

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Windsong Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Brookmont Rd Akron, OH 44333	

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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650</p> <p>Based on observation, interview, review of QSO-24-08-NH and review of facility policy, the facility failed to ensure enhanced barrier precaution (EBP) guidelines were followed for all residents that required EBP. This affected five of ten residents (Resident #1, #23, #50, #51, #57) reviewed for EBP. The facility census was 59.</p> <p>Findings Include:</p> <p>1. Review of the medical record for Resident #23 revealed and admitted [DATE]. Diagnoses included respiratory disorders, tracheostomy, morbid obesity and acute respiratory failure with hypoxia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had intact cognition. Resident #23 was on oxygen, required suctioning, had a tracheostomy and required a mechanical ventilator for respiratory support.</p> <p>Review of the physician orders for April 2024 revealed Resident #23 was on Levofloxacin (antibiotic) 500 milligram (mg) tablet for ten days for pneumonia. There were also orders for tracheostomy care, use of ventilator and suctioning when needed.</p> <p>Observation of Resident #23's room door on 04/26/24 at 5:20 A.M. revealed a yellow bag hanging from the door with personal protective equipment (PPE) in it with no signage on what type of precautions the resident was on.</p> <p>Interview on 04/26/24 at 5:28 A.M. with Registered Nurse (RN) #300 revealed she did not know if Resident #23 was on enhanced barrier precautions. RN #300 stated she did not wear a gown when connecting or reconnecting Resident #23 from the ventilator or when providing ventilator/tracheostomy care. RN #300 verified there was no enhance barrier precaution sign on Resident #23's door or wall outside of residents' room.</p> <p>Interview on 04/26/24 at 6:43 A.M. with Resident #23 revealed not all staff wore PPE when caring for him.</p> <p>2. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included unspecified tracheostomy complication and respiratory failure.</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 - Some</p>	<p>Review of the MDS assessment dated [DATE] revealed Resident #50 was cognitively impaired, on oxygen, had a tracheostomy, and received tracheostomy care, suctioning and tube feeding.</p> <p>Review of the physician orders for April 2024 revealed to change split sponge to tracheostomy daily with trach care and enteral feed order.</p> <p>Observation of Resident #50 and interview with RN #300 on 04/26/24 at 5:40 A.M. revealed Resident #50 had a tracheostomy and a feeding tube. Further observation revealed Resident #50 was not on EBP. RN #300 verified Resident #50 should be on EBP.</p> <p>3. Review of the medical record for Resident #57 revealed an admitted [DATE]. Diagnoses included gastrostomy, respiratory tract disease, acute respiratory failure with hypoxia and tracheostomy.</p> <p>Review of the physician orders for April 2024 revealed orders for tracheostomy care and enteral feed order.</p> <p>Observation of Resident #57 and interview with RN #300 on 04/26/24 at 5:40 A.M. revealed a yellow bag of PPE on Resident #57's door. RN #300 confirmed Resident #57 had a tracheostomy and was receiving tube feedings, but RN #300 did not know if Resident #57 was on EBP because there was no sign on Resident #57's door or outside the room indicating the resident was on EBP.</p> <p>4. Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypoxia and urinary retention.</p> <p>Review of the physician orders for April 2024 revealed orders for urinary catheter care and for a wound to right buttock.</p> <p>Observation on 04/26/24 at 9:30 A.M. of Resident #1 and his room revealed he was not on any type of isolation precautions. There was no signage and no PPE on the door or outside the room.</p> <p>Observation on 04/26/24 at 11:00 A.M. of Resident #1 and his room revealed Resident #1 had been placed on EBP and there was PPE and a sign on his door for EBP.</p> <p>Interview on 04/26/24 at 11:10 A.M. with the Director of Nursing (DON) verified Resident #1 was supposed to be on EBP on admission and had not been put on until 04/26/24.</p> <p>5. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnosis included human immunodeficiency virus.</p> <p>Review of Resident #51's MDS assessment dated [DATE] revealed Resident #51 had intact cognition.</p> <p>Review of the physician orders for April 2024 revealed Resident #51 had an order for an indwelling urinary catheter.</p> <p>Observation on 04/26/24 at 9:30 A.M. of Resident #51 and his room revealed he was not on any type of isolation precautions. There was no signage and no PPE on the door or outside the room.</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 - Some</p>	<p>Observation on 04/26/24 at 11:00 A.M. of Resident #51 revealed he had been placed on EBP and there was PPE and a sign on his door for EBP.</p> <p>Interview on 04/26/24 at 11:10 A.M. with the DON verified Resident #51 was supposed to be on EBP on admission related to his urinary catheter.</p> <p>Review of the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group reference QSO-24-08-NH revealed EBP recommendations include use of EBP for residents with chronic wounds or indwelling medical devices during high contact resident care activities regardless of their multidrug-resistant organism status.</p> <p>Review of the facility policy Enhanced Barrier Precautions, dated 04/23/24 revealed the facility would identify residents with central lines, urinary catheters, feeding tubes, hemodialysis catheters and tracheotomy/ventilator status regardless of Multi drug-resistant Organisms (MDRO) colonization status. High contact resident care activities requiring gown and glove use included but were not limited to tracheotomy/ventilator care. Residents identified with MDRO, wound, and or indwelling medical devices would have an EBP sign noting the PPE needed and the high contact care activities placed on the door or wall outside of the resident room.</p>		