STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366008	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Pointe Healthcare Commu	Three Merit Dr Richmond Heights, OH 44143

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on record review, interview, and review of the facility policy the facility failed to ensure care planned interventions were timely implemented for treatments for Resident #156's unstageable sacral pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed). This affected one resident (#156) out of three residents reviewed for wounds. The facility census was 154. Findings include: Review of Resident #156's medical record revealed an admitted [DATE] with diagnoses including sepsis, pneumonia, type two diabetes mellitus with diabetic chronic kidney disease, and diabetic polyneuropathy. Resident #156 had dependence on renal dialysis. Resident #156 was discharged from the facility to another skilled nursing facility on 05/01/24. Review of Resident #156's After Visit Summary and Clinical Summary dated 04/06/24 through 04/21/24 included Resident #156 was admitted to the hospital with diabetic ketoacidosis without coma associated with other specified diabetes mellitus, end stage renal disease, Influenza A, pneumonia of both lungs due to infectious organism, unspecified part of lung, and bacteremia due to gram-negative bacteria. There were no orders for treatments to Resident #156's coccyx pressure ulcer. Review of Resident #156's Nursing Admission Evaluation dated 04/21/24 at 6:55 P.M. included Resident #156 had a coccyx pressure ulcer, Stage III (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).The length was 8.0 centimeters (cm), width was 3.0 cm, and depth was not noted. The evaluation stated Resident #156 had treatment orders in place (he did not have treatment orders). Review of Resident #156's progress notes dated 04/21/24 at 7:01 P.M. revealed Resident #156 arrived at the facility via stretcher from the local hospital and his daughter and sister-in-law were at the bedside. Licensed Practical Nurse (LPN) #379 stated she did not receive report on Resident #156. Review of Resident #156's physician orders dated 04/21/24 at 7:01 P.M. revealed orders for a wound care consult. Further review did not reveal orders for treatment of Resident #156's sacral pressure ulcer. (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #156's progress notes dated 04/21/24 at 11:36 P.M. revealed Telehealth Notification notes including Resident #156 was a new admission, alert and oriented times three (person, place, time), and medications were reviewed with the nurse. Review of Resident #156's progress notes dated 04/21/24 at 11:46 P.M. included LPN #425 verified Resident #156's medications with Telehealth on call and okay to continue discharge orders, all orders were entered in the electronic system at this time. Review of Resident #156's progress notes dated 04/21/24 through 04/23/24 did not reveal evidence Resident #156's sacral pressure ulcer was monitored daily and observed for dressings, drainage, or appearance of the wound. There was no documented evidence treatments were completed. Review of Resident #156's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 04/21/24 through 04/24/24 revealed no documented evidence treatments were completed for Resident #156's sacral pressure ulcer. Review of Resident #156's physician encounter notes dated 04/22/24 at 1:00 A.M. and written by Certified Nurse Practitioner (CNP) #320 included this was a new patient visit, Resident #156 was a full code, and was admitted to the facility on [DATE] (he was admitted to the facility on [DATE]). Resident #156 had a past medical history of sepsis, pneumonia, type two diabetes mellitus, and end-stage renal disease with hemodialysis. Resident #156 was lying in his bed upon arrival, he was pleasant and appropriate and reported having pain in his buttocks. Resident #156 stated he was living at home, was independent, developed pneumonia and sepsis, became extremely weak and was unable to ambulate. Resident #156 reported he became incontinent of both bowel and bladder and often sat in his stool which led to breakdown of the skin on his buttocks. Further review of Resident #156's encounter notes plan did not reveal treatment orders for his coccyx (sacral) pressure ulcer. Review of Resident #156's care plan dated 04/22/24 included Resident #156 had impaired skin integrity of the sacrum. Resident #156 would have improved or maintained current skin status through the next review date. Interventions included administering treatments as ordered by the medical provider. Review of Resident #156's skin and wound note dated 04/23/24 at 5:35 P.M. included the reason for the visit was Resident #156 was a new admission to the facility and the visit was for a skin and wound assessment. Resident #156 presented to the facility upon admission with an unstageable pressure ulcer to the sacrum. The sacral pressure ulcer measurements were length 2.0 cm, width 1.5 cm and depth 0 cm. The wound base was one to 24 percent granulation and 75 to 99 percent slough and had a moderate amount of serous drainage. Treatment recommendations were cleanse with normal saline, apply medical grade honey, calcium alginate to the base of the wound, and secure with bordered foam. Change daily and as needed. Review of Resident #156's TAR dated 04/24/24 revealed treatment order for the sacrum, cleanse with normal saline, pat dry, apply Medihoney gel to wound bed followed by calcium alginate, and cover with foam daily and as needed every night shift. Further review of Resident #156's TAR revealed on 04/26/24 and 04/30/24 there was no documented evidence treatments were completed or reason why they were not completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/20/24 at 5:23 P.M. of the Director of Nursing (DON) and Unit Manager (UM) #386 confirmed Resident #156 did not have treatment orders for his unstageable sacral pressure ulcer from 04/21/24 until 04/23/24 at 5:35 P.M. The DON and UM #386 confirmed Resident #156's TAR did not have documented evidence treatments were completed for his sacral pressure ulcer on 04/26/24 and 04/30/24. Interview on 06/21/24 at 10:24 A.M. of Certified Nurse Practitioner (CNP) #320 confirmed Resident #156 did not have treatment orders from 04/21/24 through 04/23/24 for his unstageable sacral pressure ulcer, and the nurse should have received treatment orders when Resident #156's orders were verified with the Telehealth Nurse Practitioner when he was admitted . Review of the facility policy titled Skin Care and Wound Management Overview, dated 07/01/16, included the skin and wound management program included application of treatment protocols based on clinical best practice standards for promoting wound healing, daily monitoring of existing wounds. Obtain a physician order for treatment and document the treatment on the TAR. This deficient practice represents non-compliance investigated under Master Complaint Number OH00154408.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review, and review of the facility policy the facility failed to ensure Resident #156 had individualized care planned interventions for falls, failed to ensure a thorough investigation and accurate follow up evaluation after a fall. This affected one resident (#156) out of three residents reviewed for accidents. The facility census was 154. Findings include: Review of Resident #156's medical record revealed an admitted [DATE] with diagnoses including sepsis, pneumonia, type two diabetes mellitus with diabetic chronic kidney disease and diabetic polyneuropathy. Resident #156 had dependence on renal dialysis. Resident #156 was discharged from the facility to another skilled nursing facility on 05/01/24. Review of Resident #156's After Visit Summary and Clinical Summary dated 04/06/24 through 04/21/24 included Resident #156 was admitted to the hospital with diabetic ketoacidosis without coma associated with other specified diabetes mellitus, end stage renal disease, Influenza A, pneumonia of both lungs due to infectious organism, unspecified part of lung, and bacteremia due to gram-negative bacteria. Review of Resident #156's progress notes dated 04/21/24 at 7:01 P.M. revealed Resident #156 arrived at the facility via stretcher from the local hospital and his daughter and sister-in-law were at the bedside. Licensed Practical Nurse (LPN) #379 stated she did not receive report on Resident #156. Review of Resident #156's progress notes dated 04/21/24 at 11:36 P.M. revealed Telehealth Notification notes including Resident #156 was a new admission, alert and oriented times three (person, place, time), and medications were reviewed with the nurse. Review of Resident #156's progress notes dated 04/21/24 at 11:46 P.M. included LPN #425 verified Resident #156's medications with Telehealth on call and okay to continue discharge orders, all orders were entered in the electronic system at this time. Review of Resident #156's Nursing Admission Evaluation dated 04/21/24 included Resident #156 was at risk for falls. Review of Resident #156's care plan dated 04/22/24 included Resident #156 was at risk for falls due to polyneuropathy. Resident #156 would not sustain major injury related to falls through the review date. Resident #156 would be without falls through the review date. Interventions included assessing for falls on admission, readmission, quarterly and as needed; ensure Resident #156 was wearing appropriate non-skid footwear; initiate neurological checks if fall was unwitnessed, or the head was involved. Further review of Resident #156's care plan did not reveal interventions related to falls and Resident #156's confusion, disorientation, and dizziness. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #156's Physical Therapy noted dated 04/23/24 and signed at 2:36 P.M. by Physical Therapist (PT) #361 included Resident #156 tolerated functional mobility poorly this date stating dizziness and generalized pain. Resident #156 complained of buttock pain while in the w/c (wheelchair) and a two-inch cushion was added. Resident #156 reported mild relief. There was no documented evidence Resident #156's nurse was notified of Resident #156's pain or dizziness. Review of Resident #156's progress notes dated 04/25/24 at 5:22 P.M. included Resident #156 was alert and oriented times three (time, place, person). Review of Resident #156's progress notes dated 04/26/24 at 5:06 P.M. included Resident #156 was confused and disoriented. There was no further documentation regarding Resident #156's confusion and disorientation. Review of Resident #156's physician orders dated 04/26/24 at 5:23 P.M. revealed orthostatic hypertension (hypotension) times one, NOW, measure blood pressure and heart rate while Resident #156 was supine (lying on his back), one time only for one day. Orthostatic hypertension (hypotension) have the patient stand and measure blood pressure and heart rate again, one time only for one day. Review of Resident #156's Treatment Administration Record (TAR) dated 04/26/24 did not reveal documented evidence Resident #156's blood pressure and heart rate were checked for orthostatic hypotension as ordered by the physician. The area on the TAR on 04/26/24 for documentation of Resident #156's blood pressure and heart rate was not completed. Review of Resident #156's progress notes and vital signs tab on 04/26/24 in the electronic record did not reveal documented evidence Resident #156's blood pressure and heart rate were checked as ordered by the physician. The progress notes did not have documentation regarding why the orthostatic hypotension checks for blood pressure and heart rate were ordered, or why they were not completed on 04/26/24. Further review revealed on 04/27/24 at 1:35 P.M. (20 hours after the order was given, and 10 hours after Resident #156's fall) Resident #156's blood pressure and heart rate were checked for orthostatic hypotension, and the results were negative for orthostatic hypotension. Review of Resident #156's Follow up Report (should have been fall investigation per the Director of Nursing (DON)) dated 04/27/24 at 3:30 A.M. included around 3:30 A.M. Resident #156 attempted to use the bathroom, while standing up his blanket wrapped around his foot, and he slid across the floor and landed on his buttocks. A head-to-toe assessment was completed with no sign of injury noted, vital signs stable, and the on-call Nurse Practitioner was notified with no new orders. Further review revealed no injuries noted with unwitnessed fall, and neurological checks were not being done. The Follow Up Report did not specify what Resident #156 was wearing on his feet, if anything, and it only had one witness statement written by LPN #433 and did not include the aide witness statement who found Resident #156 on the floor. Further review revealed the form stated no noted drop between lying and standing blood pressure, but there was no lying and standing blood pressure documented on the form. Resident #156's lying and standing blood pressure and heart rate were not checked until 04/27/24 at 1:35 P.M. Resident #156 had a balance problem while walking. Review of Resident #156's witness statement undated written by LPN #433 revealed Resident #156 was found on the floor by the State tested Nursing Assistant (STNA). Resident #156 was lying on the floor asleep with his blanket. LPN #433 stated she did not witness a fall, nor did she hear calls for help. Resident #156's door was always open unless family was visiting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #156's progress notes dated 04/27/24 at 8:08 A.M. revealed on 04/27/24 around 3:30 A. M. Resident #156 attempted to use the bathroom, and while standing up his blanket wrapped around his foot, and he slid across the floor and landed on his buttocks. Head-to-toe assessment was completed, no signs of injury were noted, vital signs were stable, and the on-call Nurse Practitioner was notified with no new orders. Review of Resident #156's progress notes dated 04/27/24 at 10:30 A.M. included the post fall evaluation stated no injuries noted related to the unwitnessed fall, and Resident #156 was not transferred to the hospital. Review of Resident #156's Grievance Form dated 04/29/24 revealed Resident #156 stated no one answered him, he was yelling and could not find his call light. Unit Manager (UM) #386 was given the grievance and the resolution of the grievance was verified with a staff member that Resident #156 had a fall. The writing on the grievance form was difficult to read, and the rest of the fall resolution could not be read. Review of Resident #156's physician progress notes dated 05/01/24 at 5:59 A.M. and written by Physician #492 revealed the service date was 04/26/24 and it was an initial encounter for physical medicine and rehabilitation. The notes included Physiatry, Physical Medicine, and Rehabilitation consult was requested for management of decline in function with impaired mobility and self-care. Resident #156 was seen in room for interdisciplinary meeting and then individually with Resident #156 and his sister following the meeting. Resident #156's sister stated that Resident #156's encephalopathy and confusion had been slowly improving. Resident #156 reported dizziness upon change of position or standing, and it was difficult for Resident #156 to describe his dizziness and he denied the room spinning or syncopal (fainting) feelings. Resident #156 would require close monitoring for altered mental status, fever, and or leukocytosis that would indicate recurrent or worsening state. Interview on 06/24/24 at 9:15 A.M. of Director of Social Services (DSS) #485 revealed Resident #156's care conference was on 04/26/24 and attendees included DSS #485, Resident #156's sister, Physician #492, therapy, and UM #386. DSS #485 stated a number of things were discussed, including Resident #156 was feeling weak, therapy was working with him, his balance needed improvement, and he was also dizzy. DSS #485 stated the family filed a grievance on 04/29/24 and the grievance included Resident #156 had a fall and was yelling out for help because he could not find his call light. DSS #485 revealed Resident #156's family wanted him transferred because of concerns regarding his care. Interview on 06/24/24 at 9:57 A.M. of Certified Nurse Practitioner (CNP) #320 revealed she did not know anything about Resident #156's order to check for orthostatic hypotension, and there was no documentation explaining why it was ordered by Medical Director #494. CNP #320 stated if the order said the blood pressure and heart rate needed checked NOW then it should have been done as ordered. CNP #320 indicated Resident #156's dizziness was not brought to her attention, and there should have been precautions in place. Interview on 06/24/24 at 11:41 A.M. of Physician #492 revealed his first visit with Resident #156 was on 04/26/24. Physician #492 stated Resident #156 was admitted with sepsis, pneumonia, and he had a sacral pressure ulcer which was causing him a lot of pain. Physician #492 stated his main objective was to control Resident #156's pain, and he was having dizziness as well. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/24/24 at 12:04 P.M. of Medical Director (MD) #494 revealed he did not remember details about Resident #156 or why he ordered him to be checked for orthostatic hypotension, but it should have been done when he ordered it. MD #494 stated Resident #156's dizziness was probably caused by medications he was taking for heart failure. MD #494 indicated if Resident #156's orthostatic hypotension was positive it could have contributed to his fall. Interview on 06/24/24 at 4:20 P.M. of the Director of Nursing (DON) revealed LPN #497 no longer worked at the facility and could not be contacted to ask why Resident #156's blood pressure and heart rate were not checked for orthostatic hypotension. The DON stated on 04/26/24, Resident #156's blood pressure and heart rate were not checked for orthostatic hypotension, and she did not know why. The DON confirmed Resident #156's fall investigation did not include a witness statement from the aide, and it should have been included. The DON confirmed the fall investigation stated there was no noted drop in Resident #156's blood pressure from lying to standing and she did not know how that could be documented because there was no documentation Resident #156's blood pressure was taken while lying and standing. The DON confirmed the nurse who initiated the fall investigation used the post fall investigation instead of the fall investigation and it was completed by three different nurses and only one nurse (LPN #433) should have completed the form. The DON confirmed neurological checks were not completed after Resident #156's fall and they should have been initiated because the fall was unwitnessed. The DON confirmed UM #386 checked the box on the fall investigation form for neurological checks as not applicable, but that was incorrect. The DON stated interventions and notifications should have been done. Review of the facility policy titled Fall Prevention and Management, dated 05/25/21, included if the resident was identified to be at risk for falls, a care plan should be initiated that included a plan to potentially diminish the risk for falls. The care plan should include interventions that address environmental factors, activities of daily living (ADL) factors, risk factors that result from dementia and other mental diagnosis, medical diagnosis that put the resident at higher risk. Issues such as toileting, eating, transferring, and impulsiveness should be considered. The care plan can address furniture arrangements, footwear, medications that can cause dizziness, drowsiness, and instability. If the resident hit their head or it was an unwitnessed fall begin neuro checks per the neuro checks policy. Identify if there were any witnesses to the fall. Ask the witnesses what they saw and have them write a statement if possible. Complete the Post Fall Assessment and complete a Fall Follow Up UDA every shift for 72 hours. This deficient practice represents non-compliance investigated under Master Complaint Number OH00154408.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on record review, review of facility policy and interview the facility failed to develop and implement a comprehensive and effective pain management program for Resident #156, including a comprehensive pain assessment and effective interventions to timely treat the resident's pain. This affected one resident (#156) of three residents reviewed for pain. The facility census was 154. Actual Harm occurred on 04/21/24 when Resident #156, who was admitted to the facility with an unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcer to the sacrum, experienced moderate to severe/unbearable pain, difficulty with seated positioning, difficulty sleeping at night and pain that interfered with therapy activities and ability to complete hemodialysis treatments due to the lack of effective pain management interventions (including the administration of pain medication). Pain medication was not ordered for the resident until 04/24/24, and Resident #156 was not administered any pain medication until 04/26/24 at bedtime. Findings include: Review of Resident #156's closed medical record revealed an admitted [DATE] with diagnoses including sepsis, pneumonia, type two diabetes mellitus with diabetic chronic kidney disease, and diabetic polyneuropathy. Resident #156 had dependence on renal dialysis. Resident #156 was discharged from the facility to another skilled nursing facility on 05/01/24. Review of Resident #156's After Visit Summary and Clinical Summary dated 04/06/24 through 04/21/24 included Resident #156 was admitted to the hospital with diabetic ketoacidosis without coma associated with other specified diabetes mellitus, end stage renal disease, Influenza A, pneumonia of both lungs due to infectious organism, unspecified part of lung, and bacteremia due to gram-negative bacteria. There were no orders for pain medication. Review of Resident #156's progress note dated 04/21/24 at 7:01 P.M. revealed Resident #156 arrived at the facility via stretcher from the local hospital, and his daughter and sister-in-law were at the bedside. Licensed Practical Nurse (LPN) #379 noted she did not receive report on Resident #156. Review of Resident #156's progress note dated 04/21/24 at 11:36 P.M. revealed Telehealth Notification notes including Resident #156 was a new admission, alert and oriented times three (person, place, time), and medications were reviewed with the nurse. Review of Resident #156's progress note dated 04/21/24 at 11:46 P.M. included Licensed LPN #425 verified Resident #156's medications with Telehealth on call and okay to continue discharge orders, all orders were entered in the electronic system at this time. Review of Resident #156's Medication Administration Record (MAR) dated 04/22/24 through 05/01/24 revealed to monitor for pain every shift. There were check marks for each shift, but there was no pain rating using a scale of one to ten, zero indicating no pain, and ten indicating the worst pain, and it was unable to be determined if Resident #156 had pain based on the review of the MAR. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #156's care plan dated 04/22/24 revealed Resident #156 had complaints of acute, chronic pain or was at risk for pain due to polyneuropathy. The care plan revealed Resident #156 would be able to verbalize relief of pain through the target date of 07/21/24. Interventions included to administer non-pharmacological interventions such as repositioning, relaxation techniques; to complete a pain assessment as needed; to follow physician orders for complaints of pain; to observe for pain every shift; provide medication per orders and monitor for signs and symptoms of side effects and evaluate the effectiveness of the medication. Review of Resident #156's physician encounter notes dated 04/22/24 at 1:00 A.M. and written by Certified Nurse Practitioner (CNP) #320 included this was a new patient visit, Resident #156 was a full code, and was admitted to the facility on [DATE] (he was admitted to the facility on [DATE]). Resident #156 had a past medical history of sepsis, pneumonia, type two diabetes mellitus, and end-stage renal disease with hemodialysis. Resident #156 was lying in his bed upon arrival, he was pleasant and appropriate and reported having pain to his buttocks. Resident #156 stated he was living at home, was independent, developed pneumonia and sepsis, became extremely weak and was unable to ambulate. Resident #156 reported he became incontinent of both bowel and bladder and often sat in his stool which led to breakdown of the skin on his buttocks. Further review of Resident #156's encounter notes plan did not reveal orders for pain medication. Review of Resident #156's progress notes dated 04/22/24 at 8:42 A.M. included Resident #156 arrived at the facility on 04/21/24 at 6:55 P.M. and was accompanied by his family. Resident #156 had an open pressure wound to the coccyx. Resident #156's medications were verified. Review of Resident #156's Physical Therapy note dated 04/23/24 and signed at 2:36 P.M. by Physical Therapist (PT) #361 included Resident #156 tolerated functional mobility poorly this date stating dizziness and generalized pain. Resident #156 complained of buttock pain while in the w/c (wheelchair) and a two-inch cushion was added. Resident #156 reported mild relief. There was no evidence Resident #156's nurse was notified of Resident #156's pain. Record review revealed there was no care plan for pain related to Resident #156's unstageable sacral pressure ulcer. Review of Resident #156's skin and wound progress note dated 04/23/24 at 5:35 P.M. and written by Certified Nurse Practitioner (CNP) #491 included the reason for the visit was Resident #156 was a new admission to the facility and needed a skin and wound assessment. Resident #156 presented upon admission with an unstageable pressure ulcer to the sacrum with a length of 2.0 centimeters (cm), width of 1. 5 cm and depth was 0 cm. The wound base was 1 to 24 percent granulation tissue and 75 to 99 percent slough. Resident #156's wound pain at rest was a 3. Resident #156's Skin and Wound Plan did not include orders for pain medication. Review of Resident #156's physician encounter notes dated 04/24/24 at 1:00 A.M. written by CNP #320 included Resident #156 was sitting in his room upon arrival and continued to report he was having unbearable pain to his sacral area. Resident #156 had an unstageable wound to the sacral area. Discussed medication options with Resident #156 and he stated he was willing to try anything. Further review revealed a plan for Tramadol HCl oral tablet 50 milligrams (mg), give one tablet by mouth every six hours as needed for mild pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #156's physician orders dated 04/24/24 at 9:30 A.M. revealed the order for Tramadol HCl oral tablet 50 mg, give one tablet by mouth every six hours as needed for mild pain was written. Review of Resident #156's MAR did not reveal evidence Resident #156 received Tramadol 50 mg by mouth for pain from 04/24/24 through 04/28/24 at 12:25 P.M. Review of Resident #156's Occupation Therapy notes written by OT (Occupational Therapist) #357 and signed on 04/24/24 at 5:09 P.M. included Resident #156 was seated in a dialysis chair at the start of the session and stating he had pain everywhere. There was no evidence Resident #156's nurse was notified Resident #156 had pain. Review of Resident #156's Care Conference note dated 04/26/24 at 11:11 A.M. included physiotherapy barriers to Resident #156's improvement were dizziness and pain. Attendees to Resident #156's care conference included Resident #156's sister, Licensed Independent Social Worker (LISW) #485, Physician #492 and PT #361. Review of Resident #156's Speech Therapy notes dated 04/26/24 and signed at 1:21 P.M. by SLP (Speech Language Pathologist) #348 included Resident #156 struggled to maintain positioning due to wound on bottom which was causing significant pain. Resident #156's sister reported the physician was in and had plans to better address pain going forward. Review of Resident #156's MDS note dated 04/26/24 at 2:55 P.M. revealed Resident #156 reported having pain of nine out of ten during the MDS look-back period. The nurse on duty was notified of Resident #156's complaints of pain. Review of Resident #156's nursing progress note dated 04/26/24 at 2:55 P.M. did not reveal evidence Resident #156's pain was evaluated by a nurse or pain medication was administered. Review of Resident #156's physician orders dated 04/26/24 at 5:22 P.M. revealed an order for Percocet (oxycodone with acetaminophen) oral tablet 5-325 mg, give one tablet every morning and at bedtime for moderate pain. Review of Resident #156's MAR did not reveal evidence he received pain medication (acetaminophen, Tramadol or Percocet) for reports of pain of nine out of a ten on a pain scale of zero to ten, zero being no pain and ten indicating the worst pain, until 04/26/24 at HS (bedtime). On 04/26/24 between 8:00 P.M. and 10:00 P.M. Resident #156 received Percocet oral tablet 5-325 mg. Resident #156's pain rating was marked as zero when Percocet was administered. Review of Resident #156's progress notes dated 04/27/24 at 11:16 A.M. revealed the nurse spoke with MD #494. Pharmacy was contacted and would be contacting MD #494 for verbal prescription. The note did not specify what the verbal prescription was. Resident #156 notified. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #156's 5-day MDS 3.0 assessment dated [DATE] revealed Resident #156 was cognitively intact. The assessment revealed Resident #156 received a scheduled pain medication regimen. Resident #156 had pain or was hurting in the last five days, the pain almost constantly made it hard for him to sleep at night, and the pain occasionally interfered with therapy activities. Resident #156 rated the worst pain he experienced over the last five days as a nine on a scale of zero to ten, zero being no pain and ten being the worst pain he could imagine. Review of Resident #156's physician encounter note dated 04/29/24 at 1:00 A.M. included Resident #156 shortened his hemodialysis session today as his sacral pain was unbearable while sitting in the dialysis chair. Resident #156 had an unstageable sacral wound and was followed by wound care and the wound nurse practitioner. Resident #156 and his sister reported that Resident #156 had better managed pain with topical treatments as opposed to the systemic medication that he had. Resident #156 was scheduled Percocet with Tramadol as needed. Resident #156 reported that he got no relief from the Tramadol and minimal relief from the Percocet. Resident #156 was open to having a referral to pain management. Resident #156's pain level was a seven, and he was lying on his left side with a furrowed brown with intermittent moaning and rocking. Resident #156's plan was to coordinate care with physiatrist and continue Percocet oral tablet 5-325 mg (oxycodone with acetaminophen), give one tablet by mouth every morning and at bedtime for moderate pain. Continue to encourage Resident #156 to lay on alternating sides and consult pain management. The goal was Resident #156 would not report unmanageable pain. Review of Resident #156's OT notes written by OT #357 and signed on 04/29/24 at 4:15 P.M. included Resident #156 was lying supine at the start of the session, no noted pain, but had increased dizziness and fatigue. During therapy Resident #156 suddenly threw himself down onto the bed yelling I am just too dizzy! I hurt! There was no evidence in the notes Resident #156's nurse was notified he was in pain. Review of Resident #156's MAR dated 04/29/24 revealed Resident #156's bedtime Percocet tablet was not given. Resident #156's pain level was documented as a zero. Review of Resident #156's progress notes dated 04/29/24 at 10:52 P.M. revealed Resident #156's Percocet tablet was not given due to it being on order. Further review did not reveal evidence Resident #156's physician was notified he did not receive the Percocet per physician order. Review of Resident #156's MAR dated 04/29/24 at 10:52 P.M. revealed Tramadol 50 mg oral tablet was administered, and Resident #156's pain level was marked as zero. Review of Resident #156's Grievance Form dated 04/29/24 included Resident #156's family stated Resident #156 was not receiving his pain medication. Unit Manager (UM) #386 followed up on the grievance, and wrote the nurse was educated that when a substance order was taken, a prescription must be initiated, but did not state what the substance was. Review of Resident #156's MAR dated 04/30/24 revealed Resident #156's Percocet was not given as ordered in the morning, and there was no pain level documented. Review of Resident #156's MAR dated 04/30/24 at 8:01 A.M. revealed Tramadol 50 mg oral tablet was administered, and Resident #156's pain level was rated at an eight on a scale of zero to ten, ten being the worst pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #156's progress note dated 04/30/24 at 9:55 A.M. revealed Percocet tablet was not given due to awaiting written prescription to be faxed to pharmacy. There was no evidence Resident #156's physician was contacted regarding the need for a written prescription. Further review did not reveal evidence Resident #156's physician was notified he did not receive the Percocet per physician order. Review of Resident #156's PT notes written by PT #361 and signed on 04/30/24 at 1:31 P.M. included Resident #156 was originally not agreeable to therapy stating he did not receive his Percocet today, and he remained dizzy with mobility. Review of Resident #156's physician encounter notes written by CNP #320 dated 05/01/24 at 1:00 A.M. included Resident #156 was being discharged from the facility today (05/01/24) and nursing reported Resident #156 declined going to dialysis today. Resident #156 was lying on his bed upon arrival and his sister was present. Resident #156 reported he was unable to tolerate his pain and would wait until he was transferred to resume dialysis. Resident #156's pain level was a five. Review of Resident #156's physician progress note dated 05/01/24 at 5:59 A.M. and written by Physician #492 revealed the service date was 04/26/24 and it was an initial encounter for physical medicine and rehabilitation. The notes included Physiatry, Physical Medicine and Rehabilitation consult was requested for management of decline in function with impaired mobility and self-care. Resident #156 was seen in room for interdisciplinary meeting and then individually with Resident #156 and his sister following the meeting. Resident #156's main concern today was the pain from his sacral ulcer that prevented him from being able to sit up for long periods of time or fully participate in therapies. Resident #156 also expressed that he was unable to complete full sessions of HD (hemodialysis) due to the pain and even expressed his desire to potentially discontinue dialysis. Resident #156's pain was severe sacral pain without radiation and was a deep ache with occasional sharpness. Resident #156 reported minimal relief with current pain regimen of Percocet 5-325 mg (Resident #156 did not have Percocet ordered until 04/26/24 at 5:22 P.M.) and tramadol (ordered on 04/24/24 and first dose of Tramadol was not administered until 04/28/24 at 12:25 P.M.) every six hours as needed. Resident #156 reported insomnia and sleeping difficulty mainly due to his pain. Pain and opioid management evaluation was continuing to monitor Resident #156's pain closely. Percocet 5-325 mg two times a day for pain control. Monitor for pain and effect on therapy progress and tolerance. Review of Resident #156's progress note dated 05/01/24 at 8:37 A.M. and written by Physician #492 revealed the service date was 04/29/24 included Resident #156 was seen in room briefly while working with therapy and then later in the morning with Resident #156's sister present. Resident #156's sister expressed significant concern for Resident #156's care during his stay. Resident #156 continued to have significant pain in his sacrum that was severe today. Attempted trials with donut pillow brought to facility by the family were unsuccessful, and he was still unable to tolerate any sitting. Resident #156's pain medication was discussed, and the plan was to increase Percocet to 10-650 mg. Updates for 04/29/24 included Resident #156's sacral pain was still uncontrolled, and Percocet would be increased to 10-650 mg twice a day. Discussed need for slow titration of medication as Resident #156 was on HD (hemodialysis) and was at higher risk for adverse reactions such as somnolence and respiratory depression. Monitor for pain and effect on therapy progress and tolerance. Monitor closely for side effects and discontinue medication immediately if any signs and symptoms are present. Review of Resident #156's physician orders, MAR, and nursing progress notes dated 04/29/24 through 05/01/24 did not reveal orders for Percocet 10-650 mg to be administered twice a day. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #156's OT Discharge Summary dated 05/02/24 at 4:36 P.M. included no progress was made while on therapy services due to short treatment duration. Resident #156 met no goals at this time with barriers due to decreased activity tolerance and limited ability to participate in treatment sessions due to increased pain and fatigue. Review of Resident #156's nursing progress notes dated 04/21/24 through 05/01/24 did not reveal non-pharmacological interventions for pain control such as turning to relieve pain. Interview on 06/20/24 at 11:42 A.M. of the Director of Nursing (DON) revealed when a resident was admitted to the facility, orders should be verified by the physician. The DON stated orders should be verified as soon as possible because the sooner the resident's medications were in the system the sooner pharmacy could send them. The DON indicated if a resident had a medication ordered and it was available in the on hand medications in the automated medication dispensing system, the medication should be given, and the nurses should not wait until pharmacy delivered the medications. Interview on 06/20/24 at 5:23 P.M. of UM #386 revealed she did not know anything about Resident #156's pain or not having pain medication ordered. Interview on 06/21/24 at 10:24 A.M. of CNP #320 confirmed Resident #156 did not have pain medications ordered when he was admitted to the facility. CNP #320 stated it was absolutely a miss on my part. CNP #320 stated for renal residents she usually started with Tylenol and worked up to tramadol or stronger pain medications as needed. CNP #320 confirmed she wrote a progress note on 04/22/24 and it stated Resident #156 had pain in the buttocks and a note on 04/24/24 stating Resident #156 had unbearable pain. CNP #320 revealed she remembered Resident #156, he had difficulty moving due to pain, could not tolerate dialysis, and there was talk of getting a donut for him to sit on during dialysis. Interview on 06/24/24 at 6:50 A.M. of LPN #433 revealed when Resident #156 was admitted to the facility on [DATE] it was a very busy and chaotic night, and she was the only nurse on the nursing unit Resident #156 resided on. LPN #433 stated she did not remember many details about Resident #156, but she always checked newly admitted resident's admission orders for narcotics and if narcotics were ordered she called the resident's physician right away so the residents could receive pain medications as needed. LPN #433 stated another nurse verified Resident #156's medications with the physician and she did not know what medications were ordered. LPN #433 indicated it was very time consuming to admit a resident, verify the medications, and have all the paperwork and forms completed, and she often had to choose between finishing the admitting information or passing medications to the residents residing on the nursing unit she was assigned to. Interview on 06/24/24 at 9:15 A.M. of LISW #485 revealed Resident #156 had a grievance filed on 04/29/24 and included in the grievance was Resident #156 and his family were upset the resident did not receive his pain medications. DSS #485 stated Resident #156's family wanted him transferred (to another facility) because of concerns with his care. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/24/24 at 9:57 A.M. with CNP #320 revealed she missed ordering Resident #156's pain medication, but the nurses did not tell her Resident #156 had pain. CNP #320 stated Resident #156 did not want to go to dialysis because of the pain from his sacral wound. CNP #320 stated Physician #492 was a physiatrist and helped manage Resident #156's pain, but she was not sure if he ordered anything for pain. CNP #320 indicated MD #494 ordered Percocet, but there was no documentation in Resident #156's progress notes how we got to the Percocet. CNP #320 stated she told the nurses about the pain referral, they did not do it, and she could not remember which nurse she told. Interview on 06/24/24 at 11:41 A.M. of Physician #492 revealed his first visit with Resident #156 was on 04/26/24. Physician #492 stated Resident #156 was admitted with sepsis, pneumonia, and he had a sacral pressure ulcer which was causing him a lot of pain. Physician #492 stated Resident #156's pain was stable pretty much his whole admission. Physician #492 stated his main objective was to control Resident #156's pain, and he was having dizziness as well. Physician #492 stated on 04/29/24 Resident #156's pain was uncontrolled, and he increased the Percocet from 5-325 mg to 10-650 mg. Physician #492 stated he did not have electronic access to write orders and wrote the orders for the Percocet increase on paper orders, and flagged Resident #156's chart and told a nurse he wrote orders. Physician #492 stated he did not remember which nurse he told, but the orders did not get taken off the chart and started. Interview on 06/24/24 at 12:04 P.M. with MD #494 revealed he did not remember details regarding Resident #156, but he remembered Resident #156 was in pain and he ordered Percocet. Review of the facility on hand medications located in the automated medication dispensing system revealed oxycodone-acetaminophen 5-325 mg tablets (Percocet) were available in the system. Review of the undated facility policy titled Pain Management and Assessment included to the extent possible and in consideration of cognitive abilities, the nurse would provide a thorough assessment by observation of activities and treatment, relief for detection of pain and to attempt to identify location and any limitations imposed by the pain. Clues might include facial grimaces during care, guarding or protecting a body limb or part. Additionally, the basis for the pain management included source, type, and intensity of pain, the use of the appropriate pain management scale for the resident's ability to express pain, to include non-pharmacological and pharmacological treatment and whether each treatment was effective. Impact of pain on quality of life including sleep loss, function abilities and mood. Use of the 1 to 10 pain scale for residents with intact cognition abilities who can and are willing to determine their worst pain ever (10) and no pain (1) range using numbers. This deficiency represents non-compliance investigated under Master Complaint Number OH00154408.

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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** 42013 Based on interview, record review, and review of the facility policy the facility failed to ensure Resident #156 received dialysis on his scheduled days per physician orders. This affected one resident (#156) out of three residents reviewed for dialysis. The facility census was 154. Findings include: Review of Resident #156's medical record revealed an admitted [DATE] with diagnoses including sepsis, pneumonia, type two diabetes mellitus with diabetic chronic kidney disease, and diabetic polyneuropathy. Resident #156 had dependence on renal dialysis. Resident #156 was discharged from the facility to another skilled nursing facility on 05/01/24. Review of Resident #156's After Visit Summary and Clinical Summary dated 04/06/24 through 04/21/24 included Resident #156 was admitted to the hospital with diabetic ketoacidosis without coma associated with other specified diabetes mellitus, end stage renal disease, Influenza A, pneumonia of both lungs due to infectious organism, unspecified part of lung, and bacteremia due to gram-negative bacteria. Resident #156 received hemodialysis at the hospital on 04/19/24. Further review of Resident #156's Clinical Summary did not reveal he had hemodialysis on 04/20/24 or 04/21/24. Review of Resident #156's progress notes dated 04/21/24 at 7:01 P.M. revealed Resident #156 arrived at the facility via stretcher from the local hospital and his daughter and sister-in-law were at the bedside. Licensed Practical Nurse (LPN) #379 stated she did not receive report on Resident #156. Review of Resident #156's progress notes dated 04/21/24 at 11:36 P.M. revealed Telehealth Notification notes including Resident #156 was a new admission, alert and oriented times three (person, place, time), and medications were reviewed with the nurse. Review of Resident #156's progress notes dated 04/21/24 at 11:46 P.M. included LPN #425 verified Resident #156's medications with Telehealth on call and okay to continue discharge orders, all orders were entered in the electronic system at this time. Review of Resident #156's physician orders dated 04/22/24 revealed Dialysis days were Monday, Wednesday, and Friday. Review of an email dated 04/22/24 at 11:27 A.M. written by Intake Coordinator (IC) #496 for the dialysis company revealed per our clinical team SNF (skilled nursing facility) says Resident #156 was dialyzed yesterday (04/21/24) then sent to the facility (so no treatment was required today). IC #496 was planning to begin him on Wednesday and then three treatments per week. Review of Resident #156's care plan dated 04/22/24 included Resident #156 was currently on hemodialysis therapy. Resident #156 would be free of signs and symptoms of complications from hemodialysis through the review date. Interventions included administering medications per medical provider's orders. On dialysis days, administer medications before, during, and after dialysis according to medical providers orders; communicate with dialysis center regarding medications; in-house dialysis Monday-Wednesday-Friday; coordinate residents care in collaboration with the dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #156's Dialysis Hand Off Communication Reports revealed on 04/22/24 there was no Dialysis Report completed. Interview on 06/20/24 at 5:23 P.M. of Unit Manager (UM) #386 revealed on 04/21/24 Resident #156 arrived at the facility around 7:00 P.M. When asked about Resident #156 not having a Dialysis Communication Form on 04/22/24, UM #386 indicated Resident #156's progress notes had a note that cefazolin (antibiotic) 2 grams intravenous (IV) was administered during dialysis on 04/22/24 and that was how it was known Resident #156 had dialysis. UM #386 stated as far as she knew, Resident #156 did not miss any dialysis days. Interview on 06/21/24 at 10:09 A.M. of Dialysis Nurse #495 revealed Resident #156 did not have dialysis on 04/22/24 because he was dialyzed on 04/21/24 at the hospital before he was admitted to the facility. Dialysis Nurse #495 stated communication with the facility nurses depended on the nurse and sometimes communication was good and sometimes things got missed. Interview on 06/21/24 at 10:24 A.M. of Certified Nurse Practitioner (CNP) #320 indicated she did not have notes revealing Resident #156 had dialysis on 04/21/24 before he was transported to the facility. Interview on 06/24/24 at 6:50 A.M. of LPN #433 revealed when Resident #156 was admitted to the facility on [DATE] it was a very busy and chaotic night, and she was the only nurse on the nursing unit that Resident #156 resided on. LPN #433 stated she did not remember many details about Resident #156, but remembered another nurse verified Resident #156's medications with the physician. LPN #433 indicated it was very time consuming to admit a resident, verify the orders and have all the paperwork and forms completed, and she often had to choose between finishing the admitting information or passing medications to the residents residing on the nursing unit she was assigned to. Interview on 06/24/24 at 9:15 A.M. of Director of Social Services (DSS) #485 revealed Resident #156's family filed a complaint about issues with dialysis, and Resident #156 was not properly approved for dialysis prior to being admitted to the facility. DSS #485 stated Resident #156 missed dialysis on Monday (04/22/24) because his insurance was not fully approved, and dialysis did not have a chair time for him. DSS #485 indicated the family was upset about this. DSS #485 revealed Resident #156's family wanted him transferred because of concerns regarding his care. Interview on 06/24/24 at 12:13 P.M. of Dialysis Nurse #495 revealed she called the hospital dialysis center and found out Resident #156 did not have dialysis on 04/20/24 or 04/21/24 and should have had dialysis on 04/22/24 and received his cefazolin 2 gram IV. Interview on 06/24/24 at 12:22 P.M. of Intake Coordinator (IC) #496 revealed she communicated with nursing homes and the dialysis center, and whatever information she received from nursing homes was passed to the clinical staff at the dialysis center. IC #496 stated she probably received an email from the facility stating Resident #156 had dialysis while he was in the hospital. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/24/24 at 4:20 P.M. of the Director of Nursing (DON) confirmed Resident #156 did not have dialysis on 04/22/24 as scheduled and ordered by the physician. The DON stated she spoke with IC #496 and was told IC #496 did not speak to a nurse at the facility about Resident #156's dialysis. IC #496 stated the dialysis nurse reported facility staff told her Resident #156 had dialysis on 04/21/24. The DON stated the dialysis nurse did not verify herself but took the word of the nurses that Resident #156 had dialysis on Sunday (04/21/24). Review of the updated facility policy titled Hemodialysis Care and Monitoring included it was the policy of the facility to provide resident centered care that met the psychosocial, physical, and emotional needs and concerns of the residents. Safety was a primary concern for our residents, staff and visitors. The facility would provide resident centered care to meet the resident's need for dialysis, provide a method for coordination and collaboration between the nursing home and the dialysis facility. This deficiency represents non-compliance investigated under Master Complaint Number OH00154408.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366008	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Pointe Healthcare Commu	Three Merit Dr Richmond Heights, OH 44143

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review, and review of the facility policy the facility failed to ensure Resident #156 received medications per physician orders. This affected one resident (#156) out of three residents reviewed for medication administration. The facility census was 154. Findings include: Review of Resident #156's medical record revealed an admitted [DATE] with diagnoses including sepsis, pneumonia, type two diabetes mellitus with diabetic chronic kidney disease and diabetic polyneuropathy. Resident #156 had dependence on renal dialysis. Resident #156 was discharged from the facility to another skilled nursing facility on 05/01/24. Review of Resident #156's After Visit Summary and Clinical Summary dated 04/06/24 through 04/21/24 included Resident #156 was admitted to the hospital with diabetic ketoacidosis without coma associated with other specified diabetes mellitus, end stage renal disease, Influenza A, pneumonia of both lungs due to infectious organism, unspecified part of lung, and bacteremia due to gram-negative bacteria. Resident #156's Medication List orders included: a. cefazolin (antibiotic) 3 g (gram) in sodium chloride 0.9 percent 100 milliliter (ml) IVPB (intravenous piggyback), infuse 3 g at 200 ml per hour over 30 minutes into a venous catheter one time per week for 26 days. Give every Friday during the last half hour of dialysis, end date 05/17/24. b. cefazolin in dextrose 5 percent, 2 gram per 100 ml solution, infuse 100 ml (2 g) at 200 ml per hour over 30 minutes into a venous catheter two times a week for 25 days. Give every Monday and Wednesday during the last half hour of dialysis, end date 05/17/24. c. insulin glargine 100 units per ml injection, inject 8 units under the skin once every 24 hours. Take as directed per insulin instructions. Start 04/21/24. Review of Resident #156's progress notes dated 04/21/24 at 7:01 P.M. revealed Resident #156 arrived at the facility via stretcher from the local hospital and his daughter and sister-in-law were at the bedside. Licensed Practical Nurse (LPN) #379 stated she did not receive report on Resident #156. Review of Resident #156's progress notes dated 04/21/24 at 11:36 P.M. revealed Telehealth Notification notes including Resident #156 was a new admission, alert and oriented times three (person, place, time) and medications were reviewed with the nurse. Review of Resident #156's progress notes dated 04/21/24 at 11:46 P.M. included LPN #425 verified Resident #156's medications with Telehealth on call and okay to continue discharge orders, all orders were entered in the electronic system at this time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #156's care plan dated 04/22/24 included Resident #156 was currently on hemodialysis therapy. Resident #156 would be free of signs and symptoms of complications from hemodialysis through the review date. Interventions included administering medications per medical provider's orders. On dialysis days, administer medications before, during, and after dialysis according to medical providers orders; communicate with dialysis center regarding medications; in-house dialysis Monday, Wednesday, and Friday; coordinate residents care in collaboration with the dialysis center. Resident #156 was currently on intravenous therapy due to IV (intravenous) ATB (antibiotic). Resident #156 would be free of signs and symptoms of infection at IV insertion site, through the review date. Interventions included administering IV medications, flushes per medical provider's orders. Observe for side effects and effectiveness. Resident #156 had an infection of sepsis, pneumonia. Resident #156 would be free of signs and symptoms of infection by the review date. Interventions included administering antibiotics and antimicrobials per medical provider's orders. Resident #156 had diabetes. Resident #156 would be free from signs and symptoms of hypoglycemia and hyperglycemia through the review date. Interventions included administering insulin injections per order, obtaining blood sugars per orders, and reporting abnormal findings to the medical provider, resident, resident representative. Review of Resident #156's physician orders dated 04/21/24 revealed insulin glargine subcutaneous solution 100 units per ml, inject 8 units subcutaneously at bedtime for DM (diabetes mellitus). Review of Resident #156's Delivery Manifest revealed IV cefazolin 2 gram per 100 ml normal saline was delivered to the facility on [DATE] at 6:39 P.M. Review of Resident #156's Medication Administration Record (MAR) and nursing progress notes dated 04/22/24 and 04/24/24 revealed IV (intravenous) cefazolin 2 GM (gram) per 100 ml normal saline, give every Monday and Wednesday during the last half hour of dialysis was documented it was given in dialysis. Review of Resident #156's Dialysis Hand Off Communication Reports revealed on 04/22/24 there was no Dialysis Report completed. Further review of the Dialysis Report dated 04/24/24 revealed the area for medications given during dialysis was not completed. Review of Resident #156's Pharmacy Delivery Manifest revealed IV cefazolin 3 gram per 100 ml normal saline was delivered to the facility on [DATE] at 6:46 P.M. Review of Resident #156's MAR dated 04/26/24 (Friday) revealed IV cefazolin 3 GM per 100 ml normal saline, give every Friday during last half hour of dialysis. Further review of the MAR revealed cefazolin 3 gram per 100 ml normal saline intravenous was not documented it was administered as ordered. Review of Resident #156's progress notes on 04/26/24 revealed no documentation regarding why Resident #156's cefazolin 3 gram intravenous was not administered as ordered. Review of Resident #156's Dialysis Hand Off Communication Report dated 04/26/24 revealed none was documented in the area for medications given during dialysis. Review of the facility on hand medications available in the automated medication dispensing system revealed insulin glargine 100 units per ml pen was available. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/20/24 at 11:42 A.M. of the Director of Nursing (DON) revealed when a resident was admitted to the facility orders should be verified with the physician. The DON stated orders should be verified as soon as possible because the sooner resident's medications were in the system the sooner pharmacy could send them. The DON indicated if a resident had a medication ordered and it was available in the on hand medications in the automated medication dispensing system the medication should be given, and the nurses should not wait until pharmacy delivered the medications. Interview on 06/20/24 at 5:23 P.M. of Unit Manager (UM) #386 revealed on 04/21/24 Resident #156 arrived at the facility around 7:00 P.M. and did not receive 8 units insulin glargine 100 units per ml which was ordered to be given at 9:00 P.M. UM #386 stated the telehealth provider was called, Resident #156's medications were verified at 11:46 P.M., and it was too late to give the insulin because it was past the due time of 9:00 P.M. and the orders defaulted to the next day. When asked about Resident #156 not having a Dialysis Communication Form on 04/22/24 UM #386 indicated Resident #156's progress notes had a note that cefazolin 2 gram IV was administered in dialysis on 04/22/24 and that was how it was known Resident #156 had dialysis. UM #386 stated as far as she knew Resident #156 did not miss any dialysis days. UM #386 stated she did not know why on 04/26/24 none was marked on Resident #156's Dialysis Communication Form, and the Dialysis Nurse would need to be asked that question. Interview on 06/21/24 at 9:24 A.M. of LPN #425 revealed she was the night shift supervisor and did not remember Resident #425 because her usual assignment was in the memory care unit. LPN #425 stated she put resident orders in the electronic system and called physicians to verify medications to help the nurses on the floor. LPN #425 stated the standard procedure was to call the telehealth Nurse Practitioner (NP) to verify resident medications, and she would absolutely document what the NP told her to do regarding insulin including whether to administer the insulin or to hold it. LPN #425 stated she verified Resident #156's orders when he was admitted to the facility, but she was not the nurse taking care of him and did not remember anything about his insulin being due on 04/21/24 at 9:00 P.M. Interview on 06/21/24 at 10:09 A.M. of Dialysis Nurse #495 revealed Resident #156 did not have dialysis on 04/22/24 because he was dialyzed on 04/21/24 at the hospital before he was admitted to the facility. Dialysis Nurse #495 stated because Resident #156 did not have dialysis on 04/22/24 cefazolin 2 gram IV was not administered in dialysis. Dialysis Nurse #495 stated cefazolin 3 gram IV was not administered on 04/26/24 because the nurse did not give it to her and did not tell her it needed to be administered in dialysis. Dialysis Nurse #495 stated she did not see resident orders and relied on the nurses to tell her if something was ordered and needed to be given to a resident. Dialysis Nurse #495 indicated on 04/24/24 she gave Resident #156 cefazolin 2 gram IV but forgot to document it on the Dialysis Communication Form. Dialysis Nurse #495 stated communication with the facility nurses depended on the nurse and sometimes communication was good and sometimes things got missed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/21/24 at 10:24 A.M. of Certified Nurse Practitioner (CNP) #320 revealed she did not know anything about Resident #156 not receiving insulin on 04/21/24. CNP #320 stated Resident #156 arrived at the facility between 6:30 P.M. and 7:00 P.M. and that was plenty of time to verify Resident #156's orders and administer his insulin. CNP #320 indicated the nurse could pull insulin glargine out of the automated medication dispensing system so Resident #156 could receive his bedtime dose. CNP #320 indicated she did not have notes revealing Resident #156 had dialysis on 04/21/24 before he was transported to the facility. CNP #320 stated she did not know anything about missed doses of cefazolin 2 gram and 3 gram IV, nothing was reported to her about missed doses of cefazolin. CNP #320 revealed some negative effects of not receiving antibiotics as ordered would be the infection would not resolve and the resident could get sicker. 06/24/24 at 6:50 A.M. of LPN #433 revealed when Resident #156 was admitted to the facility on [DATE] it was a very busy and chaotic night, and she was the only nurse on the nursing unit Resident #156 resided on. LPN #433 stated she did not remember many details about Resident #156, but remembered another nurse verified Resident #156's medications with the physician. LPN #433 stated she remembered Resident #156 told her he needed his insulin, she checked his blood sugar but did not remember what it was and did not remember if she documented the blood sugar. LPN #433 stated she did not call the physician regarding Resident #156's insulin and blood sugar. LPN #433 indicated it was very time consuming to admit a resident, verify the medications and have all the paperwork and forms completed, and she often had to choose between finishing the admitting information or passing medications to the residents residing on the nursing unit she was assigned to. Interview on 06/24/24 at 12:13 P.M. of Dialysis Nurse #495 revealed she called the hospital dialysis center and found out Resident #156 did not have dialysis on 04/20/24 or 04/21/24 and should have had dialysis on 04/22/24 and received his cefazolin 2 gram IV. Interview on 06/24/24 at 4:20 P.M. of the DON confirmed Resident #156's insulin and cefazolin 2 and 3 gram IV were not given as ordered. Review of the undated facility policy titled Medication Administration included administer medication only as prescribed by the provider. Observe the five rights when giving each medication, the right resident, the right time, the right medicine, the right dose and the right route. This deficiency represents non-compliance investigated under Master Complaint Number OH00154408.