STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365847	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Manor Special Care Centre	2330 Smith Road Akron, OH 44333

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on record review, interview, observation of photographic evidence, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure communication and coordination of services with the dialysis center regarding the care of Resident #119's dialysis catheter. This affected one resident (#119) of four residents reviewed and observed for dialysis catheter care. The facility census was 112. Findings include: Review of Resident #119's closed medical records revealed an admitted [DATE] and a discharge date of [DATE]. Resident #119 had a diagnosis of chronic kidney disease and was dialysis dependent. Resident #119 expired on [DATE]. Review of Resident #119's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #119 had impaired cognition. Review of Resident #119's care plan dated [DATE] revealed Resident #119 required dialysis. Interventions included providing access site care as ordered and monitor and report signs of infection. Review of Resident #119's physician orders for [DATE] revealed an order to monitor dialysis access site for signs of infection, intact dressing and bleeding, and notify physician as needed. There were no physician orders to change the dialysis catheter dressing. Telephone interview on [DATE] at 11:20 A.M. with Resident #119's son revealed Resident #119 was admitted to the hospital's Intensive Care Unit on [DATE] and diagnosed with an infection from his dialysis catheter that spread to his heart valves. Resident #119's son stated he arrived at the hospital on [DATE] and observed the dressing over Resident #119's dialysis catheter it was soiled and dated [DATE]. Resident #119's son took a picture of the dressing over the dialysis catheter insertion site and sent the picture to the Ombudsman's office. At the time of the interview Resident #119's son provided the photograph. Observation of the photograph revealed the photo was dated [DATE] and timed 1:27 P.M. The photograph showed a viably soiled transparent dressing with gauze border covering a central venous access device located on Resident #119's right upper chest. The dressing was dated [DATE] in black marker and had dried dark red/maroon colored drainage on the border and underneath the transparent dressing was a pool of dark red drainage around the insertion site. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:21 A.M. with Licensed Practical Nurse (LPN) #392 revealed she was unsure exactly when dialysis dressings were to be changed. LPN #392 then stated I don't know, maybe every week. Interview on [DATE] at 12:26 P.M. with Dialysis Registered Nurse (RN) #413 revealed she had spoken to the Ombudsman (could not recall date) regarding Resident #119's dialysis catheter she told the Ombudsman she was not aware of any concerns related to Resident #119's dialysis catheter. RN #413 stated she had not observed any photos of the dialysis catheter or insertion site. RN #413 was shown the photograph provided by Resident #119's son and confirmed the dressing was dated [DATE]. RN #413 was unable to provide an explanation as to why the dressing had not been changed. RN #413 stated dialysis catheter dressings were usually changed on Mondays and as needed. RN #413 looked through Resident #119's dialysis treatment record and found no documentation the dressing to the dialysis catheter insertion site had been changed from [DATE] through [DATE]. RN #413 stated the facility floor nurses were supposed to monitor the dialysis site daily and report any concerns. Interview on [DATE] at 10:23 A.M. with LPN #357 revealed she had cared for Resident #119 on [DATE] and stated Resident #119's son requested that he be sent to the hospital. LPN #357 could not recall any issues with Resident #119's dialysis catheter prior to Resident #119 being sent to the hospital. LPN #357 confirmed she had signed the Treatment Administration Record (TAR) on [DATE] indicating she had assessed Resident #119's dialysis catheter site, however she could not recall if the dialysis dressing had been dated or appeared soiled. Interview on [DATE] at 9:36 A.M. with Regional Registered Nurse (RRN) #408 revealed dialysis dressings should be changed every seven days and as needed. RRN #408 stated the nursing staff was to monitor dialysis dressings and sites daily and to report any concerns to the dialysis nurses. Review of Resident #119's death certificate revealed the resident passed away on [DATE] with causes of death listed as septic shock, bacteremia (blood infection), endocarditis (infection of the hearts inner lining, usually caused by bacteria that enters the bloodstream and collects on the heart valves), and infected dialysis catheter. Review of facility policy titled Central, Venous Catheter Care revised [DATE] revealed trained and qualified dialysis care personnel were to change dressings every seven days. Review of facility policy titled Hemodialysis Care revised [DATE] revealed if a dressing was ordered over the site, monitor and change as needed. Review of CDC guidelines for the prevention of Intravascular Catheter related infections revealed the following. VII. Catheter-site dressing regimens A. Use either sterile gauze or sterile, transparent, semipermeable dressing to cover the catheter site (146, 210--212). Category IA B. Tunneled CVC sites that are well healed might not require dressings. Category II (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. If the patient is diaphoretic, or if the site is bleeding or oozing, a gauze dressing is preferable to a transparent, semi-permeable dressing (146,210--212). Category II D. Replace catheter-site dressing if the dressing becomes damp, loosened, or visibly soiled (146,210). Category IB E. Change dressings at least weekly for adult and adolescent patients depending on the circumstances of the individual patient (211). Category II F. Do not use topical antibiotic ointment or creams on insertion sites (except when using dialysis catheters) because of their potential to promote fungal infections and antimicrobial resistance (107,213). Category IA (See Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters, in Adult and Pediatric Patients, Section II.I.) G. Do not submerge the catheter under water. Showering should be permitted if precautions can be taken to reduce the likelihood of introducing organisms into the catheter (e.g., if the catheter and connecting device are protected with an impermeable cover during the shower (214,215). Category II This deficiency represents non-compliance investigated under Complaint Number OH00158341.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, review of a facility Self-Reported Incident (SRI) and investigation, review of a police report and medical examiner information, personnel file review, review of narcotic/controlled drug sheets, review of Medscape drug reference information, facility policy review and interviews, the facility failed to ensure Resident #117 was free from a significant medication error and failed to ensure the error was reported immediately so that timely and appropriate medical intervention could be provided. This resulted in Immediate Jeopardy and actual harm/death of Resident #117 when on [DATE] at approximately 6:56 A.M. LPN #381 administered Resident #56's medications that included Methadone (medication used to treat opioid use disorder) 40 milligrams (mg) and likely hydromorphone (potent opioid used to treat severe and chronic pain) eight mg to Resident #117. LPN #381 did not report the medication error and therefore no medical intervention was initiated. On [DATE] at approximately 7:15 P.M. Resident #117 was found unresponsive in a common area and resuscitative measures were initiated but ultimately unsuccessful. Resident #117 was pronounced deceased on [DATE] at 8:15 P.M. On [DATE] at approximately 9:15 P.M. LPN #381 confessed to LPN #365 she had made the medication error. However, LPN #381 later denied making the medication error upon facility investigation. On [DATE] at 2:06 P.M. a telephone interview with the Medical Examiner revealed Resident #117's initial blood work screening (postmortem) was positive for Methadone and opiates, which the resident was not ordered to receive. This affected one resident (#117) of six residents reviewed for medication administration and one resident (#117) of three residents reviewed for death. The facility census was 112. On [DATE] at 9:57 A.M. the Administrator and Regional Registered Nurse (RRN) #408 were notified Immediate Jeopardy began on [DATE] at approximately 6:56 A.M. when LPN #381 administered Resident #56's medications that included Methadone 40 mg to Resident #117. LPN #381 did not report the medication error and therefore no medical intervention was immediately initiated. On [DATE] at approximately 7:15 P.M. Resident #117 was found unresponsive in a common area and resuscitative measures were initiated. Resident #117 was pronounced deceased on [DATE] at 8:15 P.M. On [DATE] at approximately 9:15 P.M. LPN #381 confessed to LPN #365 she had made the medication error. On [DATE] at 2:06 P.M. a telephone interview with the Medical Examiner revealed Resident #117's initial blood work screening showed Methadone and opiates in Resident #117's system indicative of the medication error occurring. The Immediate Jeopardy was removed and the deficient practice corrected on [DATE] when the facility implemented the following corrective actions: On [DATE] Resident #117 passed away at the facility. On [DATE] at approximately 12:00 P.M., LPN #414 reported to the Administrator a medication error rumor involving narcotics was being spread throughout the facility. It was alleged on [DATE] LPN #381 gave medication, including narcotics, that belonged to Resident #56 to Resident #117. LPN #414 reported that LPN #381 allegedly confessed this error to LPN #365. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 1:00 P.M., LPN #381 was interviewed by the Administrator and RRN #408 regarding the medication error. LPN #381 gave a written statement denying all allegations including sharing this allegation with another nurse. LPN #381 was then suspended (on [DATE]) pending investigation. LPN #381 was subsequently terminated on [DATE] for failure to cooperate with the facility investigation. No additional/new information was obtained from LPN #381 by the facility regarding the medication error incident. On [DATE] between 12:30 P.M. and 8:30 P.M. all staff who were working at the time of the alleged incident and the following shift were interviewed by the Administrator and RRN #408. On [DATE] at approximately 1:45 P.M., LPN #365 was interviewed by the Administrator and RRN #408 and was questioned regarding knowledge of the medication error. LPN #365 provided a written statement stating she was notified of the medication error by LPN #381 on [DATE]. LPN #365 indicated she notified (by phone) Unit Manager (UM) #332 on [DATE]. LPN #365 then indicated on [DATE], she notified UM #400 in person at the facility of the alleged confession of a medication error by LPN #381 involving Resident #117. On [DATE] at approximately 2:00 P.M., RRN #408 and the Director of Nursing (DON) notified NP #410 and Physician #411 (Resident #117' primary care physician) of the alleged medication error. At the time of the notification, Nurse Partitioner (NP) #410 reported she had been aware of the alleged incident/error since [DATE] when it had been reported to her by another NP in the facility. It was noted the primary care physician had previously contacted (on [DATE]) the medical examiner with this information. On [DATE] at approximately 2:00 P.M., RRN #408 implemented a new protocol for all zeroed narcotic sheets to stay in the narcotic book until removed by unit manager and/or DON, and all empty narcotic cards were to stay in narcotic drawer until removed by unit manager and/or DON. On [DATE] at approximately 2:30 P.M., RRN #408 and the Administrator spoke with NP #410 and Physician #411 via phone and educated them of the requirement to report any allegations of abuse, neglect and misappropriation, including rumors of medication errors directly to the administrator. On [DATE] at approximately 3:00 P.M., UM #332 was interviewed by the Administrator and RRN #408. UM #332 denied hearing of the allegation prior to the time of interview. Following the interview, UM #332 was suspended pending further investigation. UM #332 returned to work on [DATE]. One on one education was provided on [DATE] by the Administrator and RRN #408 on reporting medication errors, medication administration, abuse/neglect procedures, and immediate reporting protocol to the abuse coordinator (Administrator). Education was completed again on [DATE] by the Administrator prior to returning to work. On [DATE] at approximately 3:15 P.M., UM #400 was interviewed by the Administrator and RRN #408. UM #400 denied hearing of the allegation prior to the time of interview. Following the interview, UM #400 was suspended pending further investigation. UM #400 returned to work on [DATE]. One on one education was provided on [DATE] by the Administrator regarding reporting medication errors, medication administration and abuse reporting and protocol including immediate reporting to abuse coordinator (Administrator). Education was completed again on [DATE] by the Administrator prior to returning to work. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 4:00 P.M., RRN #408 reviewed the employee files of LPN #381, LPN #365, UM #332 and UM #400 per facility investigation protocol. On [DATE] at approximately 5:00 P.M. an in-house audit was completed by the DON, Assistant Director of Nursing (ADON) and RRN #408 for all residents receiving narcotics to ensure that medication was being received as ordered. In addition, the DON and ADON interviewed alert and oriented residents without any negative findings. The DON and ADON completed assessments on residents who were not alert and oriented, and no skin concerns or behavioral concerns were identified. RRN #408, DON and the ADON completed audits of all narcotics on each medication cart to ensure all narcotics were accounted for. On [DATE] at approximately 6:00 P.M., the DON, ADON and RRN #408 completed audits of Resident #56 and Resident #117 reviewing their controlled substance narcotic individual record and identified two controlled substance individual sheets for Methadone that were zeroed out (indicating medication card was empty) for Resident #56 and two missing Methadone narcotic sheets. Upon this finding a complete review for all residents ordered narcotics was completed for two weeks prior with no additional negative findings. The missing narcotic sheets have not been recovered as of [DATE]. On [DATE] at approximately 7:30 P.M., the DON, ADON, and RRN #408 completed a house audit on all narcotic accountability sheets to ensure there was no diversion noted and narcotic shift to shift count and individual control sheets matched the narcotic cards. On [DATE] at 12:30 P.M. and 8:30 P.M., following education to the DON and ADON by RRN #408, all nursing staff were in-serviced by the DON, ADON and RRN #408 on medication administration, abuse and neglect-with protocol to report allegations directly to abuse coordinator (Administrator), shift to shift count of narcotics, destruction of narcotics, change of condition with notification to physician and family, discontinued home medications would be verified by manager and nurse, medication errors and reporting. The in-service was followed by nurses completing a medication administration competency which was completed by the DON and nursing management. Any staff not educated in person on [DATE] were educated via phone on [DATE] with follow-up in person education conducted on the employee's next working day. Completion of the education and competencies was confirmed through review of sign-in sheets and interviews with nurses. On [DATE] between 12:30 P.M. and 8:30 P.M., the DON, ADON, and RRN #408 educated nurses on principles of medication administration per policy. The education was completed by [DATE]. Completion of the education was confirmed through review of sign-in sheets and interviews with nurses. On [DATE] from approximately 12:30 P.M. to 8:30 P.M., nurses and STNAs were educated on the abuse, neglect and misappropriation policy and reporting requirements. Staff were educated that any allegation of abuse, including rumors of medications errors must be immediately reported to the administrator. This information was also posted at the nurses' station, by the time clock and in break rooms. On [DATE] at 2:00 P.M. and 8:30 P.M., after RRN #408 educated the DON and ADON, the DON, ADON and RRN #408 educated all licensed nurses of the new protocol all zero on narc sheets needing to stay on book until removed by unit manager and/or DON; all empty narc cards must stay in narc drawer until removed by unit manager and/or DON. Education was completed by [DATE]. Completion of the education was confirmed through review of sign-in sheets and interviews with nurses. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] Alert signs with reporting requirements including the telephone number for the Administrator were placed at nurse's stations, time clock and break room. On [DATE] a Self-Reported Incident was submitted to the State agency involving Resident #117. On [DATE] at approximately 4:00 P.M., the facility Corporate Medical Director (MD) #418 was notified of the alleged medication error with no additional recommendations provided. MD #418 indicated to follow facility protocols. On [DATE] the facility implemented a plan for the DON/designee to audit narcotic medications to ensure the narcotic counts were correct three times per week for three weeks and then randomly. Audits would remain in place until at least [DATE]. On [DATE] the facility implemented a plan for the DON/designee to ensure medication administration compliance by observing medication administration with two nurses three times per week for three weeks and then randomly. Audits would remain in place until at least [DATE]. On [DATE] the facility implemented a plan to ensure compliance with the zeroed narcotic control sheets by collecting empty narcotic cards with narcotic sheets from the medication carts three times per week ongoing. This process would be an ongoing protocol. On [DATE] the facility implemented a plan for the DON/Designee to ensure compliance of reporting medication errors by interviewing two nurses three times per week for three weeks and then randomly. Interviews would be ongoing. The facility implemented a plan for all negative findings to be reviewed during Quality Assurance Performance Improvement (QAPI) meetings to determine if additional audits were necessary. A QAPI meeting was held on [DATE] in person with staff that were present in the facility and via phone for those not present in facility. A QAPI meeting was held on [DATE] in person with staff that were present in the facility and via phone for those not present in facility. The QAPI committee attending the meetings included the Administrator, DON, ADON, RRN #408, Corporate MD #418, Regional Director of Operations, Physician #411, NP #410, Social Services Designee (SSD) #419, Human Resources (HR) #420, and Unit managers #332, #400 and #402. On [DATE] at approximately 3:30 P.M., the State Agency Surveyor notified RRN #408 and the Administrator of Resident #117's preliminary toxicology results (obtained from the coroner) which indicated Methadone and opioid were present. Information obtained from the coroner revealed a final report would not be available for four to 12 weeks. The Administrator contacted the Police, and the police officer indicated the investigation would be handled by the Board of Pharmacy. The DON and RRN #408 notified Physician #411 and MD #418 of the preliminary results. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:38 A.M. telephone interview with the Administrator and on [DATE] at 9:24 A.M. telephone interview with the Administrator and RRN #408 revealed while the facility was continuing to attempt to obtain additional information internally related to this incident involving Resident #117 following the communication of the preliminary toxicology report, they were dependent on external investigations being conducted by other agencies as well which were ongoing as of this date. On [DATE] the facility made a follow-up call and left a message with the Board of Pharmacy to confirm their on-going investigation and to obtain any available updates. The facility also revealed they would be adding an addendum to the previously submitted SRI with the updated information from the coroner and also to reflect that Resident #117 had passed away on [DATE]. Findings include: Review of Resident #117's closed medical records revealed an admitted [DATE] with diagnoses including cerebral palsy, developmental disorder of speech and language and cognitive deficits. Record review revealed the resident passed away in the facility on [DATE]. Review of Resident #117's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #117 was rarely understood. Resident #117 was dependent (on staff) for bed mobility, eating, toileting and personal hygiene. Review of Resident #117's care plan dated [DATE] revealed Resident #117 had impaired cognition related to cerebral palsy and difficulty communicating. Interventions included making eye contact with Resident #117 and being patient. Resident #117 was at risk for seizures. Interventions included administering medications as ordered. Review of Resident #117's physician orders for [DATE] revealed medication including Clonazepam (a benzodiazepine used to treat seizures, panic disorder and anxiety) one mg three times a day to be administered at 6:00 A.M., 2:00 P.M. and 10:00 P.M., Oxcarbazepine (seizure medication) 600 mg three times a day to be administered at 6:00 A.M., 2:00 P.M. and 10:00 P.M., and Zonisamide (seizure medication) 200 mg, three times a day to be administered at 6:00 A.M., 2:00 P.M. and 10:00 P.M. Review of Resident #117's Medication Administration Record (MAR) for [DATE] revealed LPN #381 documented Resident #117's Clonazepam, Oxcarbazepine, and Zonisamide were administered at 6:54 A.M. Review of Resident #117's progress note dated [DATE] timed 10:17 P.M. authored by LPN #310 revealed Resident #117 was found unresponsive. Resident #117 was moved to the ground, Cardiopulmonary Resuscitation (CPR) was performed, and emergency medical services (EMS) were called. CPR was unsuccessful and EMS pronounced Resident #117 deceased . Review of the facility Code Blue (an emergency code that indicates a resident is in critical condition and needs immediate medical care. It is usually used to describe a resident who is in cardiac or respiratory arrest) investigation dated [DATE] revealed Resident #117 was found unresponsive in the TV room at 7:15 P. M. CPR was initiated. EMS were called and arrived at 7:25 P.M. Resident #117 was pronounced deceased at 8:15 P.M. by EMS. Review of LPN #374's statement dated [DATE] revealed she administered Resident #117's medications around 3:,d+[DATE]:30 P.M. and Resident #117 was alert. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the MAR dated [DATE] revealed medications scheduled for 2:00 P.M. were documented as administered including Clonazepam 1mg (benzodiazepine), Oxcarbazepine 600 mg and Zonisamide 200 mg. These were the same medications scheduled for 6:00 A.M. Review of a police report dated [DATE] revealed the police responded to the emergency medical services call. The report indicated Resident #117 was deceased and no foul play was detected. Review of a facility self-reported incident (SRI) initiated on [DATE] revealed the facility reported an allegation of Neglect/Mistreatment/Abuse involving Resident #117. The date of occurrence was identified as [DATE] at 12:00 P.M. and included LPN #414 reported to the Administrator a rumor that LPN #381 had made a medication error with the resident. The SRI noted Resident #117 was no longer in the facility, but failed to include this was due to the resident passing away on [DATE]. In addition, the SRI failed to include any information related to the medication error actually occurring on [DATE]. Review of the facility's final disposition revealed the facility interviewed staff and residents but were unable to determine a medication error had occurred. The SRI included LPN #381 was suspended during the investigation. Facility staff were educated on proper medication administration and reporting of medication errors. Review of the facility investigation regarding the death of Resident #117 which was initiated on [DATE] revealed a statement authored by LPN #365 indicating on [DATE], LPN #381 arrived at LPN #365's home sometime after 9:15 P.M. LPN #381 told LPN #365 Resident #117 had passed away and on the morning of [DATE] during her morning medication pass she had given Resident #117 another resident's medications that had included narcotics. LPN #381 told LPN #365 she had not reported the medication error to anyone. After LPN #381 left LPN #365's home, LPN #365 made several attempts to contact staff that were on call including the DON, UM/LPN #332 and UM/LPN #400. UM/LPN #332 contacted LPN #365 and was made aware of what LPN #381 had reported to LPN #365. UM/LPN #332 told LPN #365 she would contact the DON. The statement also indicated on the morning of [DATE], LPN #365 spoke with UM/LPN #400 and explained the reasons for her calls and text messages on [DATE] and UM/LPN #400 stated she had not been made aware of the situation. Review of LPN #381's statement dated [DATE] revealed she could not recall giving any wrong medications and Resident #117 was fine when she had left. Review of LPN #374's statement dated [DATE] revealed on the morning of [DATE] while sitting at the nurses' station she was speaking with LPN #309 about Resident #117's death. While speaking with LPN #309, LPN #309 stated a night shift nurse (LPN #381) admitted to a fell ow night shift nurse (LPN #365) that she made a mistake and gave Resident #117, Resident #56's medications. The statement indicated LPN #309 told her the DON was aware of the situation and was handling it. Review of LPN #321's statement dated [DATE] revealed she was told and had overheard LPN #381 had administered the wrong medications to Resident #117. Review of LPN #414's statement dated [DATE] revealed LPN #321 said Resident #117 died due to a medication error made when LPN #381 administered Resident #56's medications to Resident #117 and did not report the error. (continued on next page)

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	365847	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Manor Special Care Centre	2330 Smith Road Akron, OH 44333

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of LPN #323's statement dated [DATE] revealed she observed Resident #117 in a common dining area at lunchtime on [DATE]. Resident #117 did not appear to be his chipper self. Resident #117 normally became excited and gave out high [NAME] when staff/visitors approached. Resident #117 did not respond to LPN #323, he just continued to eat his meal. LPN #323 saw Resident #117 later in a common area (time not identified in statement) and Resident #117 appeared to be taking a nap, LPN #323 indicated time went by and an aide said, Oh my God, I think he's dead. LPN #323 performed chest compressions until EMS arrived. Review of the Administrator's statement dated [DATE] revealed on [DATE], LPN #414 informed her of a rumor regarding a medication error for Resident #117. LPN #414 stated LPN #381 had administered Resident #56's medications to Resident #117; LPN #381 had confessed to LPN #365. The Administrator interviewed LPN #381 who denied making a medication error. The Administrator also interviewed LPN #365 who stated LPN #381 had confessed to making the medication error. LPN #365 stated after LPN #381 had left her home, she called UM/LPN #332 to report the incident. LPN #365 further stated she reported the incident to UM/LPN #400 on the morning of [DATE]. The Administrator interviewed UM/LPN #332 and UM/LPN #400, and both denied they had been notified of the medication error. Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses including alcoholic hepatitis, anxiety, and altered mental status. Review of Resident #56's care plan dated [DATE] revealed Resident #56 had self-care deficits related to pain, weakness and terminal illness. Resident #56 had a history of substance abuse. Interventions included if Resident #56 was symptomatic for substance abuse, hold medications and obtain urine/blood samples for drug testing. Review of Resident #56's MDS assessment dated [DATE] revealed Resident #56 had intact cognition. Review of Resident #56's physician orders for [DATE] revealed medications including Clonazepam one mg to be administered at 6:00 A.M., 2:00 P.M. and 10:00 P.M., Methadone 40 mg, every eight hours to be administered at 6:00 A.M., 2:00 P.M. and 10:00 P.M., and Hydromorphone eight mg every three hours as needed for pain. Review of Resident #56's MAR for [DATE] revealed LPN #381 documented Resident #56's Clonazepam, and Methadone were administered at 7:00 A.M. Review of Resident #56's narcotic sheet for Hydromorphone revealed LPN #381 documented the medication was signed out on [DATE] at 6:00 A.M. However, the Hydromorphone was not documented on the MAR as being administered at that time. Review of Medscape drug reference information revealed the dosage of Methadone for opioid-naive patients was 2.5 mg by mouth every eight to 12 hours; titrate slowly with dose increases no more frequent than every three to five days. Warnings included accidental exposure of even one dose, especially in children could result in a fatal overdose. Monitor for hypotension during dose initiation; use with caution in patients with hypovolemia, cardiovascular disease, or drugs which may significantly increase hypotensive effects. Concomitant use of opioids with benzodiazepines or other central nervous system depressants, including alcohol may result in profound sedation, respiratory depression, coma, and death. Onset of action when taken by mouth 0.5 to 1 hour. Duration four to eight hours; repeated administration, ,d+[DATE] hours; overdosage, ,d+[DATE] hours. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 8:00 A.M. with LPN #309 revealed she was aware of LPN #381 making a medication error involving Resident #117 and UM/LPN #332 was also aware of the situation. LPN #309 stated she had reported concerns regarding LPN #381 being unsafe including LPN #381 pre-pouring resident medications, leaving medications in resident rooms and not crushing residents' medications that were supposed to be crushed. LPN #309 stated Resident #117 was mostly nonverbal and spent most of his time in the common area playing with his toys. Resident #117 was known to high five everyone who walked past and he was chipper all the time. LPN #309 stated LPN #323 reported LPN #381 to the nursing board on [DATE] because she believed management did not do anything regarding the medication error (that occurred on [DATE]). LPN #309 reported the situation to NP #409 on [DATE] who reported it to Resident #117's NP (NP #410) on the same date. NP #410 then contacted Resident #117's physician and the Board of Pharmacy on [DATE]. Interview on [DATE] at 8:55 A.M. with the Administrator and RRN #408 revealed the Board of Pharmacy arrived at the facility on [DATE] and requested Resident #117's Medication Administration Record (MAR) and physician orders. However, they stated the Board of Pharmacy did not disclose why they requested Resident #117's information. The Administrator stated on [DATE] she was informed by LPN #414 of rumors that LPN #381 had administered Resident #56's medications to Resident #117 (on [DATE]) and they initiated an investigation at that time. Interview on [DATE] at 10:12 A.M. with LPN #414 revealed on [DATE] he had reported to the Administrator a rumor he had heard regarding LPN #381 admitting to LPN #365 she had administered Resident #56's medications to Resident #117. Telephone interview on [DATE] at 10:50 A.M. with NP #410 revealed on [DATE] she was contacted by NP #409 who reported she was told LPN #381 administered Resident #56's medications to Resident #117 (on [DATE]). NP #410 stated she was told the facility was aware of the situation. NP #410 did not talk to the administrative staff about what she was told regarding the error, but stated she contacted the physician and the Board of Pharmacy on [DATE]. On [DATE] at 12:36 P.M. an attempt to interview LPN #381 was unsuccessful. LPN #381 stated she was sleeping and would return the call. Interview on [DATE] at 2:04 P.M. with LPN #365 revealed on the evening on [DATE], LPN #381 arrived at her home sometime after 9:15 P.M. LPN #381 told her (on [DATE]) she had given Resident #117 Resident #65's Methadone and had not reported the error. LPN #365 stated after LPN #381 had left her home she called the DON, UM/LPN #332 and UM/LPN #400. UM/LPN #332 returned her call approximately 30 minutes later and she informed her what LPN #381 had stated. UM/LPN #332 said she would contact the DON. LPN #365 stated on the morning of [DATE] she informed UM/LPN #400. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:30 P.M. with LPN #323 revealed she had been aware LPN #381 admitted to LPN #365 she administered Resident #56's medications to Resident #117. LPN #323 was present on [DATE] from 7:00 A.M. to 7:00 P.M. and saw Resident #117 in a common area around lunchtime and he appeared lethargic and more tired than normal. Resident #117 normally gave high [NAME] and often yelled out to staff and residents. At approximately 7:00 P.M. LPN #323 was notified Resident #117 was unresponsive and she assisted with placing Resident #117 on the ground and performed CPR. Resident #117 had no pulse, was cold and his fingertips were blue. LPN #323 stated she had previously expressed concerns to the DON regarding LPN #381 being unsafe and stated she did not believe the management team took any action. LPN #323 said LPN #381 pre-poured resident medications and did not act like an actual nurse. During an interview on [DATE] at 3:05 P.M. with UM/LPN #332 she denied she was notified of a potential medication error or that LPN #381 confessed she made an error after Resident #117's death. UM/LPN #332 said she was not aware of the possible error involving LPN #381 until [DATE]. Telephone interview on [DATE] at 3:17 P.M. with LPN #374 revealed she was present on [DATE] from 7:00 A.M. to 7:00 P.M. and was assigned to Resident #117. LPN #374 stated she administered Resident #117's medications between 3:,d+[DATE]:30 P.M. and Resident #117 appeared to be more tired than normal. After LPN #374 left the facility at approximately 7:00 P.M. she received a phone call from LPN #310 who stated Resident #117 was unresponsive. LPN #374 returned to the facility as the paramedics were arriving. LPN #374 stated she became aware of a medication error approximately one week later and had been informed that management was aware. LPN #374 did not report what she had been told to administrative staff. Telephone interview on [DATE] at 3:26 P.M. with LPN #321 revealed she was informed LPN #381 administered Resident #56's medications to Resident #117 on the morning of [DATE]. LPN #321 was told when LPN #381 returned to the medication cart after administering medications to Resident #117 she saw Resident #117's medications were still in his cup (they had been pre-poured) and LPN #381 could not locate Resident #56's medications. LPN #321 stated on [DATE] LPN #381 admitted to LPN #365 she had administered Resident #56's medications to Resident #117. LPN #321 was told LPN #365 made management aware after LPN #381 left her home after confessing to the error. Interview on [DATE] at 6:22 A.M. with LPN #310 revealed she was Resident #117's nurse on the evening of [DATE] from 7:00 P.M. to 7:00 A.M. Shortly after LPN #310 began the shift she was alerted by Certified Nursing Assistant (CNA) #311 that Resident #117 was unresponsive. LPN #310 immediately placed Resident #117 on the ground and initiated a Code Blue. LPN #310 performed CPR until the paramedics arrived. The LPN revealed Resident #117 was already cold and blue when CPR was initiated. LPN #310 stated she had been made aware of the medication error a few days later. Interview on [DATE] at 8:38 A.M. with the Administrator and RRN #408 revealed during the Board of Pharmacy's investigation it was determined narcotic sheets for Resident #56's Methadone were missing from this time period including from [DATE]. During an interview on [DATE] at 10:06 A.M. with the DON, the DON indicated she was not aware of the medication error until [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on [DATE] at 12:32 P.M. with Physician #411 revealed he was notified on the evening of [DATE] that Resident #117 had passed away. Physician #411 was not aware of any potential medication error or any other concern regarding the resident's death and signed the resident's death certificate with the cause of death being related to the resident's diagnosis of cerebral palsy. On [DATE], NP #410 informed him of the possibility of a medication error and that NP #410 had contacted the Board of Pharmacy. Physician #411 contacted the medical examiner's office. The medical examiner's office indicated they would obtain blood, urine and fluid samples to test. Physician #411 stated if the results came back positive for opioids he could change the cause of death on the death certificate. Telephone interview on [DATE] at 12:40 P.M. with LPN #365 revealed she had text messages which she sent to the DON, UM/LPN #332 and UM/LPN #400 on [DATE] from 10:33 P.M. to 10:34 P.M. The messages indicated Call me ASAP. UM/LPN #332 returned her call at 10:59 P.M. and LPN #365 reported what LPN #381 had confessed. UM/LPN #332 told her she would contact the DON. Observation and an attempted interview on [DATE] at 1:34 P.M. revealed Resident #56 was in bed and appeared to be out of it. Resident #56 fell asleep while being asked questions. Interview on [DATE] at 1:40 P.M. with Resident #34 revealed approximately three to four months ago LPN #381 entered her room to administer her evening medications. Resident #34 questioned LPN #381 about the medications because the number of pills was more than she normally receiv [TRUNCATED]