>07/03/24 at 3:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>07/05/24 at 3:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>07/08/24 at 3:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>07/10/24 at 4:00 A.M. it was removed for PRN administration on the CDR but not documented as administered on the MAR</p> <p>Interview on 07/10/24 at 2:45 P.M. with the Director of Nursing (DON) verified the above findings, and confirmed the nurses were required to administer and document controlled medications using both the MAR and CDR to prevent medication errors.</p> <p>Review of the facility policy, Controlled Substances, revised November 2022, revealed the system of reconciling the receipt, dispensing and disposition of controlled substances included using medication administration records and declining inventory records.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41526</p> <p>Based on observation, interview, record review, and facility policy review the facility failed to maintain enhanced barrier precautions (EBP) and transmission-based precautions (TBP) appropriately as required. This affected nine residents (#2, #4, #12, #15, #21, #24, #39, #49 and #55) and had the potential to affect all 56 residents residing in the facility.</p> <p>Findings include:</p> <p>Observation on 06/17/24 at 8:20 A.M. during a facility tour revealed the following:</p> <p>An EBP sign was posted at the entrance of Resident #2's room. There was a storage bin to the left of the entrance door which held personal protective equipment (PPE). Next to the PPE storage bin placed along the hallway wall were two large garbage containers, one for soiled linen and the other for infectious garbage lined with a red trash bag.</p> <p>An EBP sign was posted at the entrance of Resident #4's room. There was no available PPE at or near the entrance for staff use with EBP.</p> <p>A TBP sign which did not designate the type of precautions and an EBP sign were posted at the entrance of Resident #21's room. The storage bin which contained PPE for staff use was moved to Resident #21's bedside and held a running large fan pointed toward Resident #21 who was lying in bed. Due to the positioning of the PPE bin, the drawers were not easily accessible to obtain PPE when needed.</p> <p>A TBP sign for contact precautions was posted at the entrance of Resident #49's room. There was no available PPE at or near the entrance for staff use with TBP.</p> <p>There was an intravenous pole at the bedside in Resident #55's room. Interview at the time of the observation with Resident #55 revealed a wound was treated with antibiotic therapy. There was no EBP posted and no PPE available at or near the room entrance.</p> <p>Resident #12 was lying in bed with a tracheostomy and an enteral feeding machine running. There was no EBP posted and no PPE available at or near the room entrance.</p> <p>Resident #39 was lying in bed with a tracheostomy. There was no EBP posted and no PPE available at or near the room entrance.</p> <p>Resident #15 was lying in bed with a tracheostomy and a urinary catheter drainage bag secured to the left bedside facing the entrance door. There was a PPE storage bin located outside of the room with no signage posted to indicate the type of precautions needed.</p> <p>Resident #24 was lying in bed with a tracheostomy. There was no EBP posted and no PPE available at or near the room entrance.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included pressure ulcer of sacral region stage IV (full thickness tissue loss with exposure of bone, muscle or tendon). A physician order dated 06/06/24 indicated contact precautions due to presence of multi-drug resistant organisms (MDRO).</p> <p>Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type II. Physician orders effective June 2024 indicated wound treatment to the left abdomen daily.</p> <p>Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type II. Physician orders effective June 2024 indicated contact isolation for the presence of a MDRO in the urine until 06/22/24.</p> <p>Review of the medical record for Resident #49 revealed an admitted [DATE]. Diagnoses included chronic kidney disease and acute kidney failure. A physician order dated 06/13/24 indicated contact precautions due to the presence of a MDRO in the urine for 14 days.</p> <p>Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included osteomyelitis of the vertebra, sacral and sacrococcygeal region and diabetes mellitus type II. Physician orders active June 2024 indicated daily wound treatment to the sacrum. A wound note dated 06/10/24 described a stage IV coccyx wound.</p> <p>Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included tracheostomy and gastrostomy status. Physician orders effective June 2024 indicated tracheostomy and gastrostomy tube care daily with enteral feedings.</p> <p>Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included tracheostomy status and gastrostomy status. Physician orders effective June 2024 indicated tracheostomy and gastrostomy tube care daily with enteral feedings.</p> <p>Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included obstructive and reflux uropathy and tracheostomy status. Physician orders effective June 2024 indicated tracheostomy and urinary catheter care daily.</p> <p>Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnoses included tracheostomy status. Physician orders effective June 2024 indicated tracheostomy care daily.</p> <p>Interview on 06/17/24 at 8:58 A.M. with the Director of Nursing (DON) verified the above findings and confirmed resident rooms were not appropriately equipped with EBP and TBP, infectious garbage and soiled linen should not be in the facility hallways, and fans should not be in use on top of PPE storage bins.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy titled, Policy on Disease-Specific Isolation/Precautions, initiated 04/01/24, revealed EBP referred to an infection control intervention designed to reduce transmission of MDRO that employed targeted gown and glove use during high contact resident care activities. EBP were indicated for residents with an infection or colonization with a MDRO when contact precautions did not apply, wounds, and/or indwelling medical devices even if MDRO status was unknown. Contact precautions were intended to prevent transmission of infections that were spread by direct or indirect contact with the resident or environment and required the use of appropriate PPE including a gown and gloves upon entering the room (i. e., before making contact with the resident or the resident's environment).</p> <p>This deficiency was an incidental finding identified during the complaint investigation.</p>		