STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365855	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurie Ann Nursing Home	2200 Milton Boulevard Newton Falls, OH 44444

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, interview, review of the medication error report review, facility policy review, the facility failed to ensure the proper route of medication administration for Resident #51. This affected one resident (#51) of eight residents reviewed for proper medication administration. The facility census was 50. Findings include: Review of the medical records revealed Resident #51 was admitted to the facility on [DATE] and discharged on [DATE]. Significant diagnoses included paraplegia, bacteremia, stage IV pressure ulcers (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) to the right and left buttocks, diabetes mellitus type II, and infection and inflammatory reaction due to cardiac valve prothesis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was cognitively intact. Review of the physician's orders revealed an order dated 04/18/24 through 05/17/24 for ceftriaxone sodium (an antibiotic) intravenous (IV) use 2000 milligrams (mg) IV two times a day and an order dated 04/18/24 through 05/17/24 ampicillin sodium injection solution (an antibiotic), use 2000 mg IV every four hours. On 05/17/24 a new order was obtained for ampicillin sodium injection solution use 2000 mg IV every four hours for two weeks. A review of a progress note dated 05/03/24 at 6:26 A.M. revealed LPN #177 misread the order for ampicillin and gave the 05/02/24, 8:00 P.M. dose intramuscularly (IM) instead of intravenously. The resident's wife was notified. The nurse practitioner was notified and stated the medication was okay to be given IM and no adverse reaction was expected. The nurse spoke with the pharmacist who said the medication was okay to be given IM. No redness or swelling was noted to the injection site. The resident stated he was not having pain. A review of the document titled, Country Club Retirement Center Medication and Treatment Errors and Omissions dated 05/03/24 signed by LPN #177 and the Director of Nursing (DON) revealed ampicillin 2000 mg was administered IM instead of IV as ordered on 05/02/24 at 8:00 P.M. by LPN #177. (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
	365855	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurie Ann Nursing Home	2200 Milton Boulevard Newton Falls, OH 44444

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/24 at 1:45 P.M. an interview with the DON verified that LPN #177 gave ampicillin 2000mg IM instead of IV as ordered and corrective actions were taken immediately. The nurse practitioner and the spouse were notified. A review of the policy titled, Specific Medication Administration Procedures, dated 07/01/21, stated the nurse is to review the five rights of medication administration three times before administering medication. The deficient practice was corrected on 05/04/24 when the facility implemented the following actions: On 05/03/24 LPN #177 received a verbal warning regarding the medication error. On 05/03/24 LPN #177 was educated on the Five Rights of Medication Administration: Right Patient, Right medication, Right dose, Right route and Right time by the DON. On 05/03/24 an ad hoc quality assurance and performance improvement (QAPI) meeting was held. Random medication administration competencies would be done by the DON for two weeks. Resident #51 was assessed on 05/03/24 by the DON and found to have no ill effects. On 05/03/24 all nursing staff were educated the DON on the Five Rights of Medication Administration: Right Patient, Right medication, Right dose, Right route and Right time. Nurses who were not present in the facility were in-served via phone by Wellness Director #126. The sign in sheets were verified on 06/18/24. On 05/03/24 medication administration competencies were conducted by the DON for LPN #126 and Registered Nurse (RN) #121 with no negative findings. On 05/09/24 medication administration competencies were conducted by the DON for LPN #177 and RNs #173 and #168 with no negative findings. On 05/14/24 medication administration competencies were conducted by the DON for LPN #133 with no negative findings. This deficiency represents non-compliance investigated under Complaint Number OH00154138.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365855	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurie Ann Nursing Home	2200 Milton Boulevard Newton Falls, OH 44444

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, observation, review of Centers for Medicare and Medicaid (CMS) Quality, Safety, and Oversight (QSO) Memo 24-08-NH, staff interview, and policy review, the facility failed to ensure residents with chronic wounds and those with indwelling medical devices were placed in enhanced barrier precautions (EBP) as required. This affected four residents (#8, #10, #26, and #39) of five residents reviewed for infection control. The facility census was 50. Findings include: On 06/17/24 from 8:50 A.M. to 9:00 A.M., observations during tour of the facility revealed there were no residents in EBP. There were several residents throughout the facility that had indwelling urinary catheters or wounds that were not in EBP as required. 1. A review of records for Resident #8 revealed an admitted [DATE] with diagnoses including obstructive uropathy. The resident had an indwelling urinary catheter. Review of the care plan updated on 05/21/24 revealed Resident #8 was at risk for infection related to the indwelling urinary catheter, and staff was to wear a gown and gloves when providing resident care. On 06/17/24 at 8:55 A.M. an observation of Resident #8 room revealed no EBP were in place. The observation was verified by Wellness Coordinator (WC) #126 at the time of the observation. 2. A review of records for Resident #10 revealed an admitted [DATE] with diagnoses including reflux uropathy. Significant orders included Glucerna 1.5 (nutritional supplement) at 50 milliliters (ml) per hour continuously via a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted into the abdomen to administer nutrition). The medical records also revealed Resident #10 had a stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) on his coccyx. Review of the care plan updated on 05/21/24 to indicate Resident #10 was at risk for infection related to the PEG tube, and staff were to wear a gown and gloves when providing resident care. On 06/17/24 at 8:55 A.M. an observation of Resident #10 room revealed no EBP were in place. The observation was verified by WC #126 at the time of the observation. 3. A review of records for Resident #39 revealed an admitted [DATE]with diagnoses including obstructive uropathy. The resident had a supra-pubic catheter (a tube inserted directly into the bladder through the abdomen for urine drainage). Review of the care plan updated on 05/21/24 revealed Resident #39 is at risk for infection, and staff was to wear gown and gloves with high contact resident care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365855	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurie Ann Nursing Home	2200 Milton Boulevard Newton Falls, OH 44444

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 - Some	On 06/17/24 at 8:57 A.M. an observation of Resident #39 room revealed no EBP were in place. The observation was verified by WC #126 at the time of the observation. 4. A review of records for Resident #26 revealed an admitted [DATE] with diagnoses including retention of urine, unspecified. The resident had an indwelling urinary catheter. Review of the care plan revealed no interventions in place for EBP. On 06/17/24 at 9:00 A.M. an observation of Resident #26 room revealed no EBP were in place. The observation was verified by WC #126 at the time of the observation. On 06/17/24 at 10:00 A.M., an interview with the Director of Nursing (DON) revealed they did not have any residents in EBP as she was going to institute the precautions today. Review of CMS's QSO-24-08-NH dated 03/20/24 pertaining to Enhanced Barrier Precautions in Nursing Homes revealed CMS was issuing new guidance for State survey agencies and long-term care facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now included use of EBP's for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multi-drug resistant organism (MRDOs status. The new guidance related to EBP's was being incorporated into F880 Infection Prevention and Control. Guidance under F880 indicated EBP's referred to an infection control intervention designed to reduce transmission of multi-drug resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. EBP's were to be used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. Review of the undated facility policy on Enhanced Barrier Precautions (EBP) that revealed EBP should be in place for residents with indwelling medical devices and wounds. This deficiency represents non-compliance investigated under Complaint Number OH00154138