

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/13/2025
NAME OF PROVIDER OR SUPPLIER  Legacy Mentor		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 Mentor Hills Drive Mentor, OH 44060	
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 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>39968</p> <p>Based on record review, staff interview and facility policy review, the facility failed to ensure a designated Grievance Officer was identified. This had the potential to affect all 96 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the Grievance Committee list revealed no staff member had been designated as the Grievance Officer.</p> <p>Interview on 02/12/25 at 10:18 A.M. with the Administrator revealed there was no designated Grievance Officer.</p> <p>Review of the facility policy titled Grievances/Complaints, Filing, updated April 2017, revealed the Administrator delegates a Grievance Officer.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51073</p> <p>Based on review of record, interview and facility policy review, the facility failed to offer/hold quarterly care conference meetings for Resident #21 and/or her representative. This affected one resident (#21) of one resident reviewed for care conferences. The facility census was 96.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included chronic diastolic heart failure, paraplegia, morbid obesity, fibromyalgia, and colostomy.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/01/25, revealed Resident #21 had no memory impairment, was alert and cooperative with normal energy.</p> <p>Review of Resident #21's medical record revealed Interdisciplinary Team (IDT)/Care Conference Notes revealed the only documented evidence of care conferences were on 06/30/23, 03/23/24, and 10/07/24 only.</p> <p>Interview with Resident #21 on 02/10/25 at 8:36 P.M. revealed the resident understood what a care conference was. She denied attending a care plan meeting for a long time. In a follow-up interview with Resident #21 on 02/12/25 at 11:53 A.M. Resident #21 stated that she did not remember meeting with staff; however, she had talked to the person in charge of the kitchen in the hallway regarding food preferences. She also stated she had been invited to meet with a group of people in the dining room but turned down attending due to concern of being exposed to illness.</p> <p>Interview with Social Worker (SW) #606 verified that Resident #21 had care conferences, but they had not occurred quarterly. Resident #21 had attended meetings but also requested SW #606 call her daughter instead of attending. There was no documented evidence that the resident or her daughter were offered quarterly care conferences.</p> <p>Review of the undated facility policy, Care Planning - Interdisciplinary Team Policy revealed that every effort would be made to schedule care plan meetings at the best time of day for both resident and family.</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> 39973</p> <p>Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to use appropriate transmission-based precautions (TBP) for Resident #84, utilize enhance barrier precautions (EBP) when indicated for Residents #12, #57 and #58 and failed to perform wound care using appropriate infection control practices for Residents #1, #12, #41, and #57. This affected one resident (#84) out of two residents reviewed for TBP, affected three residents (#12, #57 and #58) of six residents reviewed for EBP and affected four residents (#1, #12, #41, and #57) of six residents reviewed for wound care. The facility reported 27 residents (#1, #5, #7, #9, #12, #15, #17, #21, #24, #25, #32, #34, #35, #38, #39, #40, #41, #42, #52, #53, #54, #58, #80, #84, #85, #91 and #302) who had EBP, and 23 residents (#1, #4, #7, #12, #17, #21, #24, #39, #40, #41, #42, #52, #53, #54, #57, #58, #77, #84, #85, #90, #91, #298 and #302) who had wounds. This had the potential to affect all 96 residents residing at the facility.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #84 revealed an admitted [DATE] with diagnoses including enterocolitis due to clostridium difficile (C-Diff) (a highly contagious bacterium that causes diarrhea and colitis (an inflammation of the colon), diabetes, end stage renal disease, and asthma.</p> <p>Review of the care plan dated 01/03/25 revealed Resident #84 had an activities of daily living (ADL) self-care deficit related to pelvic fracture, right below the knee amputation, and limited mobility. Interventions included staff assisting with ADL on a daily basis and monitoring for fatigue.</p> <p>Review of the care plan dated 01/24/25 revealed Resident #84 had a C-Diff infection and was at risk for complications including weakness. Interventions included administer medications as ordered, labs as ordered, private room if available, and contact precautions as indicated.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #85 had intact cognition. She required supervision or touching assistance with toileting hygiene and transfers. She was occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>Review of the February 2025 physician's orders revealed Resident #84 had an order dated 01/23/25 for contact precautions due to C-Diff and to post a sign to see the nurse before entering the resident's room. The order also revealed wearing gloves, masking, and gowning as needed and washing hands when touching the environment and with direct patient care. Resident #84 also had an order for EBP dated 01/24/25.</p> <p>Observation on 02/11/25 at 7:46 A.M. revealed upon entrance to Resident #84's room there was a personal protective (PPE) cart to the right of the door with an EBP sign posted. The EBP signage revealed that staff were to clean their hands including before entering and when leaving the room, wear gloves and gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting and device care. There was nothing on the signage including wearing PPE when touching environmental surfaces and/or cleaning of the environment. There was no contact precaution signage posted.</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>Interview on 02/11/25 at 7:51 A.M. with Licensed Practical Nurse (LPN) #565 verified Resident #84 had C-Diff. She revealed she had discussed TBP with the Director of Nursing (DON) who indicated EBP was sufficient for the C-Diff infection.</p> <p>Interview and observation on 02/12/25 at 7:35 A.M. with Housekeeping #620 revealed she was assigned Resident #84's room today, 02/12/25, as well as having cleaned her room over the weekend, 02/08/25 and 02/09/25. She revealed if a resident had signage indicating EBP then she did not do anything special as that signage was more for when the aides completed direct care not for her duties as a housekeeper. She verified anytime she cleaned Resident #84's room she usually only wore gloves to clean and not a gown as Resident #84 only had signage indicating EBP precautions and was not aware of any other TBP needed. Housekeeping #620 verified on the outside of Resident #84's room, there was only EBP signage, and that was what she went by.</p> <p>Interview on 02/12/25 at 7:45 A.M. with Housekeeping #621 revealed she went by the signage on the outside of the resident door to indicate what PPE she needed to wear prior to entering. She revealed if there was signage indicating EBP; she wore gloves as that was what she wore into all rooms to clean, but she did not wear a gown or any other PPE. She revealed she was not aware of any other precautions Resident #84 was to have besides EBP.</p> <p>Interview on 02/12/25 at 8:00 A.M. with Housekeeping Supervisor #622 revealed he educated his housekeeping staff that if a resident had EBP signage on the outside of their room to wear gloves and usually a mask. He verified that residents on EBP, he instructed not to wear a gown and/or to take any precautions with the environment. He revealed he was not notified Resident #84 was on any other precautions other than EBP and/or that Resident #84 had C-Diff.</p> <p>Interview and observation on 02/12/25 at 8:10 A.M. with Registered Nurse (RN)/Wound Nurse (WN)/Infection Preventionist (IP) #568 verified that on the outside of Resident #84's room there was only signage for EBP. She verified Resident #84 had C-Diff but that she was always told that there were only two precautions used at the facility either EBP or respiratory droplet precautions. She verified she did not have signage for contact isolation. She verified under the EBP precautions that the precautions did not include anything regarding wearing a gown when entering the room, including touching environmental surfaces and/or cleaning of the environment. She verified she was unsure how housekeepers would be aware of using proper precautions as she stated, I did not think of that.</p> <p>Interview on 02/12/25 at 8:51 A.M. with the DON revealed that the facility had more than two signs to post on the outside of the doors, including signs for contact isolation. She verified Resident #84 had C-Diff, and she should have had contact isolation signage on the outside of her door to notify staff of proper precautions to take as ordered. She verified housekeepers should be wearing gowns to clean environmental surfaces when entering her room as well as to instruct any other staff or visitors that would encounter environmental surfaces.</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 labeled, Isolation- Categories of Transmission- Based Precautions, dated 2001, revealed TBP precautions were initiated when a resident developed signs and symptoms of a transmissible infection, arrives for admission with symptoms of an infection, or had a lab confirmed infection or was at risk for transmitting the infection to other residents. The policy revealed TBP were additional measures that protect staff, visitors and other residents from becoming infected. There were three types of precautions: contact, droplet, and airborne. The policy revealed when a resident was placed on TBP appropriate notification was placed on the room entrance door so that personnel and visitors were aware of the type of precautions. The policy revealed for contact precautions staff and visitors wear disposable gowns upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing.</p> <p>Review of the undated, CDC C-Diff Guideline, revealed C-Diff spreads when people touch surfaces that were contaminated with bowel movement from an infected person or when people do not wash their hands with soap and water. The guideline revealed healthcare professionals should prevent C- Diff by rapidly identifying, isolating residents with C-Diff, wear gloves and gowns, and remembering that hand sanitizer does not kill C-Diff.</p> <p>2. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including chronic kidney disease, diabetes, and nontraumatic intracerebral hemorrhage affecting the right dominant side.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #1 had impaired cognition, and he had no pressure ulcers.</p> <p>Review of the February 2025 physician's orders revealed Resident #1 had an order to cleanse his left great toe with wound cleanser, apply calcium alginate (a type of wound dressing derived from seaweed that absorbs exudate and forms a moist gel), abdominal (ABD) pad, and Kerlix gauze daily.</p> <p>Review of the care plan dated 02/11/24 revealed Resident #1 had an open area to left great toe and was at risk for complications. Interventions included administer treatment as ordered, observe and report signs of infection, and wound consult as indicated.</p> <p>Observation on 02/12/25 at 9:09 A.M. of wound care for Resident #1 completed by RN/WN/IP #568 revealed she washed her hands, applied gloves and proceeded to remove Resident #1's dressing to his left foot revealing a nickel size open area that the facility was classifying as a diabetic ulcer that contained dried blood to the top of his left toe. She proceeded to cleanse his left toe with normal saline, applied calcium alginate, ABD, wrapped with Kerlix gauze and then washed her hands.</p> <p>Interview on 02/12/25 at 9:43 A.M. with RN/WN/IP #568 verified that she removed Resident #1's wound dressing to his left foot and proceeded to cleanse the wound without performing hand hygiene.</p> <p>Interview on 02/12/25 at 1:39 P.M. with the DON verified RN/WN/IP #568 should have performed hand hygiene after removing the old dressing. She also verified this was the procedure identified in their facility policy to follow.</p> <p>3. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including glycogen storage disease, diabetes, and kidney failure.</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 care plan dated 12/18/23 revealed Resident #41 had alteration in skin integrity due to a pressure area. Interventions included check dressing for placement during provisional wound care, document wound status, and treatments as ordered.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #41 had intact cognition. He was at risk for pressure ulcers and had unhealed pressure ulcers.</p> <p>Review of the February 2025 physician's orders revealed Resident #41 orders included: cleanse with saline solution, pat dry and apply calcium alginate and cover with foam dressing every Monday, Wednesday, and Friday to right ischium wound, cleanse with saline solution, pat dry and apply collagen powder (specialized wound care product that promotes wound healing and tissue regeneration) to the wound bed and cover with foam dressing every Monday, Wednesday, and Friday to left ischium wound, and cleanse with saline solution, pat dry, and apply collagen powder and cover with foam dressing every Monday, Wednesday, and Friday to coccyx wound.</p> <p>Observation on 02/12/25 at 9:28 A.M. of wound care that was completed for Resident #41 by RN/WN/IP #568 and LPN #539 revealed RN/WN/IP #568 removed the old dressings to Resident #41's left and right ischium and his coccyx area and then proceeded to cleanse each wound with wound cleanser using a different four by four gauze dressing to clean each. RN/WN/IP #568 then proceeded to take her gloved fingers and placed into the collagen powder packet to remove the collagen with her gloved fingers. She packed the left ischium with the collagen. She then proceeded to reach back into the collagen powder packet and remove more collagen with her gloved fingers to pack the coccyx wound with the collagen. She then took the calcium alginate out of the package and placed it over the right ischium and then covered all wounds with foam dressing as ordered. She proceeded to wash her hands.</p> <p>Interview on 02/12/25 at 9:43 A.M. with RN/WN/IP #568 verified that she did not wash her hands after removing the old dressings. She also verified that she did not do each wound separately as she stated she always looked at the wounds prior and if they did not appear to show signs of infection then she completed all the wounds at the same time without washing her hands between each wound dressing.</p> <p>Interview on 02/12/25 at 1:39 P.M. with the DON verified when removing an old dressing, the nurse should have washed her hands before cleansing the wounds. The DON also verified that if a resident had more than one wound each wound was to be completed separately to avoid cross contamination.</p> <p>Review of the facility policy labeled, Wound Care, dated 2001, revealed staff was to wash their hands and put on gloves, loosen tape and remove the dressing. After removing the dressing, the nurse was to pull glove over the dressing and discard into appropriate receptacle and then wash their hands. The nurse was to put on gloves and proceed to cleanse the wound. There was nothing in the policy regarding wound care including the care of more than one wound.</p> <p>41526</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>4. Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses including left knee effusion, staphylococcal arthritis left knee, diabetes mellitus type two and methicillin susceptible staphylococcus aureus infection. Physician orders effective February 2025 indicated to flush the PICC (peripherally inserted central catheter) before and after medication administration, administer cefazolin (antibiotic) two grams intravenously every twelve hours for infection, and EBP of gown and gloves for high-contact resident care including care with any device (central line).</p> <p>Observation on 02/12/25 at 9:00 A.M. with LPN #565 of intravenous antibiotic administration via Resident #58's PICC line revealed LPN #565 wore only gloves and no gown during the procedure despite the EBP requirement. There was an EBP sign posted with a PPE cart at Resident #58's room entrance. Interview at the time of the observation with LPN #565 verified a gown was not used for EBP as required.</p> <p>5. Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including closed fracture of radius, chronic combined systolic and diastolic congestive heart failure, atrial fibrillation, and pain in right knee. The physician wound assessment dated [DATE] specified a left heel unstageable (a full-thickness skin loss with the wound base covered by necrotic tissue) pressure ulcer covered by 100 percent necrotic tissue. Physician orders effective February 2025 indicated a left heel treatment to cleanse with wound cleanser, apply betadine and cover with an ABD followed by Kerlix gauze daily and as needed. There was no physician order for EBP related to the pressure ulcer.</p> <p>Observation on 02/12/25 at 8:21 A.M. with RN/WN/IP #568 of Resident #57's wound care revealed no EBP sign or cart with PPE located outside of the resident's room. RN/WN/IP #568 obtained the treatment cart and without cleaning the cart or top of the cart entered Resident #57's room with the cart and positioned it next to the bed. RN/WN/IP #568 then performed the following actions: a pair of scissors, an opened package of bulk gauze pads, a bottle of betadine, and closed packages each of an ABD and Kerlix gauze were removed from the treatment cart and placed on the cart top; hand hygiene was completed followed by application of gloves, but there was no gown donned as required for EBP; Resident #57's sock was removed from the left foot; the soiled dressing was cut open, removed while spraying the area with wound cleanser and placed laid open underneath Resident #57's suspended heel; without disposing of the soiled dressing, changing gloves or performing hand hygiene, placed a soiled gloved hand into the clean package of bulk gauze pads, obtained a small stack of gauze pads and cleansed the wound using the gauze and wound cleanser while the heel was suspended above the removed soiled dressing; placed the used gauze onto the soiled dressing, bundled it up, disposed of it, and rested the foot down onto the bed, not on a clean barrier; with both soiled gloved hands, opened each clean dressing package of an ABD and Kerlix gauze and laid the packages open on top of the treatment cart; opened the betadine bottle; reached inside the package of bulk gauze and obtained a small stack of clean gauze pads; poured betadine onto the bulk gauze and applied the betadine; while still wearing the same soiled gloves, picked up the clean ABD dressing and applied it; while still wearing the same soiled gloves, picked up the clean Kerlix gauze and applied it; inserted each soiled gloved hand into the right and left shirt pockets and upon removal held a pen and used it to date the clean dressing; picked up the resident's sock with the soiled gloved hands and applied it to the left foot and adjusted the blankets over the foot; the soiled gloves were removed followed by performing hand hygiene; the opened bulk package of gauze pads were placed back into the treatment cart with the betadine bottle; and the treatment cart was removed from the room. Interview at the time of the observation with RN/WN/IP #568 verified the above findings.</p> <p>(continued on next page)</p>		

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