| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365706 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pleasant Lake Villa | 7260 Ridge Rd<br>Parma, OH 44129 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650<br><br>Based on observation, interview, record review, and facility policy review the facility failed to ensure recommended guidelines were followed for changing disposable respiratory equipment for Residents #12, #15, and #83. This affected three residents (#12, #15, and #83) of six residents reviewed for respiratory care. The facility census was 181.<br><br>Finding include:<br><br>1. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including pneumonia, epilepsy, heart failure, and chronic kidney disease.<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had short-term and long-term memory problems and used oxygen daily.<br><br>Review of Resident #12's physician's orders revealed an order dated 05/14/24 to change the oxygen tubing and clean the filter weekly per facility policy and change the aerosol tubing and setup and clean the filter weekly per facility policy.<br><br>Review of the medication administration record (MAR) for May 2024 revealed aerosol treatments were signed off as administered as ordered, and Resident #12 required oxygen daily.<br><br>Review of the treatment administration record (TAR) for May 2024 revealed Resident #12's aerosol mask and tubing and oxygen tubing was last changed on 05/29/24.<br><br>Observation on 06/03/24 at 12:13 P.M. of Resident #12 revealed the resident was wearing oxygen via nasal cannula that was not dated. The aerosol mask and tubing hooked up to the nebulizer was not in a bag and was not dated. The tubing dated 05/29/24 was in a clean bag on top of the oxygen concentrator. The bag with the new aerosol tubing and mask was still in the bag sitting on top of side table, not in use.<br><br>Interview on 06/03/24 at 12:14 P.M. with Licensed Practical Nurse (LPN) #916 revealed oxygen tubing, aerosol masks, and tubing were to be replaced weekly and should be dated when changed. LPN #916 verified Resident #12's oxygen tubing, aerosol mask, and tubing were not dated to indicate when they were last changed, and the new tubing, dated 05/29/24, was still in the bag, not in use.<br><br>(continued on next page) |



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

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including dementia, heart disease, and anxiety.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #15 had impaired cognition and used oxygen.<br><br>Review of Resident #15's physician's orders for June 2024 revealed there was no order to change oxygen tubing weekly. A new order was put in on 06/04/24 to change the oxygen tubing, after surveyor intervention.<br><br>Observation on 06/03/24 at 2:15 P.M. of Resident #15's oxygen tubing with LPN #916 revealed the oxygen tubing was dated 03/05/24. LPN #916 verified the date on the tubing and stated the oxygen tubing should be changed weekly.<br><br>Interview on 06/03/24 at 2:17 P.M. with Director of Nursing (DON) verified oxygen tubing was to be changed weekly due to infection control. The DON verified Resident #15 did not have an order to change her oxygen tubing weekly, and there was no documented evidence that Resident #15's oxygen tubing had been changed since 03/05/24.<br><br>3. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with a diagnosis of acute respiratory failure.<br><br>Review of Resident #83's physician orders for June 2024 revealed an order to administer oxygen via nasal cannula at three liters per minute. There was no order to change the oxygen tubing weekly.<br><br>Observation 06/04/24 at 10:18 A.M. revealed Resident #83 in bed with oxygen on via nasal cannula at 2.5 liters per minute. There was no date on the nasal cannula tubing to indicate when it was last changed. The date on the storage bag for the oxygen tubing and nasal cannula was 4/30/24. Interview with LPN #909 at the time of the observation verified there was no date on the oxygen tubing and stated nasal cannula tubing was to be changed weekly.<br><br>Review of the facility policy titled Operational Policy and Procedures- Respiratory Service, dated 07/06/2021, revealed oxygen cannulas, oxygen humidifier bottles, oxygen supply line, and nebulizer kit for aerosols should be changed weekly and disposable supplies need to be dated when changed. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650<br><br>Based on observation, interview, record review, and facility policy review revealed the facility failed to ensure multiple dose medications were dated when opened. This affected five residents (#39, #54, #81, #88 and #285) of 15 residents reviewed with insulin pens and two medication carts (Rosewood back and Oakwood front) of five medication carts reviewed. The facility census was 181.<br><br>Findings Included:<br><br>1. Review of the medical record revealed Resident #285 was admitted to the facility on [DATE] with a diagnosis of type II diabetes. Review of the physician orders for June 2024 revealed an order for Insulin Glargine (long-acting insulin)100 unit/milliliter (ml) solution pen-injector.<br><br>Observation on 06/06/24 at 10:01 A.M. of Oakwood front medication cart revealed Resident #285's insulin Glargine pen was dispensed on 04/25/24 and not dated to indicate when it was opened.<br><br>Interview on 06/06/24 at 10:05 A.M. with Registered Nurse (RN) #995 verified Resident #285's insulin was dated when it was opened, and the dated insulin dispensed from pharmacy was 04/25/24.<br><br>2. Review of the medical record revealed Resident #88 was admitted to the facility on [DATE] with a diagnosis of type II diabetes. Review of the physician orders for June 2024 revealed Humalog (short-acting insulin) 100 unit/ml inject as per sliding scale.<br><br>3. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with a diagnosis of type II diabetes. Review of the physician orders for June 2024 revealed Humalog injection solution per sliding scale.<br><br>4. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE] with a diagnosis of type II diabetes. Review of the physician order for June 2024 revealed Humalog 100 unit/ml inject as per sliding scale.<br><br>5. Review of the medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnosis of type II diabetes. Review of the physician order for June 2024 revealed Humalog 100 unit/ml inject as per sliding scale and Basaglar Kwik Pen solution 100 unit/ml (long-acting insulin) inject 21 units subcutaneously one time a day.<br><br>Observation on 06/06/24 at 10:26 A.M. of Rosewood back medication cart for medication storage revealed Resident #88 Humalog flex pen, Resident #54's Humalog flex pen, Resident #39's Humalog flex pen and Resident #81's Humalog and Basaglar flex pens were opened and were not dated to indicate when they were opened.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 06/06/24 at 10:30 A.M. with the Director of Nursing (DON) verified insulin was to be dated when it is opened and should not be used after the manufactures expiration date. The DON verified Resident's #39, #54, #81, #88 and #285 insulins were in use and were not dated per the facility policy.<br><br>Review of the facility policy titled Medication Storage in the Facility, dated 11/2021, revealed that nurses shall place a date opened on medications. The manufacture's expiration date will be followed. |