STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365758	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parma Care Center	5553 Broadview Rd Parma, OH 44134

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review, interview, and policy review the facility failed to ensure accurate documentation related to medication administration; ensure a clear and accurate reconciliation of controlled substances; ensure controlled medications were not administered without physician orders, and as needed medications were not removed from secured storage areas prior to being requested or needed by the residents. This affected seven (Residents #16, #5, #14, #40, #84, #85 and #79) of seven residents reviewed for medication administration. The facility census was 82. Findings include: 1. Medical record review revealed Resident #16 was admitted on [DATE] and readmitted on [DATE] with diagnoses including mild intellectual disability, Alzheimer's disease, cerebral infarction (stroke), convulsions, pulmonary/heart disease, peripheral vascular disease, gastritis/colitis with esophageal reflux disease, high blood pressure/cholesterol, end stage kidney disease, diabetes mellitus, psychotic disorder, depression, anxiety, and osteoarthritis. Review of Resident #16's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 received high risk medications including an anticonvulsant medication. Review of a physician order dated 03/18/22 indicated to administer Resident #16 Lacosamide 100 milligrams (mg) orally at bedtime for seizures related to unspecified convulsions. Review of Resident #16's plan of care indicated Resident #16 had a seizure disorder and history of a stroke. Interventions included to administer medications as ordered, observe for effectiveness and side effects, and document the location of seizure activity, type of seizure activity, duration, level of consciousness, and post-ictal state after seizure activity. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #16's Controlled Substance Accountability Sheet for the documentation of Lacosamide administration dated 03/18/25 indicated inaccurate documentation of the date and time the medication was dispensed, amount administered, quantity wasted/destroyed and quantity remaining. On 04/23/25 the documentation indicated one tablet of Lacosamide remained in stock. On 04/24/25 at 9:00 A.M. the documentation indicated one tablet was dispensed, one tablet administered and the quantity remaining zero. The quantity remaining should have been one. On 04/24/25 at 4:00 P.M. the documentation indicated no tablets were dispensed and one tablet was administered with one tablet remaining which was incorrect. The remaining amount should have been zero. On 04/28/25 the documentation indicated there was one tablet of Lacosamide remaining, one tablet dispensed, one tablet administered and should have one tablet remaining. The documentation indicated no tablets remained. It was not clear upon reviewing the Controlled Substance Accountability Sheet where the Lacosamide was obtained; sometimes the medication was removed from the medication cart and sometimes the medication was removed from the electronic medication dispensing system. The electronic medication dispensing system was used when the medication was available in Resident #16's stock of medication. An interview with Registered Nurse (RN) #90 on 04/28/25 at 11:30 A.M. verified she had documented Resident #16's Lacosamide removal and administration to Resident #16 on the Controlled Substance Accountability Sheet incorrectly. An interview with Director of Nursing and Administrator on 04/29/25 at 12:00 P.M. verified the above findings and they confirmed the documentation on Resident #16's Controlled Substance Accountability Sheet was incorrect. 2. Medical record review revealed Resident #5 was admitted on [DATE] and readmitted on [DATE] with diagnoses including morbid obesity, fractured right arm/right clavicle/thoracic vertebra, depression, sleep apnea, dislocation of right acromioclavicular joint, epilepsy, nervous system diseases, chronic kidney disease, peripheral vascular disease, high cholesterol, constipation, vitamin D deficiency, anxiety, and gastroesophageal reflux disease. A review of Resident #5's physician orders dated 03/01/25 to 03/31/25 indicated to administer oxycodone hydrochloride five milligram (mg) tablet orally every six hours as needed for pain. Medical record review revealed Resident #14 was admitted on [DATE] with diagnoses including surgical joint replacement, arthropathies, cataracts, eye disease, cardiac pacemaker/defibrillator, anxiety, depression, atrial-fibrillation, osteoarthritis, dilated cardiamyopathy, gastroesophageal reflux disease, fibromyalgia, heart failure, high cholesterol, high blood pressure, and migraine. A review of Resident #14's physician orders dated 03/01/25 to 03/31/25 indicated to administer Tramadol hydrochloride 50 mg orally every six hours as needed for mild pain. Medical record review revealed Resident #40 was admitted on [DATE] and readmitted on [DATE] with diagnoses including rhabdomyolosis (muscle injury where muscles break down), schizoeffective disorder, hypo-osmoality, alcohol abuse, anemia, osteoarthritis, lupus erythmatosis (body's immune system attacks tissues and organs), heart attack, low magnesium and potassium level, atrial-fibrillation, depression, Raynaud's syndrome, vascular heart disease, retinopathy, cataracts, urinary retention with neuromuscular bladder, angioneurotic edema (unpredictable frequent edematous episodes of cutaneous and mucosal tissues such as lips, eyes, oral cavity, larynx, and gastrointestinal system.), and acute respiratory/kidney failure. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #40's physician orders dated 03/01/25 to 03/31/25 indicated to administer Ativan 0.5 mg orally every six hours as needed and to administer oxycodone 10 mg every six hours as needed for pain. A review of the Controlled Dispensing documentation for removal of controlled substances from the electronic dispensing system dated 03/31/25 revealed from 7:32 P.M. to 7:33 P.M. one oxycodone five mg tablet and one lorazepam (Ativan) 0.5 mg tablet was removed for Resident #40, one Tramadol 50 mg tablet was removed for Resident #14 and one oxycodone five mg tablet was removed for Resident #5. An interview with Registered Nurse (RN) #92 on 04/29/25 at 9:27 A.M. revealed she had been disciplined for removing Resident #5, Resident #14, and Resident #40's controlled narcotics at the same time from the electronic dispensing system in the facility. RN #92 stated she had difficulty walking and did not want to walk back and forth three times because she knew she would be administering the as needed medications to Resident #5, Resident #14 and Resident #40 some time during her 12 hour shift. A review of the facility documentation of the investigation of RN #92 dated 04/01/25 revealed Resident #5, Resident #14 and Resident #40's controlled narcotic medications were removed from the electronic dispensing system at the same time. The investigation indicated the Director of Nursing (DON) received the daily electronic dispensing system report with controlled narcotics pulled from the night before. After reviewing, the DON noted that narcotics were all pulled around the same time. Due to narcotics being as needed, the DON questioned why they were pulled simultaneously. The DON interviewed the listed residents on the report and all residents confirmed they received their medications. The DON and the Administrator spoke with RN #92 who stated, I pulled them at the same time to save myself a trip. 3. Medical record review revealed Resident #85 was admitted on [DATE] and readmitted on [DATE] with diagnoses including emphysema, malnutrition, iron deficiency anemia, atherosclerotic heart disease, cardiomyopthy, hypo-osmoality, osteoarthritis, bone density disorder, left pubis pelvic fracture, and post-traumatic headache with acute post-traumatic general pain. Review of Resident #85's physician order dated 03/28/25 indicated to administer oxycodone hydrochloride 2. 5 mg every eight hours as needed for pain due to diagnosis of a fracture of left pubis. Review of Resident #85's Medication Administration Record (MAR) dated 04/01/25 to 04/30/25 indicated on 04/02/25 Resident #85 received oxycodone hydrochloride 2.5 mg orally at 1:22 A.M. Review of Resident #85's Controlled Substance Accountability Sheet dated 03/29/25 to 04/10/25 indicated on 04/02/25, Registered Nurse (RN) #92 removed oxycodone five milligram (mg) tablet to administer to Resident #85 at 1:30 and 7:30. There was no documentation to indicate if the medication was administered in the A.M. or P.M. An interview with RN #92 on 04/29/25 at 4:15 P.M. revealed she had administered Resident #85's oxycodone medication two hours early. RN #92 confirmed Resident #85's physician order for oxycodone indicated the oxycodone could be administered for pain every eight hours and she administered the oxycodone medication at 1:30 A.M. and 7:30 A.M. on 04/02/25 which was six hours between doses and should not have been administered until eight hours between doses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 04/30/25 at 12:45 P.M. with the Administrator verified there was no documentation that Resident #85 was administered the oxycodone 2.5 mg dose at 7:30 A.M. on Resident #85's Medication Administration Record (MAR) or clinical record. The Administrator confirmed the documentation on Resident #85's narcotic control sheet did not indicate if the oxycodone removed from the medication cart was removed during the morning hours, afternoon hours or evening hours at 1:30 and 7:30 on 04/02/25. The Administrator also verified RN #92 had removed Resident #85's oxycontin medication from the medication cart at 7:30 A. M. on 04/02/25 but did not document the administration of the oxycontin medication in Resident #85's clinical record and/or MAR. 4. Medical record review revealed Resident #84 was admitted on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease, heart failure, hydronephrosis, gastritis, uropathy, high blood pressure, diabetes mellitus, high cholesterol, atherosclerotic heart disease, cerebral infarction (stroke), diaphragmatic hernia, anxiety with adjustment disorder, obstructive sleep apnea, osteoporosis, urinary retention, right tibia/fibula fracture, and neuropathy. Further review of the medical record including Resident #84's physician orders revealed there was no physician order for the administration of liquid Morphine. Review of Resident #84's Medication Administration Record (MAR) dated 09/01/25 to 09/31/25 revealed no documentation Resident #84 was administered liquid Morphine. An interview with Registered Nurse (RN) #90 on 04/28/25 at 11:06 A.M. revealed RN #90 stated she had administered Resident #84 liquid Morphine without an order. RN #90 said she gave the dosage of Morphine to Resident #84 on or about 09/25/24. Resident #84 had complained of pain and RN #90 found a bottle of liquid Morphine in the locked medication drawer of the medication cart and measured five milligrams (mg) of the liquid and administered the Morphine to Resident #84. RN #90 stated she could not explain how a bottle of liquid Morphine was labeled with Resident #84's name without a physician order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of RN #90's statement sent to the Ohio Board of Nursing (OBN) dated 01/09/25 revealed that on or about 09/25/24, RN #90 administered Morphine to Resident #84. The statement indicated it had been said that the resident had not had an order for Morphine and also had a listed allergy to Morphine. That particular day RN #90 had shared with a co-worker (unnamed) that Resident #84 did not seem to be doing well and that RN #90 thought she may be starting the process of dying. RN #90 made the co-worker aware that Resident #84 was still lucid and if he wanted to go and say hello and visit it might be a good time. When the co-worker returned, he had stated that Resident #84 had a complaint of pain and requested pain medication. Together RN #90 and the co-worker walked back to the medication cart where RN #90 pulled the narcotic medication record, opened the narcotic drawer where Resident #84's prescribed Morphine was found. RN #90 then drew up the Morphine medication, entered Resident #84's room and made Resident #84 aware of the administration of the requested pain medication of Morphine and that the liquid Morphine would be placed under her tongue, RN #90 then administered the Morphine. After RN #90 was done both staff exited the room. RN #90 returned to the medication cart, documented the medication was given on the paper chart, and then went to the electronic chart and was unable to find the order for the Morphine medication listed. RN #90 notified the primary care Certified Nurse Practitioner (CNP) of the error. The CNP asked if there were any adverse reactions and to please continue to monitor. The resident was in the care of Hospice at that time. Having been an RN Case Manager for a hospice company in the past, RN #90 was aware that hospice treated the symptoms of a dying resident which also meant that if a resident had a said allergy to a medication with no history of anaphylactic reaction the symptoms were treated. Resident #84 had shown no signs or symptoms of adverse reaction. RN #90 reported the medication error her next shift to the Director of Nursing (DON). RN #90 received verbal disciplinary action for the error. Also, being made aware, moving forward, to report any medication error to management immediately. RN #90 indicated had the resident not had a valid written prescription the medication would not have been available or received by the facility from the pharmacy. The medication was clearly labeled with Resident #84's name. A review of the OBN letter dated 01/27/25 revealed the OBN had investigated RN #90 for administering Morphine medication to a resident without a physician order. The Nursing Board recommended RN #90 complete additional training prior to her RN license renewal within 180 days of the date of the investigation on 01/25/25. An interview with the Administrator and DON on 04/29/25 at 12:45 P.M. verified the above findings and confirmed RN #90 had administered the Morphine medication to Resident #84 without a physician order. It could not be confirmed where the Morphine bottle came from and/or if it had Resident #84's name on the label. 5. Medical record review revealed Resident #79 was admitted on [DATE] with diagnoses including traumatic subdural hemorrhage, glaucoma, high blood pressure, legal blindness, obesity, peripheral vascular disease, psychosis, mood disorder, pseudobulbar affect, arthopathies, insomnia, and ringing of the ears. A review of Resident #79's nursing progress notes dated 04/27/25 timed 9:07 A.M. revealed Resident #79 was crying loudly and not able to state why he was crying. Resident #79 denied pain and was pulling on his catheter, Redirection and repositioning were ineffective. Ativan was administered with good results noted. Further review of Resident #79's medical record revealed there was no order for the administration of Ativan to Resident #79. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 04/29/25 at 3:38 P.M. revealed she was informed by Registered Nurse (RN) #92 that she had administered Resident #21 the Ativan medication and had documented the administration of the Ativan in the nursing progress notes in Resident #79's clinical record by accident. The DON verified the documentation of the administration of the Ativan medication in Resident #79's progress note dated 04/27/25 at 9:07 A.M. was inaccurate. Resident #79 did not receive the Ativan medication. Review of the facility's policy titled Medication Administration - Preparation and General Guidelines revised August 2014 indicated medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications would do so only after they had been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The policy further indicated the facility had sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. The policy indicated the FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, were applied for each medication being administered. A triple check of these Five Rights was recommended at three steps in the process of preparation of a medication for administration: (1) when the medication was selected, (2) when the dose was removed from the container, and finally (3) just after the dose was prepared and the medication put away. a. Check #1: Select the Medication - label, container and contents checked for integrity, and compared against the medication administration record (MAR) by reviewing the Five Rights. b. Check #2: Prepare the dose - the dose was to be removed from the container and verified against the label and the MAR by reviewing the five Rights. When medications were administered from a central location, such as the medication room, medications for the immediate administration time were to be prepared not more than 60 minutes in advance for all residents, or per applicable state law or regulation. In no case should more that one dose time be prepared in advance. Documentation (including electronic) indicated the individual who administered the medication dose recorded the administration on the resident's medication administration record (MAR) directly after the medication was given. At the end of each medication pass, the person administering the medications was to review the MAR to ensure necessary doses were administered and documented. In no case was the individual who administered the medications to report off-duty without first recording the administration of any medications. This deficiency represents non-compliance investigated under Complaint Number OH00165067.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, record review, interview and policy and procedure review the facility failed to ensure staff performed hand hygiene during medication administration to Resident #40 and Resident #50 to prevent cross contamination of germs and failed to initiate isolation precautions for Resident #20 to prevent the spread of influenza. This affected two out of three residents observed during medication administration and one out of three residents reviewed for isolation precautions. The facility census was 82. Findings include: 1. Medical record review revealed Resident #40 was admitted on [DATE] and readmitted on [DATE] with diagnoses including rhabdomyolosis (muscle injury where muscles break down), schizoeffective disorder, hypo-osmoality, alcohol abuse, anemia, osteoarthritis, lupus erythmatosis (body's immune system attacks tissues and organs), heart attack, low magnesium and potassium level, atrial-fibrillation, depression, Raynaud's syndrome, vascular heart disease, retinopathy, cataracts, urinary retention with neuromuscular bladder, angioneurotic edema (unpredictable frequent edematous episodes of cutaneous and mucosal tissues such as lips, eyes, oral cavity, larynx, and gastrointestinal system), and acute respiratory/kidney failure. Medical record review revealed Resident #50 was admitted on [DATE] and readmitted on [DATE] with diagnoses including right lower leg pain, acute cough, intervertebral disc degeneration of the lower back, high blood pressure, gastroesophageal reflux disease, chronic kidney disease, scoliosis, group B vitamin deficiency, encephalopathy, and anemia. An observation of Licensed Practical Nurse (LPN) #91 administer 11 medications to Resident #40 on 04/28/25 at 8:59 A.M. revealed a failure to perform hand hygiene to prevent cross contamination of germs. LPN #91 dispensed the following medications in a medication cup: - lactobacillus acidophilus two capsules - colace 100 milligram (mg) tablet - duloxetine 30 mg tablet - potassium chloroide 10 milliequivalents (mEq) tablet - Lasix 20 mg tablet - Thera M multivitamin with minerals supplement 1 tablet - ethylene glycol powder 1 gram (gm) - thiamin 100 mg tablet - sodium chloride 1 gm tablet (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- sertraline 50 mg tablet - sertraline 25 mg tablet LPN #91 then removed the two lactobacillus acidophilus capsules from the medication cup and opened the capsules with her bare hands to empty the capsules in the medication cup mixed with applesauce. LPN #91 proceeded to administer the above listed medications to Resident #40 and did not perform hand hygiene after administering Resident #40's medications. LPN #91 then proceeded to remove Resident #50's medications from the medication cart and administer the following seven oral medications to Resident #50: - guaifenesin 600 mg tablet - amlodipine 5 mg tablet - colace 100 mg tablet - senna 8.6 mg tablet - metoprolol 37.5 mg tablet - pantoprazole 40 mg tablet - losartan potassium 100 mg tablet After administering the above seven medications LPN #91 failed to perform hand hygiene. An interview with LPN #91 on 04/28/25 at 9:40 A.M. confirmed she opened the lactobacillus using her bare hands, did not perform hand hygiene after administering Resident #40's medications, and did not perform hand hygiene after administering medications to Resident #50. Review of the facility's policy titled Medication Administration - Preparation and General Guidelines revised August 2014 indicated medications were to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications were to do so only after they had been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The policy further indicated the facility had sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. The procedure included: Handwashing and Hand Sanitization: The person administering medications was to adhere to good hand hygiene, which included washing hands thoroughly - before beginning a medication pass, - prior to handling any medication, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- after coming into direct contact with a resident, - before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations, and before and after administration of medications - via enteral tubes. - Examination gloves were to be worn when necessary Hand sanitization was to be done with an approved sanitizer - between hand washings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface). - at regular intervals during the medication pass such as after each room, again assuming handwashing was not - Sanitization was not a substitute for proper handwashing, and washing should be done if there is any question. indicated. 2. Medical record review revealed Resident #20 was readmitted on [DATE] with diagnoses including spastic paraplegia, asthma, diabetes mellitus, anemia, heart failure, kidney disease, atherosclerotic heart disease, morbid obesity, gout, edema, high blood pressure, depression, insomnia, hypothyroidism, deep vein thrombosis of right lower extremity, cognitive impairment, anxiety with restlessness/agitation, osteoarthritis, abnormal liver function, rotator cuff tear of right shoulder, disorder of kidney and ureter, vitamin D deficiency, high potassium level, gastroesophageal reflux disease, embolism of left popliteal vein, respiratory synctial virus (RSV), hearing loss, eye diseases, high cholesterol, dizziness, low blood pressure, low heart rate, urinary retention, hydronephrosis, and pulmonary embolism. Further review of the medical record revealed nursing progress notes dated 03/19/25 which indicated Resident #20 was readmitted to the facility from the hospital with a diagnosis of influenza A. The nursing progress note revealed Resident #20 had a moist cough, abnormal lung sounds on both sides and was receiving Tamiflu medication to treat the diagnosis of influenza A. Further review of Resident #20's clinical record revealed no documentation that isolation precautions were implemented. A review of Resident #20's physician orders dated 03/01/25 to 03/31/25 revealed no order to implement isolation precautions. The above was confirmed with the Director of Nursing on 04/29/25 at 12:00 P.M. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the the facility's undated policy and procedure titled Isolation - Categories of Transmission-Based Precautions revealed the policy statement indicated transmission-based precautions were initiated when a resident developed signs and symptoms of a transmissible infection; arrived for admission with symptoms of an infection; or had a laboratory confirmed infection; and was at risk of transmitting the infection to other residents. The indications for contact precaution isolation included : 1. Contact precautions were to be implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 2. Contact precautions were also used in situations when a resident was experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that could not be contained and suggested an increased potential for extensive environmental contamination and risk of transmission of a pathogen, even before a specific organism has been identified. 3. Contact precautions were to be used for residents infected or colonized with MDROs in the following situations: a. When a resident had wounds, secretions, or excretions that are unable to be covered or contained; and b. On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission was occurring. 4. These strategies could differ depending on the prevalence or incidence of the MDRO in the facility and region. For example, additional usage of PPE (enhanced barrier precautions) could be used for residents who did not meet criteria for contact precautions but were infected or colonized with MDROs (or have risk factors for MDRO acquisition). 5. The decision on whether contact precautions were necessary were to be evaluated on a case by case basis. 6. The individual on contact precautions was to be placed in a private room if possible. If a private room was not available, the infection preventionist was to assess various risks associated with other resident placement options (e.g., cohorting, placing with a low risk roommate). 7. Staff and visitors were to wear gloves (clean, non-sterile) when entering the room. a. While caring for a resident, staff were to change gloves after having contact with infective material (for example, fecal material and wound drainage). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parma Care Center	5553 Broadview Rd Parma, OH 44134

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Gloves were to be removed and hand hygiene performed before leaving the room. c. Staff were to avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. 8. Staff and visitors were to wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. 9. When transporting individuals with skin lesions, excretions, secretions, or drainage that was difficult to contain, contact precautions were to be taken during resident transport to minimize the risk of transmission. This deficiency represents non-compliance investigated under Complaint Number OH00165067.