

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Wyant Woods Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Wyant Rd Akron, OH 44313	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, interview, record review, and policy review the facility failed to ensure Resident #165's diabetes was managed appropriately by ensuring insulin was administered according to physician orders. This affected one (#165) of four residents observed for medication administration. The facility census was 170.</p> <p>Findings include:</p> <p>Review of Resident #165's medical records revealed an admitted [DATE]. Diagnoses included diabetes, developmental delays and schizophrenia.</p> <p>Review of Resident #165's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #165 had intact cognition and required moderate assistance with toileting, bathing and personal hygiene.</p> <p>Review of Resident #165's current physician orders for September 2024 revealed Resident #165 was ordered Fiasp (fast acting insulin) 15 units before meals.</p> <p>Observation of medication administration on 09/10/24 at 7:56 A.M. for Resident #165 with Registered Nurse (RN) #427 revealed RN obtained Resident #165's insulin pen and the packaging indicated to administer 12 units. RN #427 removed the Fiasp out of the package and dialed in the dosage of the insulin to be administered. Observation of the pen revealed the dosage was dialed to deliver 18 units. RN #427 took the pen back and stated Oh I was only supposed to draw up 12 units. RN #427 then dialed in 12 units of Fiasp and administered the Fiasp.</p> <p>Interview on 09/10/24 at 1:08 P.M. with the Director of Nursing (DON) confirmed Resident #165's physician orders were to administer 15 units of Fiasp.</p> <p>Review of facility policy titled Medication Administration undated revealed to administer medications only as prescribed by the provider.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157395.</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733</p> <p>Based on observation, interview, record review, and policy review the facility failed to maintain proper infection control techniques during wound care and insulin administration. This affected one (#40) of three residents observed for wound care, one (#165) of one resident observed for insulin administration, and had the potential to affected 52 residents (#2, #11, #12, #19, #21, #22, #26, #27, #35, #40, #46, #55, #56, #59, #62, #64, #69, #72, #73, #81, #83, #87, #91, #98, #102, #103, #106, #110, #111, #112, #115, #120, #122, #123, #126, #128, #129, #131, #134, #137, #140, #141, #142, #147, #149, #151, #153, #156, #157, #165 #166 and #169) residing on the Oak and Walnut halls where Registered Nurses #427 and 304 were providing care. The facility census was 170.</p> <p>Findings include:</p> <p>1. Review of Resident #40's medical records revealed an admitted [DATE]. Diagnoses included diabetes and non-compliance with medical treatments.</p> <p>Review of Resident #40's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had intact cognition.</p> <p>Review of Resident #40's care plan dated 09/06/24 revealed Resident #40 required Enhanced Barrier Precautions (EBP) related to a wound. Interventions included to wear appropriate Personal Protective Equipment (PPE) during high contact care.</p> <p>Review of Resident #40's current physician orders for September 2024 revealed Resident #40 required EBP related to</p> <p>wound.</p> <p>Observation on 09/10/24 at 10:28 A.M. revealed a sign posted outside of Resident #40's room that indicated Resident #40 was on (EBP) and an isolation bin with PPE was located outside of Resident #40's room. Interview with Registered Nurse (RN) #427 at the time of observation revealed she believed Resident #40 was no longer on EBP because he had completed his course of antibiotics for an infection in his wound. RN #304 and RN #427 proceeded to enter Resident #40's room without donning PPE. RN #427 placed wound care supplies on Resident #40's bedside table without cleaning the surface of the table or placing a barrier down. RN #427 placed a soiled towel that was on the floor underneath Resident #40's left leg and then using scissors that were removed from her pocket cut the dressing covering Resident #40's wound. RN #304 and RN #427 cleansed Resident #40's wound, and while wearing the soiled gloves RN #427 proceeded to open Resident #40's dresser drawers to look for additional wound care supplies. Without changing gloves or completing hand hygiene the RNs placed a new dressing on Resident #40's wound. RN #427 returned to Resident #40's drawer and obtained a pair of socks and placed them on Resident #40's feet. After completing the wound care RN #304 and RN #427 discarded their gloves and without completing hand hygiene exited 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>Interviews with RN #304 and RN #427 immediately after the observation revealed they did not don PPE prior to entering Resident #40's because they did not believe he required isolation; RN #304 and RN #427 confirmed they had not performed hand hygiene; RN #427 confirmed she placed a soiled towel under Resident #40's leg stating it was already dirty, and RN #427 confirmed she did not clean the surface of the table or disinfect the scissors she removed from her pocket stating she was not aware that was a required.</p> <p>Immediately after interviewing RNs #304 and #427, Unit Manager LPN #326 and Wound Care Nurse LPN #352 asked how Resident #40's dressing change went they were made aware of the observations. LPNs #326 and #352 confirmed Resident #40 was currently on EBP and staff were required to wear PPE prior to providing care.</p> <p>Review of facility policy titled Enhanced Barrier Precautions undated, revealed EBP was indicated for residents with wounds and staff were to don PPE when providing high contact care activities.</p> <p>2. Review of Resident #165's medical records revealed an admitted [DATE]. Diagnoses included diabetes, developmental delays and schizophrenia.</p> <p>Review of Resident #165's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #165 had intact cognition and required moderate assistance with toileting, bathing and personal hygiene.</p> <p>Review of Resident #165's current physician orders for September 2024 revealed Resident #165 was ordered Fiasp (fast acting insulin) 15 units before meals.</p> <p>Observation of medication administration on 09/10/24 at 7:56 A.M. for Resident #165 with Registered Nurse (RN) #427 revealed RN #427 checked Resident #165's blood sugar. RN #427 then obtained Resident #165's Fiasp insulin pen and dialed in 12 units and administered the insulin to Resident #165. RN #165 did not wear gloves while obtaining the blood sugar or while preparing or administering the insulin, nor did RN #165 complete hand hygiene after completion of the tasks.</p> <p>Interview with RN #427 at time of observation confirmed she did not wear gloves while obtaining the blood sample and completing the blood sugar check or while administering Resident #165's insulin. RN #427 stated she was unaware she was required to wear gloves during these tasks. RN #427 stated she should have performed hand hygiene after completion of blood sugar check and insulin administration.</p> <p>Review of facility's undated policy titled Medication Administration revealed staff were to perform appropriate hand hygiene before and after each residents' medication was administered.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157390 and OH00157395.</p>		