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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365665	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Wind Health Care Center	300 23rd Street NE Massillon, OH 44646

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, record review, and interview the facility failed to cover an indwelling urinary catheter drainage bag. This affected one resident (Resident #276) out of two residents reviewed for indwelling urinary catheters. The facility census was 75. Findings Include: Review of the medical record for Resident #276 revealed an admitted [DATE] with diagnoses including history of falls, history of urinary tract infection (UTI), chronic kidney disease, and type two diabetes mellitus. Resident #276 required assistance from staff for activities of daily living (ADL) tasks, used a front wheeled walker for ambulation assistance, and was receiving physical and occupational therapy services. Review of Resident #276 physician orders revealed an order dated 10/03/24 for foley catheter bag cover every shift, an order dated 10/04/24 for privacy cover to foley catheter drainage bag every shift for maintaining dignity, and an order dated 10/03/24 for foley catheter care every shift. Review of Resident #276 baseline care plan dated 10/03/24 revealed Resident #276 was admitted with an indwelling urinary catheter. Observation on 10/07/24 at 1:05 P.M. revealed Resident #276 resting in bed watching television, a partially filled urinary catheter drainage bag was hanging from the bed frame without privacy cover or bag in place. Observation on 10/08/24 at 3:14 P.M. revealed Resident #276 sitting at edge of bed watching television, a urinary catheter drainage bag was hanging from the bed frame without privacy cover or bag in place. Interview on 10/08/24 at 3:14 P.M. with State tested Nursing Assistants (STNAs) #527 and #543 confirmed Resident #276 indwelling urinary catheter drainage bag was uncovered and visible from the room's doorway. STNA #527 stated there should be a privacy bag or a drainage bag with an attached cover over the drainage bag and the lack of the privacy bag would be resolved by placing a privacy bag on Resident #276's indwelling urinary catheter drainage bag. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/10/24 at 8:16 A.M. revealed Resident #276 sleeping in bed with the lights turned off. An empty urinary catheter drainage bag was hanging from the bed frame without privacy cover or bag in place. Interview on 10/10/24 at 8:16 A.M. with Licensed Practical Nurse (LPN) #314 confirmed Resident #276 indwelling urinary catheter partially filled drainage bag was hanging on the bed frame, uncovered and not placed in a privacy bag.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, record review, interview and facility policy review, the facility failed to ensure enteral tube feeding bottles and water flush bags were properly labeled with the flow rate and the date and time the bottles/bags were hung for administration for Resident #176, and failed to ensure orders were obtained for Resident #177 regarding cleaning and flushing of an enteral feeding tube. This affected two residents (Resident #176 and #177) out of two residents reviewed for enteral tube feedings. The facility census was 75. Findings Include: 1. Review of the medical record for Resident #176 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), depression, anxiety, heart failure, and placement of a percutaneous endoscopic gastrostomy (PEG) tube. Resident #176 was cognitively intact and required assistance from the staff for activities of daily living (ADL) tasks including medication administration and tube feeding formula administration. Review of the physician orders for Resident #176 revealed an order dated 09/25/24 for two times a day (Enteral) Jevity 1.5 at 85 milliliters (ml) per hour for 12 hours (on at 7:00 P.M. and off at 7:00 A.M.) with water flush of 245 ml every four hours. Resident #176 also had an order dated 09/24/24 for a regular diet, pureed texture, honey consistency liquids. Review of Resident #176's Medication Administration Record (MAR) dated 10/01/24 to 10/10/24 revealed administration (Enteral) Jevity 1.5 at 85 milliliters (ml) per hour for 12 hours (on at 7:00 P.M. and off at 7:00 A.M.) with water flush of 245 ml every four hours. Observation on 10/07/24 at 10:35 A.M. revealed Resident #176 was in bed and a tube feeding administration pole was at the bedside. Hanging from the pole was an empty formula bottle of Jevity 1.5. The bottle had no flow rate, date, or time marked on it to indicate when it was first hung to be administered to Resident #176. The resident was not hooked up to the feeding at the time of the observation. Observation on 10/08/24 at 1:32 P.M. and 1:47 P.M. revealed Resident #176 resting in bed with the unattached tube feeding tube hanging from the pole at bedside. There was an empty bottle of Jevity 1.5 enteral formula with no rate, date, and time of when administered hanging from the pole. There was also a half-filled water flush bag hanging from the pole with no rate, date, and time labeled on the bag. An interview on 10/08/24 at 1:47 P.M. with Licensed Practical Nurse (LPN) #313 confirmed the above findings. Review of the facility's policy titled, Enteral Feedings Safety Precautions, dated 05/24, revealed, On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	22653 2. Review of Resident #177's medical record revealed diagnoses including osteomyelitis of the left ankle and foot, cellulitis of the left lower extremity, abscess of the left foot, history of sepsis, type two diabetes mellitus, heart disease, schizophrenia, and gastrostomy. A nursing admission assessment dated [DATE] indicated Resident #177 had a feeding tube. Resident #177 required supervision with eating. Resident #177 had an order dated 10/03/24 for a low concentrated sweet diet with regular texture. Review of medication orders dated 10/03/24 revealed orders for medications including ferrous sulfate, provera, metoprolol tartrate, risperidone, ascorbic acid, quetiapine fumarate, amlodipine, atorvastatin calcium, pantoprazole sodium, and zinc sulfate which could be administered via mouth or through the feeding tube. There were no orders for care of the feeding tube (cleansing the insertion site or flushes). During an interview on 10/07/24 at 11:26 A.M., Resident #177 reported she had a feeding tube which she had staff use for some medication administration. On 10/07/24 at 4:44 P.M., Unit Manager (UM) #915 verified there were no orders for tube care or water flushes.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review and interview, the facility failed to ensure parameters were in place for the administration of pain medications. This affected one resident (Resident #2) of five reviewed for unnecessary medications. The facility census was 75. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included respiratory failure, cerebral palsy, depression, tracheostomy and scoliosis. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was severely cognitively impaired. She was totally dependent for oral and personal hygiene, toileting, dressing and showering. She received hospice services. Review of the physician's orders for October 2024 revealed an order for Acetaminophen 500 milligrams (mg) 1 tablet via peg tube every eight hours as needed for pain which began on 07/25/24 and an order for Morphine 0.5 milliliters (ml) every two hours as needed for pain which began on 08/26/24. Review of the care plan dated 08/28/24 revealed Resident #2 had the potential for pain due to quadriplegia, convulsions, contractures and scoliosis. Interventions included anticipating the need for pain relief, administering medications as ordered, evaluating the effectiveness of pain interventions and monitoring and recording complaints of pain. Review of the Medication Administration Record (MAR) for September 2024 revealed Resident #2 received one does of Morphine on 09/01/24 for a pain level of six and one dose for a pain level of eight, two doses on 09/02/24 for a pain level of seven, one dose on 09/03/24 for a pain level of three and two doses for a pain level of eight, one dose on 09/04/24 for a pain level of eight and one dose for a pain level of seven, two doses on 09/05/24 for a pain level of seven, one dose on 09/06/24 for a pain level of seven and one dose for a pain level of eight, one dose on 09/07/24 for a pain level of four and one dose for a pain level of eight, one dose on 09/08/24 for a pain level of four, one dose on 09/09/24 for a pain level of seven, two doses on 09/10/24 for a pain level of seven, one dose on 09/07/24 for a pain level of seven and one dose for a pain level of eight, one dose on 09/12/24 for a pain level of eight and one dose for a pain level of seven, one dose on 09/13/24 for a pain level of nine and one dose for a pain level of three, one dose on 09/14/24 for a pain level of seven and one dose for a pain level of eight, one dose on 09/15/24 for a pain level of seven and two doses for a pain level of eight, one dose on 09/16/24 for a pain level of eight and one dose for a pain level of five, one dose on 09/17/24 for a pain level of six and two doses for a pain level of eight, one dose on 09/18/24 for a pain level of four and one dose for a pain level of seven, one dose on 09/19/24 for a pain level of three, two doses of 09/21/24 for a pain level of two, one dose on 09/23/24 for a pain level of two, one dose on 09/24/24 for a pain level of three, one dose on 09/26/24 for a pain level of three, one dose on 09/27/24 for a pain level of eight and one dose on 09/29/24 for a pain level of four. The resident was never administered Acetaminophen. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for October 2024 revealed Resident #2 received one dose of Morphine on 10/01/24 for a pain level of two and two doses for a pain level of eight, one dose on 10/05/24 for a pain level of zero, one dose on 10/06/24 for a pain level of three, one dose on 10/07/24 for a pain level of zero and one dose for a pain level of eight, one dose on 10/08/24 for a pain level of three, two doses on 10/09/24 for a pain level of zero and three doses on 10/01/24 for a pain level of zero. Interview on 10/10/24 at 9:43 A.M. with Licensed Practical Nurse (LPN) #309 revealed she usually gave Morphine for a pain level of seven or above, she did not have guidelines for when it would be appropriate for administer Acetaminophen instead of Morphine for Resident #2. Interview on 10/10/24 at 1:12 P.M. with the Director of Nursing (DON) verified the above findings on the MARs and confirmed there were no parameters specified for when Acetaminophen would be administered instead of Morphine for Resident #2. Review of the facility policy titled Administering Pain Medications dated October 2010 revealed the facility would assess the residents' level of pain prior to administering medication and administer medication as ordered.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45441 Based on record review and interview, the facility failed to completely and accurately report staff hours worked for the Payroll Based Journal (PBJ) report. This had the potential to affect all 75 residents residing in the facility. Findings include: Review of the PBJ report revealed excessively low weekend staffing for the third quarter of 2024. Review of the staffing schedules for the nurses and State tested Nurse Aides (STNA) for the third quarter of 2024 revealed on 05/24/24, 05/25/24 and 06/16/24 there was insufficient direct care staff in the facility to provided a minimum of 2.5 hours of direct care per resident per day. Interview on 10/10/24 at 2:00 P.M. with the Administrator revealed during the third quarter of 2024 when the facility utilized agency staff to cover shifts this data was not submitted to the corporate office for the PBJ so the data reported for the third quarter of 2024 was not accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observations, policy review, medical record review and interview, the facility failed to implement isolation protocols and failed to maintain infection control during tracheostomy care and blood glucose monitoring. This had the potential to affect all 75 residents in the facility. Findings include: 1. Review of Resident #178's medical record revealed diagnoses including history of malignant neoplasm of the breast and intestine and dyspnea. On 09/28/24, Resident #178 tested positive for COVID-19 and was placed in droplet isolation. The isolation was to be discontinued 10/09/24. On 10/07/24 at 12:47 P.M., Certified Occupational Therapy Assistant (COTA) #820 was observed opening Resident #178's door to exit into the corridor. The N95 mask she was wearing in Resident #178's room remained on. After opening the door, COTA #820 removed the N95. Without performing hand hygiene, COTA #820 reached around the door and into the isolation cart to obtain a new N95 mask and held it over her face. COTA #820 pushed the goggles she had been wearing onto the top of her head and walked down the hall without disinfecting the goggles or performing hand hygiene. COTA #820 stopped at room [ROOM NUMBER] and got a surgical mask from Resident #177's isolation cart. Resident #177 had orders for enhanced barrier precautions due to presence of a feeding tube. COTA #820 continued down the hall without performing hand hygiene or disinfecting the goggles or the drawers of Resident #177's or Resident #178's isolation carts. On 10/08/24 at 1:35 P.M., as State tested Nursing Assistant (STNA) #520 was being interviewed regarding the location of surgical masks as there were none in Resident #178's isolation cart and it was what the facility required to be worn outside the COVID isolation rooms. STNA #520 provided a box of surgical masks. Housekeeper #701, who was in the hallway and overheard the conversation, inquired of STNA #520 if she was supposed to change masks when going in and out of the droplet isolation rooms. STNA #520 responded it was required to prevent spreading COVID. Upon entering Resident #178's room on 10/08/24 after the interview, it was noted the isolation barrel by the door and the trash can by the sink in the room were overflowing with trash. Disposable gowns were noted flowing down the sides of both receptacles. On 10/08/24 at 1:40 P.M., Housekeeper #701 stated it was up to the nursing assistants to dispose of trash in the isolation rooms. On 10/08/24 at 2:48 P.M., STNA #520 verified Housekeeper #701 was unaware of the need to change masks when going in and out of droplet isolation rooms when she made the inquiry earlier that day. STNA #520 reported it was the responsibility of housekeeping to empty the isolation barrels and trash. On 10/08/24 at 2:48 P.M., STNA #520 was observed leaving Resident #178's (who was positive and in isolation for COVID-19) room. STNA #520 walked up the hall and got hand sanitizer from on top of a locked box by room [ROOM NUMBER]. No eye protection was observed being worn. STNA #520 indicated she did not know eye protection was required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/08/24 at 3:05 P.M., Housekeeping Director #903 stated it was the responsibility of the housekeeping department to empty isolation trash and verified staff needed to change masks when entering/exiting covid rooms. On 10/08/24 at 3:15 P.M., COTA #820 verified she had left Resident #178's room on 10/07/24 and verified hand hygiene was not completed after removing the old N95 because there was no hand sanitizer. COTA #820 verified the goggles had been pushed up to the top of her head without disinfecting until she returned to therapy where she had disinfectant wipes because there were none available in the cart. On 10/08/24 at 3:48 P.M., Unit Manager (UM) #915 stated hand sanitizer should be available in the isolation carts. Disinfectant wipes were not kept in the isolation carts so they could be used when staff exited the room. Staff had to request the disinfectant wipes from the nurse. 2. Review of Resident #2's medical record revealed diagnoses including acute and chronic respiratory failure and tracheostomy status. On 10/07/24 an order was written for contact isolation for extended-spectrum beta-lactamases (ESBL) in the sputum. On 10/09/24 at 12:05 P.M., Licensed Practical Nurse (LPN) #308 was observed preparing medication for administration to Resident #2. Signs were posted for contact precautions and enhanced barrier precautions. Housekeeper #701 was in Resident #2's room cleaning. The only personal protective equipment (PPE) worn was a pair of gloves. On 10/09/24 at 1 P.M. Housekeeper #701 verified she had not worn a gown into Resident #2's room. Housekeeper #701 stated nobody informed her Resident #2 had been added to contact isolation. Review of the facility's policy titled Isolation Categories of Transmission-Based Precautions (revised January 2012) revealed transmission-based precautions would be used whenever measures more stringent than standard precautions were needed to prevent or control the spread of infection. For residents on contact precautions, a disposable gown should be worn upon entering the room or cubicle in addition to gloves. Surveyor: [NAME], APRIL (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observation on 10/09/24 at 9:55 A.M. revealed Respiratory Technician (RT) #407 conducting tracheostomy care for Resident #57. RT #407 donned Personnel Protective Equipment (PPE), including gloves, and entered Resident #57's room where Resident #57 was laying in bed covered with bed linens and a blanket. RT #407 placed the tracheostomy cleaning package, several packages of gauze sheets, the replacement inner cannula, a split gauze to cover the tracheostomy insertion site, and normal saline for cleaning the tracheostomy insertion site on the blanket at the foot of Resident #57's bed on top of Resident #57's legs. RT#407 opened the tracheostomy cleaning tray removing the sterile gloves package and placing the package on the blanket, there had been no sterile barrier sheet to place under the sterile gloves package. RT #407 donned the sterile gloves over the existing gloves which were already in place, removed the used inner cannula and placed the cannula on the packaging for the sterile gloves. RT #407 then placed the new inner cannula into the tracheostomy tube, retrieved the used inner cannula from the opened package and rolled the used inner cannula into one sterile glove and removed the other sterile glove while keeping the used inner cannula rolled into the gloves and disposed of the used inner cannula into the waste reciprocal. RT #407 donned a new pair of gloves and proceeded to clean the tracheostomy insertion site and placed the clean split gauze around the tracheostomy and removed the cleaning tray from the on top of the bed and disposed of all items in the waste reciprocal. RT #407 removed the PPE and gloves then washed hands and exited Resident #57's room. Review of Resident #57's medical record revealed readmitted [DATE] with diagnoses including chronic respiratory failure, high blood pressure, heart failure, and type two diabetes mellitus. Resident #57 was dependent on staff assistance for all cares and activities of daily living (ADL) tasks including tracheostomy care. Resident #57 had severely impaired cognition with a Brief Interview Mental Status (BIMS) score five out of a possible 15 total score dated 08/30/24 Review of Resident #57's physician orders revealed an order dated 09/01/24 for tracheostomy size #6 XLT Proximal Cuffed every shift for acute and chronic respiratory failure with hypoxia, an order dated 05/24/24 for Trach care Q-shift and as needed (PRN) every shift for chronic respiratory failure with hypoxia change inner cannula, cleanse area around the trach and neck, change trach ties every shift and PRN, and an order dated 07/31/24 to change trach tube every 90 days and PRN one time a day every 90 days. Review of Resident #57's Quarterly [NAME] Data Set (MDS) dated [DATE] revealed Section K: Swallowing/Nutritional Status marked with abdominal feeding tube (PEG) being used, and Section O: Special Treatments, Procedures, and Programs marked with tracheostomy being used. Review of the care plan for Resident #57 revealed a tracheostomy care plan dated 06/14/24 including intervention for tracheostomy care as ordered. Interview on 10/09/24 at 9:57 A.M. with RT #407 confirmed the tracheostomy cleaning supplies and sterile glove package had been placed on Resident #57 bed blanket on top of Resident #57's legs and there had been no sterile barrier sheet placed underneath the tracheostomy supplies. RT #407 stated the bedside table is usually used to keep the tracheostomy supplies off the bed and there should have been a sterile sheet placed for the tracheostomy supplies to be kept on during the procedure. Review of the facility's policy titled, Tracheostomy Care dated 10/23 revealed, Open tracheostomy cleaning kit. Set up supplies on sterile field. (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 - Many	4. Review of the medical record for Resident #34 revealed admitted [DATE] with diagnoses including epilepsy, type one diabetes mellitus (DM), anxiety, unspecified dementia, and high blood pressure. Resident #34 had severely impaired cognition and required assistance from staff to complete activities of daily living (ADL) tasks including administration of medications. Review of the physician orders for Resident #34 revealed an order dated 08/02/24 for Insulin Lispro 100 units per milliliter (ml) inject subcutaneously two times a day for DM with blood sugar readings and sliding scale dosing at 7:30 A.M. and 12:00 P.M. Review of the comprehensive care plan for Resident #34 revealed a diabetes mellitus care plan dated 08/02/23 with interventions including fasting blood sugar as ordered by the physician and diabetes medications as ordered by the physician. Review of Resident #34's Medication Administration Record (MAR) dated 10/01/24 to 10/09/24 revealed the blood sugar reading obtained at 12:20 P.M. results were recorded as 388 requiring six units of the Insulin Lispro to be administered per sliding scale dosing. Observation on 10/09/24 at 12:20 P.M. revealed Resident #34 sitting at a table in the main dining room facing the television with back to the majority of the room, eating the lunch meal. Licensed Practical Nurse (LPN) #822 approached Resident #34 at the table and explained blood sugar check and insulin administration needed to be completed. LPN #822 placed the glucometer, insulin pen, lancet, and several alcohol wipes directly on the table without a barrier in place. LPN #822 requested Resident #34 to hold out her right hand, then LPN #822 cleaned her right pointer finger with alcohol wipe, placed the used wipe directly on the table, pricked her finger with the lancet using another alcohol wipe to clean the blood from her finger and placed the used wipe on the table. LPN #822 then obtained the blood sugar reading, placing the glucometer directly on the table with the used strip still in the machine. LPN #822 then proceeded to administer Resident #34's insulin via a pre-filled insulin pen, once the insulin was administered, LPN #822 gathered up the supplies from the table and left the dining room. Interview on 10/09/24 at 12:28 P.M. with LPN #822 confirmed during the obtaining of Resident #34's blood sugar and administration of the Insulin Lispro, LPN #34 had not used a barrier for the required supplies storage on the tabletop, had placed used alcohol wipes directly on the table, and had placed the glucometer with the used blood strip on the table after obtaining a blood sample for testing. LPN #822 stated Resident #34 had been taken to the dining room for the lunch meal before completing the procedure for blood sugar checks and insulin administration. Review of the facility's policy tilted, Infection Control Guidelines for All Nursing Procedures dated 12/29/20 revealed, Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. 47569