

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2025
NAME OF PROVIDER OR SUPPLIER  Ohio Living Breckenridge Village		STREET ADDRESS, CITY, STATE, ZIP CODE  36855 Ridge Rd Willoughby, OH 44094	

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 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** 41526</b></p> <p>Based on observation, interview, record review, facility policy and staff training review, and review of the Centers for Medicare and Medicaid (CMS) Quality, Safety, and Oversight (QSO) Memo 24-08-NH, the facility failed to use a gown for required enhanced barrier precautions (EBP) while administering medications through a gastric tube for Resident #44, failed to clean a wrist blood pressure monitor between use on Resident's #44 and #52, and failed to maintain a clean wall-mounted fan while in use and directed toward clean linen in the laundry area. This affected two residents (#44 and #52) of 60 residents reviewed for infection control and had the potential to affect all 60 residents residing in the facility. The facility reported 13 residents (#17, #22, #25, #30, #32, #44, #48, #113, #120, #121, #125, #126 and #162) on EBP precautions.</p> <p>Findings include:</p> <p>1. Observation on 05/13/25 at 8:06 A.M. with Licensed Practical Nurse (LPN) #615 of medication administration for Resident #44 revealed LPN #615 prepared three medications for administration into a gastric tube while at the medication cart then entered Resident #44's room which had a sign posted on the door to observe EBP with gowns and gloves stored in a door rack for staff use. LPN #615 donned gloves but did not put on the required gown before engaging Resident #44 and administering the medications through the gastric tube. Once completed, LPN #615 removed the soiled gloves, performed hand hygiene and then left the resident's room. Interview at the time of the observation with LPN #615 confirmed not wearing the required gown for EBP.</p> <p>Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including encephalopathy, diabetes mellitus type two, hypertensive heart disease with heart failure and gastrostomy status. The Admission Minimum Data Set (MDS) assessment completed on 03/06/25 indicated Resident #44 had moderate cognitive impairment, and the plan of care dated 02/28/25 specified a need for enteral feeding through a gastric tube.</p> <p>Review of CMS QSO Memo 24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, revealed EBP are indicated for residents with indwelling medical devices even if the resident is not known to be infected or colonized with a multidrug resistant organism (MDRO). The effective date for implementation of EBP under the guidelines was 04/01/24.</p> <p>Review of the facility policy, Enhanced Barrier Precautions, revised 09/14/23, revealed EBP required the use of gloves and a gown with residents who had an indwelling medical device during high-contact resident care.</p> <p>(continued on next page)</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility staff training completed on 05/13/25 revealed the use of a gown and gloves for high-contact resident care activities was indicated for residents with indwelling medical devices.</p> <p>2. Observation on 05/13/25 at 8:06 A.M. with LPN #615 of medication administration for Resident #44 revealed LPN #615 obtained a blood pressure reading using a wrist monitor prior to medication preparation then placed the monitor on top of the medication cart without cleaning it after use. LPN #615 then prepared Resident #44's medications, administered them as ordered and then moved the medication cart to where Resident #52 was located. LPN #615 picked up the soiled blood pressure monitor and used it to obtain Resident #52's blood pressure prior to preparing the resident's medications. Once completed, LPN #615 returned to the medication cart and set the soiled blood pressure monitor on top of the medication cart without cleaning it after use. Interview at the time of the observation with LPN #615 verified the wrist blood pressure monitor was not cleaned after use between Resident's #44 and #52.</p> <p>Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including encephalopathy, diabetes mellitus type two, hypertensive heart disease with heart failure and gastrostomy status.</p> <p>Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including chronic kidney disease, palliative care, dementia, atrial fibrillation and congestive heart failure.</p> <p>Review of facility staff training completed on 05/13/25, entitled Infection Control Review - Shared Medical Devices, revealed cleaning and disinfecting shared medical devices between residents are crucial for preventing the spread of infections, reducing healthcare-associated infections, and protecting residents' safety.</p> <p>3. Observation on 05/14/25 at 11:19 A.M. with Housekeeping Supervisor (HS) #610 of the laundry room revealed in the clean laundry area there were two unknown laundry workers actively folding linen out of a large mostly filled clean linen cart. In proximity was a large wall mounted fan blowing air toward the two laundry workers and the clean linen. The fan had visible dirt buildup with accumulated dirt seen flapping from the air flow out of the fan toward the clean linen. Interview at the time of the observation with HS #610 confirmed the wall mounted fan being used in the clean laundry area was visibly dirty and blowing toward the clean linen.</p>		