STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview, and review of facility policy the facility failed to ensure Resident #27's representative was notified of changes in condition related to an active infection which required a change in treatment and of positive cultures for multi drug-resistant organisms which required care plan updates. This affected one resident (Resident #27) of three residents (Residents #27, #39, and #79) reviewed. The facility census was 81. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] and a re-entry date of 03/14/24. Diagnoses included intractable epilepsy, temporal sclerosis, essential (primary) hypertension, bipolar disorder, hypothyroidism, gastrostomy status, depression, candidiasis, enterocolitis due to clostridium difficile, altered mental status, and presence of a neurostimulator. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 04/23/24 revealed Resident #27 had severely impaired cognition. Further review of the MDS revealed Resident #27 received enteral feedings and was dependent for all activities of daily living. Review of lab reports from cultures swabbed from the axilla and groin of Resident #27 on 04/22/24 revealed a positive culture for Candida auris (C. auris) on 04/29/24 and a positive culture for Carbapenem Resistant Acinetobacter baumanii (CRAB) on 04/30/24. Review of the discontinued and completed order list revealed an order dated 04/10/24 for Resident #27 to be placed in contact isolation for Clostridium difficile (C. diff.) infection and C. auris. Review of the discontinued and completed orders list revealed an order dated 05/02/24 for Resident #27 to be placed in contact isolation for CRAB. Review of the care plan isolation history revealed Resident #27's care plan was initially updated on 04/13/24 to reflect Resident #27 required contact isolation precautions for C. diff. Further review of the care plan dated 06/18/24 revealed Resident #27 had interventions including contact isolation precautions due to CRAB. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Warren Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2473 North Rd NE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes from 03/17/24 through 04/29/24 revealed no notes that Resident #27's representative was notified of her C. diff. infection or need for contact isolation. Further review of the progress notes revealed there were no notes entered between 04/29/24 and 05/08/24 and no documentation Resident #27's representative was notified of the positive cultures for C. auris and CRAB or that she was placed in contact isolation. Interview on 07/18/24 at 2:54 P.M. with the Director of Nursing (DON) confirmed staff should notify the resident's representative when there was a positive infection, need for a change in treatment, or a positive culture for a multi-drug resistant organism (MDRO). Further interview conducted on 07/18/24 at 3:45 confirmed there was no documentation found to reflect the resident representative for Resident #27 was notified she contracted C. diff., C. auris, or CRAB. Review of the policy titled Change in a Resident's Condition or Status dated May 2017 revealed that unless specified otherwise by the resident, the resident's representative was to be notified when there was a significant change to the resident's physical, mental, or psychosocial status, the resident was to be informed of changes in medical condition or status, and the information should be documented in the medical record. The policy further defined a significant change as a change that was not self-limiting and required changes to clinical interventions or the care plan. This deficiency represents non-compliance investigated under Complaint Number OH00155063.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview, and review of facility policy, the facility failed to implement a person-centered comprehensive care plan that addressed the physical, mental, and psychosocial needs of Resident #27. This affected one resident of five residents (Residents #27, #14, #39, #67, and #79) whose care plans were reviewed for appropriate person-centered interventions. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] and a re-entry date of 03/14/24. Diagnoses included intractable epilepsy, temporal sclerosis, essential (primary) hypertension, bipolar disorder, hypothyroidism, gastrostomy status, candidiasis, enterocolitis due to clostridium difficile, altered mental status, and depression. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 04/23/24 revealed Resident #27 had severely impaired cognition and a primary medical condition listed as epilepsy. Further review of the MDS revealed Resident #27 had bipolar disorder, had been taking an antidepressant, and exhibited verbal and physical behaviors for four to six days of the seven-day look-back period. The MDS dated [DATE] also revealed Resident #27 was screened using the Patient Health Questionnaire-9 (PHQ-9), a screening tool for measuring the severity of depression, and was assessed to be exhibiting signs of moderately severe depression. Review of the orders revealed an order dated 04/19/24 for venlafaxine hydrochloride (HCl) 24 hour extended release (ER) capsules, give Resident #27 one capsule via percutaneous endoscopic gastrostomy (PEG) tube (a surgically placed tube in the stomach for nutrition and medications) every morning for depression. Review of the Psychiatric Progress Note dated 04/18/24 revealed Nurse Practioner (NP) #448's assessment and plan for Resident #27 included continuing clonazepam as prescribed for seizures and management of agitation, monitor for effectiveness in managing anxiety symptoms, monitor Resident #27's mood and consider adding an additional mood stabilizer if condition worsens, start Resident #27 on Effexor (venlafaxine) for depression and monitor for potential side effects, improvement of symptoms, or the need to adjust the dosage or consider an alternative medication. Review of the progress notes from the past three months revealed Resident #27 was transferred to the emergency roiagnom on [DATE] and 05/25/24 for an increase in seizure activity. Further review of the progress notes revealed two nursing notes on 04/16/24 which stated NP #449 referred to Resident #27's seizures as unstable and poorly controlled. Review of the care plan last reviewed and updated on 06/18/24 revealed no care plan focus, goals, or interventions were in place to address Resident #27's diagnoses of epilepsy, bipolar disorder, or depression. Further review of the care plan revealed no care planned interventions related to Resident #27's hospitalization s for increased seizure activity or use of a psychotropic or antidepressant. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Warren Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 2473 North Rd NE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/18/24 at 11:8 A.M. with Licensed Practical Nurse (LPN) #388 confirmed Resident #27 had a recent increase in seizures. During the interview, LPN #388 was unable to say what specific seizure precautions were in place for Resident #27 or whether she had any care plan interventions for depression. Interview on 07/18/24 at 1:55 P.M. with State tested Nurse Aide (STNA) #344 revealed she did not know if any seizure precautions were required for Resident #27 and did not know what behaviors Resident #27 exhibited during seizures but would notify the nurse if she noticed any concerns. A follow-up interview with LPN #388 on 07/18/24 at 2:01 P.M. revealed she had not found resident-specific seizure precautions for Resident #27 and was not sure her seizure disorder was identified on the current care plan. Interview on 07/18/24 at 2:33 P.M. with the Director of Nursing (DON) confirmed the care plan provided the surveyor was the current care plan for Resident #27. The DON further confirmed Resident #27's primary diagnosis was epilepsy, there were no interventions related to epilepsy or seizures, and the care plans should reflect interventions that addressed each resident's medical and psychosocial needs as indicated by their diagnoses. A follow-up interview with the DON on 07/18/24 at 3:32 P.M. confirmed Resident #27's care plan interventions were all discontinued when she was hospitalized in March 2024 and some of the interventions, including the care planning for her seizure disorder, were not put on the current care plan after her re-entry to the facility on [DATE]. Review of the policy titled Activities of Daily Living last revised March 2018 revealed that care and services would be provided to prevent or minimize functional decline, including the treatment for depression or symptoms of depression, and appropriate care and services would be carried out according to the plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00155063.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on medical record review, interview, and package insert for Venlafaxine Extended Release (ER) the facility failed to ensure drug irregularities noted by the pharmacist were reported to the attending physician and acted upon timely. This affected one resident (Resident #27) of three residents (Residents #27, #39, and #79) who were reviewed for appropriate medications. The facility census was 81. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] and a re-entry date of 03/14/24. Diagnoses included intractable epilepsy, temporal sclerosis, essential (primary) hypertension, bipolar disorder, hypothyroidism, gastrostomy status, depression, candidiasis, enterocolitis due to clostridium difficile, altered mental status, and presence of a neurostimulator. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 04/23/24 revealed Resident #27 had severely impaired cognition and a primary medical condition listed as epilepsy. Further review of the MDS revealed Resident #27 had bipolar disorder, had been taking an antidepressant, and exhibited verbal and physical behaviors for four to six days of the seven-day look-back period. Review of the orders revealed an order dated 04/19/24 for venlafaxine hydrochloride (HCl) 24 hour extended release (ER) capsules, give Resident #27 one capsule via percutaneous endoscopic gastrostomy (PEG) tube (a surgically placed tube in the stomach for nutrition and medications) every morning for depression. Review of the progress notes revealed a note dated 05/10/24 which indicated the pharmacist noted an irregularity during the monthly review of Resident #27's drug regimen and directed facility staff to see the pharmacists report for the noted irregularities. Review of the document titled Note To Attending Physician/Prescriber dated 05/10/24 revealed the order for venlafaxine ER capsules 37.5 milligram (mg) should not be opened and mixed in water per manufacturers specification and the physician should consider changing the order to the immediate release formulation venlafaxine tablet, 37.5 mg via PEG tube every morning. Further review revealed the recommendation was not reviewed with the physician or prescribing provider until 07/18/24. The document did not specify who the nurse practitioner was that acknowledged receipt of the pharmacist's recommendation. Review of the medication administration records for May, June, and July 2024 revealed Resident #27 continued to receive venlafaxine ER capsules through her PEG tube after the pharmacist noted this formulation was not appropriate for opening and mixing with water for PEG tube administration through 07/18/24. Interview on 07/18/24 at 2:01 P.M. with Licensed Practical Nurse (LPN) #388 confirmed when she gave Resident #27 her ordered medication, the extended-release capsules were opened and mixed with liquid for administration. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 07/18/24 at 2:33 P.M. confirmed the facility had not communicated the pharmacist's medication irregularities report dated 05/10/24 for Resident #27 to the prescribing provider or attending physician until 07/18/24. Further interview with the DON revealed she was provided the wrong pharmacist contact information when she was hired by the facility and the pharmacist had the previous DON's contact information. Review of the Venlafaxine ER package insert revealed the medication should not be chewed, divided, crushed, or mixed with water for administration and should be taken per administration recommendations to decrease the risk of overmedication. This deficiency represents non-compliance investigated under Complaint Number OH00155063.