STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365731	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Park Care Center	8 East Park Circle Brook Park, OH 44142

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** 42013 Based on interview, record review, and review of the facility Appointment and Transportation Form the facility failed to ensure Resident #53's frequent urinary tract infections were comprehensively assessed, care planned, and treated timely to assist in preventing re-occurring infection. This affected one resident (Resident #53) out of three residents reviewed for urinary tract infections. The facility census was 52. Findings include: Review of Resident #53's medical record revealed an admitted [DATE] and diagnoses included displaced fracture of lateral end of right clavicle, subsequent encounter for fracture with routine healing, adjustment disorder with depressed mood, and paroxysmal atrial fibrillation. Review of Resident #53's care plan dated 08/07/23 included Resident #53 had mixed bladder incontinence related to impaired mobility. Resident #53 would remain free from skin breakdown due to incontience and brief use through the review date. Interventions included to encourage fluids during the day to promote prompted voiding responses; to monitor and document intake an output per facility policy; to monitor and document for signs and symptoms of UTI (urinary tract infection) including pain, burning, blood tinged urine, altered mental status. Further review of Resident #53's care plan did not reveal a care plan was initiated for multiple recurrent urinary tract infections until 05/10/24. Review of Resident #53's progress notes dated 08/08/23 at 8:58 A.M. included a urine sensitivity reported to CNP (Certified Nurse Practitioner), orders received for Bactrim DS (antibiotic) 160 mg, one tablet by mouth BID (two times a day) for seven days for UTI. Review of Resident #53's physician orders dated 10/17/23 revealed Cipro (Ciprofloxacin) oral tablet 250 mg, give one tablet by mouth two times a day for UTI for ten days. Review of Resident #53's progress notes dated 11/17/23 revealed Resident #53 to begin antibiotics Cipro for UTI, Resident #53's daughter and Resident #53 aware and in agreement. Review of Resident #53's physician orders dated 12/23/23 revealed Cipro (Ciprofloxacin) oral tablet 250 mg, give one tablet by mouth two times a day for UTI. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Infection Control Log dated 02/2024 included Resident #53 had a UTI and was started on Macrobid 100 mg on 02/03/24. Further review of the Log on 03/07/24 revealed Resident #53 had a positive urine culture and was started on Cipro/ Cefepime. On 04/13/24 Resident #53 had a positive urine culture result and was started on Ceftriaxone. On 05/11/24 at Resident #53 was started on Bactrim for a UTI. Review of Resident #53's physician orders dated 04/29/24 revealed U/A C&S (urinalysis, urine culture and sensitivity) on 04/30/24, one time only for labs for one day. Review of Resident #53's Treatment Administration Record (TAR) dated 04/30/24 at 6:29 A.M. revealed documentation Resident #53's urine for urinalysis and culture and sensitivity was collected. Review of Resident #53's lab results reported 04/30/24 revealed Resident #53's urine specimen to be collected on 04/30/24 was unable to be obtained and the urinalysis and urine culture and sensitivity was not completed. Review of Resident #53's progress notes dated 04/29/24 through 05/06/24 did not reveal documentation regarding Resident #53's urine specimen for urinalysis and culture and sensitivity. Review of Resident #53's Physician Progress Note dated 05/01/24 written by Nurse Practitioner (NP) #241 included Resident #53 was seen as follow-up with frequent UTIs and altered mental status. Order was placed to obtain urinalysis and was not collected, order replaced for collection of urinalysis. Review of Resident #53's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] included Resident #53 had moderate cognitive impairment. Resident #53 had impairment on one side and used a wheelchair. Resident #53 required partial to moderate assistance with toileting, was always incontinent of urine and occasionally incontinent of bowel. Review of Resident #53's physician orders dated 05/06/24 revealed follow-up urinalysis and urine culture and sensitivity, may straight cath to collect, every shift for UTI. Review of Resident #53's physician orders dated 05/10/24 revealed Bactrim DS (Sulfamethoxazole-Trimethoprim) oral tablet 800-160 mg, give one tablet by mouth two times a day for infection for 14 days. Review of Resident #53's care plan dated 05/10/24 included Resident #53 had recurrent UTI's and incontinence. Resident #53 would have no complications related to UTI through the next review. Interventions included to encourage fluids; perform incontinence care after each episode of incontinence; U/A (urinalysis) and C&S (culture and sensitivity) as ordered. On 05/14/24 an intervention for urology consult as needed was added. On 05/13/24 a care plan was initiated for Resident #53 had an infection UTI. Resident #53 would be free from complications related to infection through the review date. Interventions included to monitor, document, report to the physician as needed signs and symptoms of UTI; administer antibiotics per physician orders. Review of Resident #53's physician orders dated 05/28/24 included Urology appointment on 05/31/24 at 11:00 A.M., daughter will meet patient at appointment, and staff escort needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365731	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's progress notes dated 05/29/24 at 3:33 P.M. written by the Director of Nursing (DON) revealed spoke with Resident #53's daughter, she is postponing transfer to new facility until 06/01/24 due to Resident #53's urology appointment on 05/31/24. Review of Resident #53's Appointment and Transport Form included Resident #53 had a urology appointment on 05/31/24 at 11:00 A.M., an ambulette was needed and Resident #53's daughter would meet Resident #53 at the appointment. There were no instructions for a staff escort as ordered by the physician. Review of Resident #53's progress notes revealed a late entry note dated 06/27/24 revealed on 05/31/24 at 3:40 P.M. the DON spoke with Resident #53's daughter, Resident #53 had an appointment with the urologist, daughter told the DON she was going to meet Resident #53 at the appointment since it was the first appointment. Resident #53 did not have escort since Resident #53's daughter was going to meet her there. Resident #53's daughter did not go to the appointment and did not contact the DON prior to the appointment that she was not going to attend the appointment. Resident #53 was not seen, and the appointment needed to be rescheduled. Interview on 06/26/24 at 5:15 P.M. with Family Member (FM) #242 revealed Resident #53 had a very important urology appointment on 05/31/24 related to her many UTI's. FM #242 stated Resident #53 had so many bad urinary tract infections during the year she resided in the facility, and also needed intravenous antibiotics to treat some of them. FM #242 stated she could not attend the appointment because of work related issues, but she felt okay with that because she knew Resident #53 had an staff escort to the appointment and would be seen by the urologist. FM #242 indicated she received a call from the urology office and was told Resident #53 was not seen by the urologist because she did not have a staff escort, and she needed someone with her. FM #242 stated the head nurse told her she thought FM #242 was going to be at the appointment, and that was why no staff escort was sent with Resident #53. FM #242 indicated no one from the facility called to ask if she was going to be at the appointment, but the facility knew an aide needed to go with Resident #53. Resident #53 needed assistance with transfers, and could only walk a few steps before collapsing. Interview on 06/27/24 at 4:30 P.M. with Nurse Practitioner (NP) #241 revealed NP #241 confirmed Resident #53 had many urinary infections, but she did not think about a urology consult because she thought the urine infections were caused by cross contamination from her incontinence brief. NP #241 stated Resident #53 was at a greatly increased risk of urinary tract infections due to incontinence. NP #241 confirmed Resident #53 had many urine infections, there were no guidelines related to urine infections, and Resident #53's Primary Care Physician knew she had urinary tract infections. NP #241 stated Resident #53 should have had frequent checks for incontinence and changed as needed. NP #241 stated she did not give orders to encourage fluids. NP #241 confirmed on 04/30/24 Resident #53 had a urine specimen for urinalysis and culture and sensitivity ordered to be sent, it was not sent on 04/30/24 as ordered, and was not sent until 05/06/24. NP #241 stated it was not okay to wait six days to send a urine specimen, and Resident #53's urine specimen should have been sent as soon as possible. (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 06/27/24 at 5:00 P.M. with DON and ADON (Assistant Director of Nursing) #243 confirmed Resident #53 had many recurrent UTI's. The DON stated both ADON #243 and the DON were new to the facility, started working there in 02/2024, and were still getting caught up and familiar with the facility. The DON stated by the time she realized Resident #53 had quite a few recurrent UTI's, FM #242 had already asked about Resident #53 having a urology consult. The DON confirmed there were no orders to increase fluids related to Resident #53's urinary tract infections. The DON confirmed Resident #53's urine specimen for urinalysis and culture and sensitivity was documented on the TAR it was collected on 04/30/24, but it was collected by an agency nurse, the nurse no longer worked at the facility and could not be asked what happened with the urine specimen. The DON indicated Resident #53's urine specimen was not sent until 05/06/24 because it could not be obtained until then. The DON confirmed on 05/31/24 Resident #53 did not have a staff escort provided for her urology appointment. The DON indicated either the nurses or the DON put appointment orders in the electronic system, then a Transportation Form was filled out and given to the Scheduler to arrange transportation. The DON stated the request for a staff escort did not get transcribed onto the Transportation form, and the scheduler did not know to provide a staff escort for Resident #53's appointment. The DON stated it was an oversight and not done intentionally. This deficiency represents non-compliance investigated under Complaint Number OH00154424.