

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Pine Ridge Skilled Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  463 East Pike Street Morrow, OH 45152	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39967</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was provided with an adequate privacy curtain. This affected one (Resident #20) of one resident reviewed for privacy. The facility census was 47.</p> <p>Findings include:</p> <p>Review of Resident #20's chart revealed Resident #20 admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus without complications, congestive heart failure, hypothyroidism, hypertension, major depressive disorder, anxiety disorder, chronic kidney disease, insomnia, rheumatoid arthritis, cellulitis of right lower limb, acute respiratory failure with hypoxia, and unspecified psychosis not due to a substance or known physiological condition.</p> <p>Review of Resident #20's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact.</p> <p>Observation of Resident #20's room on 11/12/24 at 9:30 A.M. revealed the privacy curtain between Resident #20 and Resident #20's roommate's bed did not cover the whole track and there was a gap that was approximately two feet wide that was not covered on the privacy curtain track.</p> <p>Interview with Resident #20 on 11/12/24 at 9:30 A.M. revealed Resident #20's privacy curtain between her bed and her roommate's bed did not shut all the way. Resident #20 stated that she did not like that her privacy curtain did not shut all the way because she was always partially viewable to her roommate.</p> <p>Interview with the Director of Nursing (DON) on 11/13/24 at 12:30 P.M. verified the privacy curtain between Resident #20 and Resident #20's roommate's bed did not cover the whole track and there was a gap that was approximately two feet wide that was not covered on the privacy curtain track.</p> <p>Review of the facility's dignity policy dated August 2009 revealed staff shall promote, maintain and protect resident privacy including bodily privacy during assistance with personal care and during treatment procedures.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42492</p> <p>Based on interviews, medical record review, and policy review, the facility failed to ensure the provider and family were notified when medications were unavailable for administration as ordered. The affected two (Residents #42 and #20) of eight residents reviewed for notification. The facility census was 47.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included acute on chronic diastolic heart failure, stage three chronic kidney disease, and type two diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was cognitively intact, had no behaviors, did not wander, and did not reject care.</p> <p>Review of the medical record revealed progress notes dated 11/11/24, 11/04/24, 10/28/24, 10/21/24, 10/14/24, 10/07/24, and 09/30/24 revealed no documentation of family or provider notification that Ozempic medication was not available and was not given.</p> <p>During an interview on 11/12/24 at 9:36 A.M. Resident #42 and her daughter each stated they were unsure if Resident #42 had a current order for Ozempic medication because the resident was not receiving shots and they had not received any notification that the medication was discontinued.</p> <p>During an interview on 11/14/24 at 10:55 A.M. Assistant Director of Nursing (ADON) #92 verified Resident #42's medical record had no documentation regarding provider or family notification when Ozempic medications were not administered 11/11/24, 11/04/24, 10/28/24, 10/21/24, 10/14/24, 10/07/24, and 09/30/24.</p> <p>39967</p> <p>2. Review of Resident #20's chart revealed Resident #20 admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus without complications, congestive heart failure, hypothyroidism, hypertension, major depressive disorder, anxiety disorder, chronic kidney disease, insomnia, rheumatoid arthritis, cellulitis of right lower limb, acute respiratory failure with hypoxia, and unspecified psychosis not due to a substance or known physiological condition.</p> <p>Review of Resident #20's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact and required supervision with eating and oral hygiene. Resident #20 required maximal assistance with toileting, showering, lower body dressing, putting on and taking off footwear, rolling left and right, sitting to lying, lying to sitting, sitting to standing, chair transfers, toilet transfers, and tub transfers, and moderate assistance with upper body dressing, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #20's Medication Administration Record (MAR) from 09/01/24 to 11/13/24 revealed Resident #20 was ordered Trulicity subcutaneous solution pen injector 4.5 milligrams (mg) inject 4.5 mg in the morning every Thursday related to type two diabetes mellitus without complications on 05/02/24. Further review of Resident #20's MAR revealed Resident #20 did not receive her Trulicity 4.5 mg on 09/12/24, 10/24/24, and 10/31/24.</p> <p>Review of Resident #20's progress notes from 09/01/24 to 11/13/24 revealed no documentation related to Resident #20's Trulicity 4.5 mg not being given on 09/12/24, 10/24/24, and 10/31/24. There was also no documentation that Resident #20's physician was notified that Resident #20's Trulicity 4.5 mg was not given on 09/12/24, 10/24/24, and 10/31/24.</p> <p>Interview with Resident #20 on 11/12/24 at 9:30 A.M. revealed Resident #20 had not received her Trulicity.</p> <p>Interview with Director of Nursing (DON) on 11/13/24 at 2:13 P.M. verified Resident #20's Trulicity 4.5 mg was not given per the physician order on 09/12/24, 10/24/24, and 10/31/24 because it was not available at the facility. The DON also verified there was no documentation Resident #20's physician was notified Resident #20 did not receive her Trulicity 4.5 mg on 09/12/24, 10/24/24, and 10/31/24.</p> <p>Review of policy titled, Change in Condition &amp; Physician Notification Policy, dated 09/2020 revealed the nurse notified the physician and the resident/resident representative when there was a medication omission or a need to alter medications.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</b></p> <p>Based on interview, medical record review, and policy review, the facility failed to ensure residents had comprehensive care plans. This affected two (Residents #42 and #20) of eight residents reviewed for care plans. The facility census was 47.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #42 was admitted tot he facility on 08/06/24. Diagnoses included acute on chronic diastolic heart failure, stage three chronic kidney disease, and type two diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was cognitively intact, had no behaviors, did not wander, and did not reject care.</p> <p>Review of the care plan dated 08/08/24 revealed no care plans for diabetes, congestive heart failure, and chronic kidney failure.</p> <p>During an interview on 11/14/24 at 10:40 A.M. the Director of Nursing (DON) verified Resident #42's care plan was incomplete and did not address the resident's known medical conditions.</p> <p>39967</p> <p>2. Review of Resident #20's chart revealed Resident #20 admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus without complications, congestive heart failure, hypothyroidism, hypertension, major depressive disorder, anxiety disorder, chronic kidney disease, insomnia, rheumatoid arthritis, cellulitis of right lower limb, acute respiratory failure with hypoxia, and unspecified psychosis not due to a substance or known physiological condition.</p> <p>Review of Resident #20's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact and required supervision with eating and oral hygiene. Resident #20 required maximal assistance with toileting, showering, lower body dressing, putting on and taking off footwear, rolling left and right, sitting to lying, lying to sitting, sitting to standing, chair transfers, toilet transfers, and tub transfers, and moderate assistance with upper body dressing and personal hygiene. Resident #20 had minimal difficulty with hearing with no hearing aids.</p> <p>Review of Resident #20's ear care visit dated 06/29/24 revealed Resident #20 had hearing loss in both ears, but it was worse in the left ear. Resident #20 had a whisper test completed. Resident #20 could not hear the whisper test.</p> <p>Review of Resident #20's ear care visit dated 08/06/24 revealed Resident #20 had a perforated ear drum on the left side and a diagnosis of Eustachian tube dysfunction.</p> <p>Review of Resident #20's care plan on 11/13/24 revealed Resident #20 did not have a care plan for hearing impairment.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #20 on 11/12/24 at 9:35 A.M. revealed Resident #20 had difficulty hearing and needed hearing aids.</p> <p>Interview with the DON on 11/14/24 at 11:16 A.M. verified Resident #20 did not have a care plan for hearing impairment. The DON verified Resident #20 was listed as having hearing impairment on the 10/04/24 MDS.</p> <p>Review of policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016 revealed the facility developed and implemented a comprehensive care plan for each resident which incorporated identified problem areas and risk factors associated with identified problems.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42492</p> <p>Based on interviews, medical record review, and policy review, the facility failed to ensure medications were available and administered as ordered. This affected two (Residents #20 and #42) of five residents sampled for medications administration. The facility census was 47.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #42 was admitted tot he facility on 08/06/24. Diagnoses included acute on chronic diastolic heart failure, stage three chronic kidney disease, and type two diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was cognitively intact, had no behaviors, did not wander, and did not reject care.</p> <p>Review of the medical record revealed Resident #42 had physician orders dated 08/12/24 for Ozempic (0.25 or 0.5 milligram (mg)/dose) Subcutaneous Solution Pen-injector 2 mg/3 milliliters (ml) (Semaglutide) Inject 0.5 mg subcutaneously once weekly every Monday for Diabetes.</p> <p>Review of the Medication Administration Record (MAR) dated November 2024 revealed Resident #42 did not receive weekly Ozempic administrations on 11/04/24 and 11/11/24.</p> <p>Review of the MAR dated October 2024 revealed Resident #42 did not receive weekly Ozempic Administrations scheduled on 10/07/24, 10/14/24, 10/21/24, and 10/28/24.</p> <p>Review of the MAR dated September 2024 revealed Resident #42 did not receive Ozempic Administration as ordered on 09/30/24.</p> <p>Review of progress notes dated 11/11/24, 11/04/24, 10/28/24, 10/21/24, 10/14/24, 10/07/24, and 09/30/24 revealed Resident #42 did not receive Ozempic medication because the medications was not available form the pharmacy.</p> <p>During an interview on 11/12/24 at 9:36 A.M. Resident #42 and her daughter each stated Resident #42 had been giving herself a weekly shot at home for diabetes management and the facility had not been administering the medication. Both were unsure if the order was still active or had been discontinued.</p> <p>During an interview on 11/14/24 8:28 A.M. Assistant Director of Nursing (ADON) #92 verified Resident #42 had not received weekly Ozempic shots as ordered since September 2024 due to an error in the the electronic ordering process. The ADON stated nurses were expected to phone the pharmacy when medications were unavailable and stated no nurse had called the pharmacy to inquire why the medication was not available until the ADON called last week, date unspecified.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of policy titled, Medication Administration - General Guidelines, dated 11/2018 revealed medications were administered in accordance with written orders of the prescriber. When medications with an active, current order were not available, the facility contacted the pharmacy and documented an explanatory note in the electronic health record.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39967</p> <p>Based on observation, interview and record review, the facility failed to ensure food items, a kitchen dehumidifier, and the kitchen flooring were maintained in a manner to prevent foodborne illness. This affected 47 out of 47 residents that resided in the facility. The facility census was 47.</p> <p>Findings include:</p> <p>Observation of the kitchen on 11/12/24 at 8:31 A.M. revealed there was a black substance and a gray fuzzy substance on the dehumidifier in the kitchen. There was also black substance built up on the kitchen floor and a frozen pack of raw original bratwurst on a Styrofoam tray that was covered with plastic wrap in the freezer that was next to a bag of frozen asparagus.</p> <p>Interview with Dietary Supervisor #72 on 11/12/24 at 8:31 A.M. verified there was a black substance and a gray fuzzy substance on the dehumidifier in the kitchen. Dietary Supervisor #72 also verified there was also a black substance built up on the kitchen floor and a frozen pack of raw original bratwurst on a Styrofoam tray that was covered with plastic wrap in the freezer that was next to a bag of frozen asparagus.</p> <p>Observation of the room tray food cart on 11/12/24 at 11:44 A.M. revealed residents were served a piece of cake, chicken fettuccine Alfredo, vegetables, and a roll. The chicken fettuccine Alfredo, vegetables, and roll were covered but the cake was open to air on the food cart. Further observation of the food cart revealed a fly was sitting on a piece of cake in the food cart.</p> <p>Interview with Licensed Practical Nurse (LPN) #88 on 11/12/24 at 11:44 A.M. verified the cakes were uncovered in the food cart. LPN #88 also verified there was a fly on a piece of cake in the food cart.</p> <p>Review of the facility's undated dietary policy revealed food shall be prepared and served in a manner that meets the individual needs of each resident.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</b></p> <p>Based on observation, interview, medical record review and policy review, the facility failed to ensure appropriate signage was posted for residents in transmission-based and enhanced barrier precautions. This affected two (Residents #201 and #6) of two residents reviewed for infection control signage. The facility census was 47.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #201 was admitted to the facility on [DATE]. Diagnoses included chronic combined congestive heart failure, unspecified chronic obstructive pulmonary disease, unspecified pulmonary disease, and type two diabetes.</p> <p>Review of the medical record revealed on 11/05/24 revealed Resident #201 was assessed for mental status and was cognitively intact.</p> <p>Review of the medical record revealed Resident #201 had physician orders dated 11/06/24 for isolation precautions two times a day for c-diff toxin.</p> <p>Observation on 11/12/24 at 9:47 A.M. revealed Resident #201 was in his room with the door closed. There was a bin located outside of the room which contained Personal Protective Equipment (PPE), but there was no sign posted on door or any walls adjacent to the door to indicate transmission-based precautions.</p> <p>During an interview on 11/12/24 at 2:13 P.M. the Director of Nursing (DON) stated Resident #201 was a new admission with no wounds or medical devices and had no orders for transmission-based precautions. The DON checked the medical record, verified Resident #201 had order for isolation precautions for C-diff, and verified there was no sign for precautions posted on or near the resident's door.</p> <p>Review of policy titled, Isolation Precautions, dated August 2019 revealed when transmission-based isolation was implemented, a sign was placed on the door or doorframe directing visitors to see a nurse before entering the room.</p> <p>25908</p> <p>2. Resident #6 was readmitted to the facility on [DATE]. Diagnoses included insomnia, bipolar, and diabetes.</p> <p>Observations on 11/12/24 at 10:00 A.M. and 2:00 P.M. revealed a infection control cart outside Resident #6's room. No signage was noted on the door or on the cart.</p> <p>Interview with the DON on 11/12/24 at 2:13 P.M. revealed the resident was on Enhanced Barrier Precautions (EBP) due to a recent surgery with a JP (Jackson Pratt) tube in place.</p> <p>Review of the physician's orders for 11/12/24 revealed the resident should be in enhanced barrier precautions.</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 - Few</p>	<p>Review of the Enhanced Barrier Precautions policy dated 04/01/24 revealed the facility will implement a strategy to identify residents with EBP such as signage placed outside the room.</p>