

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 07/29/2024
NAME OF PROVIDER OR SUPPLIER East Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, facility policy review and interview, the facility failed to ensure Resident #99's received assistance with activities daily living (ADLs) to maintain adequate and necessary personal and oral hygiene.</p> <p>Actual harm occurred on 06/21/24 when Resident #99, who was totally dependent on staff assistance for ADLs, did not receive sufficient hygienic care and developed maggots in her mouth and nose, requiring hospitalization . This affected one resident (#99) of three residents reviewed for ADL care. The facility census was 47.</p> <p>Findings include:</p> <p>Review of Resident #99's closed medical record revealed the resident was admitted on [DATE] and discharged to the hospice house on 06/21/24 with diagnoses including amyotrophic lateral sclerosis (ALS), dysphagia and gastrostomy status.</p> <p>Review of Resident #99's ADL Self-Care Performance Deficit Care Plans with an admitted [DATE] revealed the resident required one staff participation with personal hygiene and oral care.</p> <p>Review of Resident #99's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem and was dependent (helper completed all effort and resident did none of the effort to complete the activity).</p> <p>Review of Resident #99's hospice Visit Summary forms from 05/03/24 to 06/21/24 revealed the resident received mouth care and a bed bath on 06/14/24 and on 06/21/24 by hospice staff. No visits from hospice services were conducted between 06/15/24 to 06/20/24.</p> <p>Review of Resident #99's ADL Look Back Report form from 06/14/24 to 06/21/24 revealed the resident was provided oral care on 06/15/24 at 3:56 A.M.; on 06/16/24 at 12:51 A.M.; on 06/17/24 at 12:09 A.M.; and on 06/18/24 at 1:06 P.M. The documentation did not reveal evidence the resident was provided any oral care on 06/19/24 or 06/20/24. The documentation also did not reveal evidence the resident was provided oral care for first and second shifts on 06/15/24; first and second shifts on 06/16/24; first and second shifts on 06/17/24; or second or third shifts on 06/18/24.</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 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #99's progress note dated 06/21/24 at 11:00 A.M. authored by Licensed Practical Nurse (LPN) #821 revealed a full body assessment was completed by the nurse and two staff members. Tiny white worms were noted on top of the resident's tongue when mouth care was provided. The resident sneezed and more tiny white worms came out of her nostrils. The concern was reported to the administration and the physician. A call was placed to the hospice nurse who was asked to return to the facility to address.</p> <p>Review of Resident #99's progress note dated 06/21/24 at 12:30 P.M. authored by LPN #821 indicated the hospice nurse returned to the facility to assess the resident.</p> <p>Review of Resident #99's progress note dated 06/21/24 at 2:00 P.M. authored by LPN #821 indicated the hospice nurse collected a tiny white worm specimen to send with the resident to the ER. A call was placed to 911 per hospice and the resident's son was notified via the phone by the hospice nurse and updated on the resident's condition.</p> <p>Review of Resident #99's progress note dated 06/21/24 at 5:17 P.M. authored by the Administrator indicated the hospice nurse informed him that she spoke with the resident's family, and they were aware of the reason for hospitalization and in agreement with the plan. The hospice nurse stated they were going to ensure a head CAT scan (CAT or CT which was a computed tomography scan or medical imaging technique that uses X-rays and computers to create detailed cross-sectional images of the inside of the body) and a chest X-ray were completed, and that the family had already asked about an in-patient hospice house.</p> <p>Review of Resident #99's progress note dated 06/21/24 at 11:27 P.M. authored by LPN #822 indicated a call was placed to the ER to obtain an update on the resident. The resident had been transported by a private ambulance to the hospice center.</p> <p>Review of Resident #99's hospital documentation dated 06/21/24 indicated the resident presented from the skilled nursing facility (SNF) for concerns of larvae in the resident's nose. Nursing was completing oral and mouth care and noted larvae in the nose. The resident had ALS and was nonverbal. She had a percutaneous endoscopic gastrostomy tube (PEG tube which was passed into a resident's stomach through the abdominal wall to provide a means of feeding when oral intake was not adequate). The resident was on hospice services, and they provided care as well. The hospice team was worried about the resident's airway and sent the resident in for an airway assessment. A CAT of the facial area was ordered to evaluate the extent of an intraoral involvement or airway involvement. The CAT of the facial without contrast was obtained per the request of hospice services and there was no evidence of an erosive abnormality noted in the facial region. A reassessment of the resident did not reveal evidence of intraoral larvae or maggots. The resident did have a dry tongue and received all nutrition through the PEG tube. The resident was moved to the hospice care center and would be discharged from the ED for hospice ongoing care. The larvae were sent for an analysis but were most likely consistent with a fly.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Timeline of Events (facility investigative report) for Resident #99 dated 06/21/24 indicated at 9:30 A.M. the facility notified hospice of an intolerance to the current tube feeding regimen and the hospice nurse reported that a tiny white worm was found on the resident's chest when providing a bed bath. At 9:50 A.M., the facility nurse and two staff members completed a full body assessment and noted that white worms were on top of the resident's tongue during oral care. The resident sneezed and more came out of the nasal passages. The Administrator, physician and hospice were notified. At 11:30 A.M., the hospice nurse returned to the facility and obtained a specimen to send to the emergency room (ER). The family was notified at this time. At 2:37 P.M., the facility completed oral assessments on all residents to ensure no other residents were affected. No other concerns were identified. Housekeeping did an audit of rooms and the building, and no other flies were noted. Window screens were audited, and six screens were noted to have holes in them. Tape was applied to the holes until repairs could be made. Audits would be completed three times a week for oral care for five residents per the Director of Nursing (DON) and/or designee. The concern would be reviewed in the quality assurance perform improvement (QAPI) meeting.</p> <p>Information obtained from the resident's family as part of the complaint investigation revealed Resident #100 had been admitted to the facility since late April 2022 and had a diagnosis of ALS. The family revealed they had been contacted by a hospice nurse, (this nurse visited the resident weekly) on Friday 06/21/24 indicating she had some bad news. The family revealed what was reported to them left them horrified and speechless. The nurse informed the family that a nurse's aide found fly larvae in the resident's mouth. The family stated literal fly eggs that had hatched into larvae and were now feeding on my poor mother, while she laid in bed not being able to move or help herself. The resident was transferred to the hospital for a CT scan to determine how deep the bug infestation had made it into her sinuses and lungs. The family indicated the next 24 hours were very rough having to endure multiple bug larvae being extracted from her body.</p> <p>Interview on 07/29/24 at 8:15 A.M. with the Administrator indicated he was aware that the hospice nurse had observed a maggot on Resident #99's shirt/gown on 06/21/24.</p> <p>Interview on 07/29/24 at 8:23 A.M. with State tested Nursing Assistant (STNA) #814 indicated she assisted STNA #817 with Resident #99's ADL care when the hospice nurse had discovered a maggot crawling across the resident's gown. STNA #814 confirmed she had looked in Resident #99's mouth during oral care and had observed five maggots in the resident's mouth. She stated she also did see a maggot drop out of the resident's left nostril during care. She stated the resident always had her mouth open and could not move independently from the neck down. She stated the resident was dependent on all care.</p> <p>Telephone interview on 07/29/24 at 8:48 A.M. with Licensed Social Worker (LSW) for hospice house #816 revealed Resident #99 was admitted to their facility on 06/21/24 and discharged home on 06/28/24. She was aware of maggots in the resident's mouth and nose but unable to provide further details.</p> <p>(continued on next page)</p>		

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