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	10/07/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, and review of the facility policy the facility failed to ensure enhanced barrier precautions (EBP) were maintained while tracheostomy, ventilator, and feeding tube related care were performed by multiple staff members. This affected one resident (Resident #73) of three residents who had tracheostomies and who were observed during the administration of medications or procedures. The facility census was 77. Findings include: Review of the medical record for Resident #73 revealed an original admitted [DATE] and a re-entry date of 07/17/24. Diagnoses included epilepsy, acute and chronic respiratory failure, congestive heart failure, muscular dystrophy, chronic obstructive pulmonary disease (COPD), neuromuscular dysfunction of bladder, anxiety disorder, sepsis, ileus, tracheostomy status, and attention to gastrotomy. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 09/09/24 revealed Resident #73 had intact cognition and was dependent on staff for activities of daily living. Resident #73 had an indwelling urinary catheter, unhealed Stage III (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) or Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling) pressure ulcers, a feeding tube, and required tracheostomy care, suctioning, and invasive mechanical ventilation. Review of the physician's orders for Resident #73 revealed an order dated 07/18/24 for EBP related to tracheostomy, percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube inserted into the stomach for nutrition and/or medication), candida aureus, suprapubic catheter, wound, pseudomonas aeruginosa, and Acinetobacter baumannii. Review of the care plan dated 06/06/24 revealed Resident #73 had the need for EBP related to an increased risk for multidrug-resistant organism (MDRO) infections due to indwelling medical devices and wound status. Interventions included to don appropriate personal protective equipment (PPE) prior to providing high-contact resident care and for device care or use, including urinary catheter, PEG tube, wound, and tracheostomy or ventilator care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/03/24 from 5:25 P.M. to 5:35 P.M. revealed Licensed Practical Nurse (LPN) #254 prepared medication for PEG tube administration, entered the room of Resident #73, placed the mediation and water on the bedside table, donned gloves (no gown), then proceeded to disconnect the ventilator tubing and drain the condensation out of the tubing before reconnecting the ventilator tubing. Ongoing observation revealed LPN #254 then provided tracheal suctioning and informed Resident #254 she would get the respiratory therapist (RT) to come and assess his respiratory status further. LPN #254 removed her gloves, washed her hands, picked up the medication cups, and continued down the hall to request that RT #185 assess Resident #73 and perform cough assist treatments (a procedure that uses a machine to help clear chest secretions by simulating a natural cough) per the resident's request. During this time, LPN #254 was also observed briefly entering a resident's room at the other end of the hallway in response to an activated call light while still carrying Resident #73's prepared medication. Observation on 10/03/24 from 5:35 P.M. to 5:40 P.M. revealed RT #185 changed a piece of the ventilator tubing for Resident #73 and performed tracheal suctioning with no gown. Further observation revealed RT Student #257 performed cough assist treatments, changed the ventilator tubing again, and suctioned his tracheostomy with gloves but no gown. During this observation, RT #185 held the old ventilator tubing in the air, filled with thick mucus, waved it in a left to right motion several times, while urging Resident #73 to look at the mucus-filled tubing as an example of how mucus gets plugged in his airway when there is not enough humidification. RT #18 did this while wearing no gloves or gown. Observation on 10/03/24 from 5:42 P.M. to 5:50 P.M. revealed LPN #254 administered medication and water flushes to Resident #73 via the PEG tube. LPN #254 removed the saturated PEG tube dressing, discarded it in the trash can, cleaned the stoma, applied medicated cream, and a new dry split-gauze dressing to the PEG tube site. During this observation, LPN #254 wore gloves but not a gown and was noted to have to lean against Resident #73's bed linen to perform the medication administration and PEG tube care. Interview on 10/03/24 at 5:53 P.M. with LPN #254 confirmed she did not wear a gown to empty the condensation on Resident #73's ventilator tubing, administer his pain medication and water flushes, remove the saturated PEG tube split gauze dressing, or perform PEG site care. During the interview, LPN #254 also confirmed that RT #185 and RT Student #257 performed ventilator tubing changes, cough assist treatment, and suctioning without donning gowns. Interview on 10/03/24 at 6:10 P.M. with LPN #152 confirmed when a resident had orders for EBP, all care requiring direct contact with that resident required staff to wear a gown and gloves. LPN #152 further confirmed Resident #73 was placed in EBP, and a gown and gloves should have been worn to provide care involving high contact care or care pertaining to any medical devices, which included his tracheostomy, PEG tube, and ventilator. Review of the facility policy titled Enhanced Barrier Precautions, updated on 09/27/24, revealed nursing home residents with wounds and indwelling medical devices were high risk for the acquisition and/or colonization of multidrug-resistant organisms (MDROs) and the use of a gown and gloves for high-contact resident care activities for nursing home residents with wounds or indwelling medical devices was indicated regardless of the presence of an MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Center for Clinical Standards and Quality/Quality, Safety & Oversight (QSO) Group memorandum summary, reference number QSO-24-08-NH, issued 03/20/24, revealed EBP in long-term care facilities became effective on 04/01/24 to align with nationally accepted standards. The QSO memorandum further revealed EBP was to include residents with chronic wounds and/or indwelling medical devices, including feeding tubes and tracheostomies, during high contact care regardless of their status related to multidrug-resistant organisms. This deficiency represents non-compliance investigated under Complaint Number OH00157581.