STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365969	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anchor Lodge Nursing Home Inc	3756 W Erie Ave Lorain, OH 44053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review, the facility failed to ensure the accuracy of the medical record. This affected one (Resident #32) of six residents observed for medication administration. The facility census was 91.Findings Included:Review of the medical record revealed Resident #32 admitted to the facility on [DATE]. Diagnoses included asthma, major depressive disorder, dysphagia (difficulty swallowing) following a cerebral infarction (stroke), gastrostomy status (a surgical opening into the stomach to place a feeding tube), and epilepsy.Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2025, revealed Resident #32 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident had a feeding tube during the seven-day assessment look-back period.Review of Resident #32's Care Plan Report included a focus area revised 08/04/2025 indicating the resident had an altered nutritional status and received nothing by mouth (NPO). Interventions instructed staff to maintain the resident's NPO status (initiated 07/24/2025).Review of the physician order recap report for Resident #32 revealed an order dated 07/23/2025 for the resident to be NPO; however, the resident also had orders to administer the following medications by mouth (PO):-Keppra (anti-seizure medication) 500 milligrams (mg), give one tablet by mouth every morning and at bedtime, ordered 09/17/2025.-Lamictal (anti-seizure medication) 100 mg, give one table by mouth every morning and at bedtime, ordered 09/17/2025.-Tramadol 50 mg, give 50 mg by mouth every six hours as needed for chronic pain, ordered 10/27/2025.Review of Resident #32's Medication Administration Record (MAR) dated 11/2025, revealed the staff documented that the resident's Keppra, Lamictal, and Tramadol were administered by mouth.During medication administration observation on 12/03/2025 at 8:16 A.M., Licensed Practical Nurse (LPN) #5 administered Resident #32's Keppra via the feeding tube, not by mouth.During an interview on 12/03/2025 at 10:31 A.M., LPN #5 revealed Resident #32's orders were to give the medications by mouth; however, the resident did not take anything by mouth, and everyone knew the medications were given via the feeding tube. LPN #5 revealed the resident's MAR was inaccurate because it showed that the resident received the medications by mouth.During a telephone interview on 12/04/2025 at 9:38 A.M., LPN #8 also stated Resident #32 took all medications through the feeding tube and received nothing by mouth. She stated she was not aware that she was signing off that she gave Resident #32 medications by mouth. She stated that the MAR was not accurate because the resident received all medication via the feeding tube.During a telephone interview on 12/04/2025 at 8:01 A.M., Registered Nurse (RN) #9 stated Resident #32 took all medications via the feeding tube and nothing by mouth. She stated she had not realized she was signing off the medication was given by mouth and stated the medical record was not accurate.During an interview on 12/03/2025 at 4:05 P.M., the Clinical Coordinator #26 stated if a resident had orders for medications to be administered by mouth but they were not supposed to receive anything by mouth, she would contact the physician to get clarification. She stated Resident #32 did not take anything by mouth, and if the nurses were documenting Resident #32 received their medication by mouth, the resident's medical record was inaccurate. During an interview on 12/04/2025 at 8:37 A.M., the Director of Nursing (DON) stated the nurses should read medication orders completely and get clarification, if needed. She stated if the nurses were documenting that Resident #32 was receiving their medications by mouth, the medical record was inaccurate because the resident received nothing by mouth.During an interview on 12/04/2025 at 8:52 A.M., the Administrator stated she deferred all nursing questions to the DON but stated that she expected the staff to follow the facility's policy and procedures.Review of the facility policy titled, Medication Administration Policy, dated 03/2022, indicated, 2. The EMAR (electronic medical record) will be utilized to reference current orders to which medications are due for administration. The policy also revealed, 10. Any errors should be reported to the Director of Nursing, resident physician and resident/resident representative/POA (power of attorney).

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review, the facility failed to ensure staff wore proper personal protective equipment (PPE) when providing care. This affected one (Resident #32) of one resident reviewed for feeding tubes, who was on enhanced barrier precautions (EBP). The facility census was 91. Findings Included:Review of the medical record revealed Resident #32 was admitted on [DATE]. Diagnoses included oropharyngeal dysphagia (difficulty swallowing) following a cerebral infarction (stroke) and gastrostomy status (a surgical opening into the stomach to place a feeding tube).Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2025, revealed Resident #32 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident had a feeding tube and had received 51 percent or more of their total calories and 501 cubic centimeters (cc) or more of fluid through the feeding tube during the seven-day assessment look-back period.Review of Resident #32's Care Plan Report included a focus area initiated 10/08/2025 that indicated the need for enhanced barrier precautions (EBP) due to increased risk of multidrug resistant organism (MDRO) acquisition related to an indwelling medical device. Interventions directed staff to provide EBP related to the resident's feeding tube; and to don (put on) appropriate personal protective equipment (PPE) prior to providing high-contact resident care activities such as changing briefs or assisting with toileting and when using or providing care to the feeding tube (initiated 10/08/2025).Review of the physician orders recapitulation report for Resident #32 revealed an active order started on 10/08/2025 for EBP related to a percutaneous endoscopic gastrostomy tube (feeding tube). Observations on 12/03/2025 at 8:13 A.M. revealed Certified Nursing Assistant (CNA) #11 entered Resident #32's room wearing a mask. The CNA put on gloves once she entered the room but did not put on a gown. The observation revealed CNA #11 removed the resident's adult brief and provided incontinence care for the resident without wearing a gown.During an interview on 12/03/2025 at 10:36 A.M., CNA #11 revealed she was aware Resident #32 was on EBP and that she should have worn a gown when providing care because the resident had a feeding tube. CNA #11 also stated PPE was available behind the resident's door. According to CNA #11, she was nervous and forgot to wear a gown.Observations on 12/03/2025 at 8:30 A.M. , revealed Licensed Practical Nurse (LPN) #5 entered Resident #32's room and donned gloves but did not don a gown. During the observation, LPN #5 administered medication through the resident's feeding tube without wearing a gown.During an interview on 12/03/2025 at 10:31 A.M., LPN #5 stated she forgot Resident #32 was on EBP due to a feeding tube, until it was mentioned by the surveyor. LPN #5 stated she should have been wearing a gown when administering the resident's medications via the feeding tube.During an interview on 12/03/2025 at 4:05 P.M., the Clinical Coordinator #26 stated Resident #32 had a feeding tube and staff should use EBP, which included wearing a gown when providing care to the resident.During an interview on 12/04/2025 at 8:37 A.M., the Director of Nursing (DON) stated staff should wear a gown when providing care to a resident on EBP. She stated staff should have worn the proper PPE when providing care for Resident #32.During an interview on 12/04/2025 at 8:52 A.M., the Administrator stated she deferred all nursing questions to the DON but stated she expected the staff to follow the facility's policies and procedures. Review of the facility policy titled, Enhanced Barrier Precautions, dated 07/2022, indicated, It is the policy of the [corporate name] that enhanced-barrier precautions will be used in adjunct with standard precautions for residents known to be colonized or infected with a multi-drug-resistant organism (MDRO) as well as those at increased risk of MDRO acquisition. The policy also indicated, Enhanced Barrier Precautions: Are designed to reduce transmission of multidrug-resistant organisms. Enhanced Barrier Precautions (EBP) involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at risk of acquiring an MDRO (i.e. residents with wounds or indwelling medical devices). The policy revealed that Examples of high-contact resident care activities included Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator.