STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365727	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pebble Creek Healthcare Center	670 Jarvis Rd Akron, OH 44319

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure Resident #69 received appropriate and timely incontinence care. This finding affected one (Resident #69) of three residents reviewed for incontinence care. Findings include: Review of Resident #69's medical record revealed the resident was admitted on [DATE] with diagnoses including paraplegia complete, neuromuscular dysfunction of the bladder and colostomy status. Review of Resident #69's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #69's physician orders revealed an order dated 06/21/24 for colostomy care every shift, monitor for stoma changes; and an order dated 06/21/24 to change the suprapubic catheter as needed for occlusion/dysfunction every shift. Review of Resident #69's care plans indicated a consult was obtained with palliative care and would go outside or common areas without pants but covered his lower body with towels. Was admitted with impaired skin integrity and was non-compliant with preventative and protective interventions related to skin despite education. Had behaviors of making false statements related to not getting meals, then found hoarding food items in his room. admitted for skilled care and refused to allow adjustments to personalized wheelchair for skin protection and prevention. Would grab onto another resident's motorized wheelchair for a ride despite education related to safety. Refused to wear clothing on his lower body and covered himself with sheets and towels. Review of Resident #69's progress note dated 07/08/24 at 3:24 A.M. authored by Physician #701 revealed the resident had a history of chronic pain and opioid abuse and spends long periods of time outside. Patient now essentially unresponsive and barely upright. He had been in and out of the building. The blood pressure was 178/83, heart rate 77 beats per minute (BPM), respirations 17 and pulse oximetry 97% (percent). The resident was slumped over, breathing and arousable but barely. No Narcan was available in the building. The telehealth physician was concerned for an overdose and emergency medical services (EMS) were called immediately. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's telehealth notification progress note dated 07/08/24 at 3:59 A.M. authored by Licensed Practical Nurse (LPN) #989 indicated the resident was unable to stay awake while talking to him and unable to sit up straight. He refused to be put in bed after the intravenous antibiotic was administered and stated he was going outside to smoke. He never made it outside and was found in his chair at his door slumped over in his chair. Telehealth was called and notified of the resident's condition. An order was obtained to administer Narcan, but it was unavailable. An order was obtained to call 911 immediately and they were notified when they arrived of the resident's condition. They were also notified that the resident's ostomy was just changed prior to shift change and he refused all other care including to be placed in bed. The rapid response team was rude during the transport of the resident. The resident was transferred to the gurney and his seat was filled with urine and stool all over the floor. Resident #69 had a habit of taking off his ostomy and never putting it back on. Review of Resident #69's progress note dated 07/08/24 at 1:41 P.M. authored by Registered Nurse (RN) Clinical Manager #981 indicated the resident was admitted to the hospital with a diagnosis of decubitus ulcer. Review of Resident #69's hospital Emergency Department (ED) Provider Note form authored by Physician #702 dated 07/08/24 indicated the resident presented with an altered level of consciousness and arrived via EMS from the skilled nursing facility (SNF). Per report, the resident was found in his room in a wheelchair covered in feces with a urine puddle under his chair after the facility called for a suspected overdose. The EMS stated the resident had been in the facility for a few weeks and was alert and oriented times one. The [AGE] year-old male present to the ER via EMS for altered mental status and had a past medical history of paraplegia, neurogenic bladder, decubitus ulcers, suprapubic catheter and colostomy placement. The resident was recently admitted to the hospital for decubitus ulcers and left lower extremity osteomyelitis. He was placed on Vancomycin antibiotic and declined a recommended left above the knee amputation (AKA). He was discharged to the SNF for intravenous (IV) Vancomycin and wound management. The EMS described a traumatic scene of neglect including large amounts of feces to be strewn across the resident and urine that began to puddle on the floor out of the resident's catheter bag. A colostomy bag was not attached, and the resident had altered mentation for no obvious reason. The resident was placed on oxygen by EMS. Resident #69 presented to the ED covered in feces and urine, the ostomy was uncovered/unbagged, the peripherally inserted central catheter (PICC) line was covered in feces and the resident was oriented to self. The resident had obvious multiple decubitus wounds that do not look obviously infected on the resident's sacrum and right thigh. The Disposition/Plan indicated the resident was present to the ER via EMS for altered mental status. Once the resident arrived to the ER, the resident was cleaned including but not limited to the PICC line, suprapubic catheter, and the ostomy with no bag attached. The resident's decubitus ulcers were examined and redressed. A urinalysis was ordered, but due to the complexity of the suprapubic catheter and the amount of feces that was found on the resident, an inpatient urologist would need to be consulted for management and replacement. Based on the resident's presentation and lab work, the resident was not believed to be suffering from an acute stroke, hypoglycemia, anemia or sepsis. The resident was believed to be suffering from failure to thrive secondary to neglect and was admitted for further management in addition to IV antibiotics and wound management. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/10/24 at 10:56 A.M. with Nurse Practitioner (NP) #703 indicated Resident #69 had expressed to her that he wanted to care for his own colostomy and Suprapubic catheter. NP #703 confirmed the resident had a habit of lying his suprapubic catheter on the ground and was educated multiple times. She stated he had refused her to assess him and on a specific incident, she had refused to allow her to assess his colostomy bag. She had never noticed urine or stool on the resident's floor and the staff cleaned the room multiple times. NP #703 confirmed the resident went out to smoke. Telephone interview on 07/10/24 at 12:03 P.M. with Resident #69 indicated the facility provided good care to him and he changed his own catheter and ostomy bags. He stated on 07/07/24 during the dayshift, his suprapubic catheter bag was leaking, and the nurse changed the bag. Resident #69 confirmed it solved the issue until later during the night on 07/07/24 when the resident's bag started leaking again. He stated he did not tell the nursing staff and just cleaned it up with a towel. Resident #69 stated the facility did not do anything wrong and the colostomy bag came off on its own during the nightshift. He denied concerns with his care while in the facility. Telephone interview on 07/10/24 at 12:36 P.M. with LPN #989 indicated she went in to Resident #69's room around 10:00 P.M. on 07/07/24 and the resident was in his room. LPN #989 denied any urine or feces on the resident or floor at that time. She stated she went in the resident's room shortly before 2:00 A.M. during a wellness check and the resident was in his wheelchair in his room sleeping. She denied the resident had urine or feces on his person or stool. When questioned, she stated the resident refused to allow staff to put him in bed. She stated at 2:00 A.M., she went in Resident #69's room and administered his scheduled pain medications. She stated at that point, the resident was groggy but arousable. LPN #989 indicated the resident told her he wanted to go outside to smoke. LPN #989 denied the resident had urine or feces on his person at this point. She stated she was at the desk charting around 2:45 A.M. when she realized Resident #69 did not go outside to smoke so she went to check on the resident and found him slumped over in his wheelchair in the doorway of the resident's room. She stated she tried to arouse the resident, immediately took vitals and called the physician. She stated at this point, she had noticed the urine on the floor of the resident's room underneath of his chair but did not see any feces on the resident. LPN #989 stated she was more concerned with determining the cause of the change in condition and the telehealth physician told her to administer Narcan for a suspected drug overdose. LPN #989 indicated she went to the Omnicell medication distribution center to obtain the Narcan and determined the medication was not loaded for the resident's use. She confirmed she sent the resident out by 911 and when they arrived, it was discovered the resident was sitting in feces and was set with urine. Email interview on 07/11/24 at 10:55 A.M. with EMS #705 indicated their department received a call from the SNF on 07/08/24 at 3:33 A.M. and they arrived on the scene at 3:42 A.M. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 07/11/24 at 11:03 A.M. with EMS #704 indicated when their squad arrived at the facility on 07/08/24, there was a horrendous smell coming from down the hallway. EMS #704 stated when they arrived, it was clear the smell was coming from Resident #69's room. The resident was sitting just inside the doorway with his head slumped over to his knees and his airway was not protected. Three staff members were standing outside the room in the hallway looking in and not providing care to the resident. Resident #69 was adjusted to sit upright by EMS #704 and that was when the resident was observed to having caked on stool on his person and lap. The resident was moved to the gurney by the squad and more caked on stool was located on the wheelchair seat. EMS #704 indicated it appeared to be a large amount of stool on the wheelchair seat and resident which appeared to be more than one instance of incontinence. EMS #704 confirmed the resident's colostomy bag was not in place at the time of the observation. Telephone interview on 07/11/24 at 12:48 P.M. with EMS #711 stated he had responded to a call from the facility because of a suspected overdose and change in mental status. EMS #711 indicated when they arrived on the scene, a bunch of staff members were outside of Resident #69's room looking in. He stated the resident had his eyes open and was mumbling. EMS#711 confirmed the resident had a large amount of fecal matter on his genitals and caked on his body and clothing. He also stated urine was puddled underneath of the wheelchair with a trail across the room and towards the window. EMS #711 stated the resident appeared extremely disheveled and he did not believe the caked on fecal matter and urine on the floor and on the resident was a recent occurrence. Telehealth interview on 07/11/24 at 12:59 P.M. with Physician #701 revealed she had assessed Resident #69 on 07/08/24 for a change in mental status. She stated she did observe something on his shirt and thought it was vomit. She stated he was seated in his wheelchair and was sitting upright with his head slumped over and looking downward. She stated she suspected the resident had overdosed on something and she ordered Narcan for the resident. Physician #701 stated the facility could not get the Narcan out of their system and she ordered the resident to go to the hospital. She denied the resident was neglected when questioned. Review of the undated Routine Resident Care policy revealed it was the policy of the facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor lifestyle and preferences while in the facility. Review of the undated Male and Female Perineal Care policy indicated the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the residents' skin conditions. This deficiency represents non-compliance investigated under Complaint Numbers OH00155493 and OH00154792.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, interview, and record review, the facility failed to ensure Resident #69 was free from significant medication error. This finding affected one (Resident #69) of three residents reviewed for medication administration. Findings include: Review of Resident #69's medical record revealed the resident was admitted on [DATE] with diagnoses including paraplegia complete, neuromuscular dysfunction of the bladder and colostomy status. Review of Resident #69's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #69's progress note dated 07/08/24 at 3:24 A.M. authored by Physician #701 revealed the resident had a history of chronic pain and opioid abuse and spends long periods of time outside. Patient now essentially unresponsive and barely upright. He had been in and out of the building. The blood pressure was 178/83, heart rate 77 beats per minute (BPM), respirations 17 and pulse oximetry 97% (percent). The resident was slumped over, breathing and arousable but barely. No Narcan (medication to treat narcotic overdose in an emergency) was available in the building. The telehealth physician was concerned for an overdose and emergency medical services (EMS) were called immediately. Review of Resident #69's telehealth notification progress note dated 07/08/24 at 3:59 A.M. authored by Licensed Practical Nurse (LPN) #989 indicated the resident was unable to stay awake while talking to him and unable to sit up straight. He refused to be put in bed after the intravenous antibiotic was administered and stated he was going outside to smoke. He never made it outside and was found in his chair at his door slumped over in his chair. Telehealth was called and notified of the resident's condition. An order was obtained to administer Narcan, but it was unavailable. An order was obtained to call 911 immediately and they were notified when they arrived of the resident's condition. They were also notified that the resident's ostomy was just changed prior to shift change and he refused all other care including to be placed in bed. The rapid response team was rude during the transport of the resident. The resident was transferred to the gurney and his seat was filled with urine and stool all over the floor. Resident #69 had a habit of taking off his ostomy and never putting it back on. Review of Resident #69's progress note dated 07/08/24 at 1:41 P.M. authored by Registered Nurse (RN) Clinical Manager #981 indicated the resident was admitted to the hospital with a diagnosis of decubitus ulcer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/10/24 at 12:36 P.M. with LPN #989 indicated she went in to Resident #69's room around 10:00 P.M. on 07/07/24 and the resident was in his room. LPN #989 denied any urine or feces on the resident or floor at that time. She stated she went in the resident's room shortly before 2:00 A.M. during a wellness check and the resident was in his wheelchair in his room sleeping. She denied the resident had urine or feces on his person or stool. When questioned, she stated the resident refused to allow staff to put him in bed. She indicated at approximately 2:00 A.M., she went in Resident #69's room and administered his scheduled pain medications. She stated at that point, the resident was groggy but arousable. LPN #989 indicated the resident told her he wanted to go outside to smoke. LPN #989 denied the resident had urine or feces on his person at this point. She stated she was at the desk charting around 2:45 A.M. when she realized Resident #69 did not go outside to smoke so she went to check on the resident and found him slumped over in his wheelchair in the doorway of the resident's room. She stated she tried to arouse the resident, immediately took vitals and called the physician. She stated at this point, she had noticed the urine on the floor of the resident's room underneath his chair but did not see any feces on the resident. LPN 989 stated she was more concerned with determining the cause of the change in condition and the telehealth physician told her to administer Narcan for a suspected drug overdose. LPN #989 indicated she went to the Omnicell medication distribution center to obtain the Narcan and determined the medication was not loaded for the resident's use. She confirmed she sent the resident out by 911 and when they arrived, it was discovered the resident was sitting in feces and was set with urine. Interview on 07/10/24 at 1:32 P.M. with the Director of Nursing (DON) indicated the Narcan was loaded in the Omnicell but LPN #989 was attempting to remove the medication by the brand name of Narcan instead of the generic name of Naloxone. The DON confirmed the facility had both nasal spray and injectable forms of the medication. Observation on 07/10/24 at 1:35 P.M. with RN Clinical Manager #981 of the Omnicell medication distribution center revealed the Narcan, under the name Naloxone, was available in both nasal spray and injectable forms. RN Clinical Manager #981 confirmed she educated LPN #989 on how to remove Narcan from the machine since she was a new nurse.